

Factors Affecting the Uptake of Modern Contraception Services among Women of Reproductive Age in Nigeria

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Abstract

Contraception has proven to be an effective way of controlling fertility and spacing births. Studies have shown that contraception can avert high risk pregnancies and consequently reduce maternal deaths. Uptake of modern contraception is promoted as a mechanism to address the reproductive health needs of men and women, as well as the crucial challenge of rapid population increase. Therefore, this study was conducted to assess the factors affecting the uptake of modern contraception services among women of reproductive age in Oyo state, Nigeria.

A cross sectional descriptive study using a two stage systematic sampling technique was used to select 530 women of reproductive age in five wards using sample size based on proportion to size in 20,000 households. Respondents were interviewed using a semi structured questionnaire which included questions on socio-demographic characteristics, awareness, knowledge, factors affecting the usage of modern contraceptives and perception of contraceptive use. Knowledge was assessed on a 5 point scale in which score of ≤ 2 were rated poor while perception was scored on a 36 point-scale in which scores ≤ 18 rated low. Data were analysed using descriptive statistics, Chi-square test and logistic regression at p=0.05.

Age of respondents was 30.3 ± 7.8 years and 73.0% were married. Sixty percent were muslims and 34.5% had secondary education. Seventy two percent of the respondents were self-employed. About 90% had good knowledge of contraception while 60.8% had ever used contraceptives. The commonest source of information about contraception was mass media (72.8%). Twenty six percent obtained husbands' approval before using contraceptives while 20.0% had used modern contraceptives before first birth. Fifty percent of the respondents agreed that contraception helps in improving standard of living and 64.7% had good perception about contraception. Factors that hindered effective uptake of contraceptive services included poor service providers' attitude (33.3%) and congestion at the service centers (4.5%). Respondents with non-use of contraceptive before first birth were less likely to subsequently use contraceptives (OR = 0.324, 95%CI = 0.1-0.5). Husband's approval of contraceptives use was the major determinant of women's contraceptive use (OR = 3.4, 95%CI = 1.3-8.7). About 42.0% of the respondents had family planning centers not more than 5 kilometers walking distance to their residence. Twenty-one percent of those who had to take transportation to the service venues did not use contraception services.

Majority of the women in Ibadan North West were knowledgeable and aware of contraception services but husband's approval on the use of modern contraceptives remains poor. Programmes that enhance husbands' approval of modern contraception are thus recommended.

Keywords: Contraception uptake, Husband's approval, Service provider's attitude.

Introduction

Nigeria is the most populous country in sub-Saharan Africa, with the current estimate of 167 million people (NPC, 2012). In recent decades, fertility has declined only slightly from a Total Fertility Rate (TFR) of 6.3 births per woman in 1981–82, to 6.0 in 1990 and 5.7 in both 2003 and 2008, and a slight decrease to 5.5 in 2013 according to findings of the Nigeria Demographic and Health Surveys (NPC, 2013). Similarly, contraceptive use has increased slightly since 1990, 3.5% of currently married women ages 15–49 years were using a modern contraceptive method, compared with 8.2% in 2003 and 9.7% in 2008 (Federal Office of Statistics, 2009). For traditional methods, the increase was from 6.0% married women ages 15–49 years using contraception in 1990 to 12.6% in 2003, 14.6% in 2008 and



15% in 2013 (NPC, 2013). Approximately 42% of the country's population is under the age of 15 years and 55% are between the ages of 15 and 49 years. Nigeria's young age distribution is due in part to its high fertility as the average number of children born to a woman in Nigeria is 5.7. In Nigeria, having a large family is highly valued, thus decreasing the acceptance of modern contraception to space or limit births (MLE, 2010).

In 2008, it was estimated that 46% of Nigerians lived in an urban environment (MLE, 2010). Nigeria has at least 6 cities with over 1 million residents in 2006: Lagos, Kano, Ibadan, Kaduna, Port Harcourt and Benin city (NPC, 2006) and recently, the number of cities with over 1 million residents increased to 10 namely: Ibadan and Lagos in the South West, Kaduna and Kano in the North West, Abuja in the North Central, Maiduguri in the North East, Benin City and Port Harcourt in the South South, and Enugu and Owerri in the South East (MLE, 2013). In 2008, 66% of Nigeria's urban population was reported to be living in slums with little access to basic amenities Nigeria has some of the worst poverty and health statistics in Africa; 92% of the population lives on less than U.S.\$2 per day (Anyadike, 2012). In addition, Nigeria has one of the highest infant mortality rates (100 deaths per 1,000 live births) and an adjusted maternal mortality ratio of 800 per 100,000 live births. Nigeria has one of the fastest population growth rates in the world, 3.2% according to the 2006 Population and Housing Census. At this rate, it would only take only 22 years for Nigeria's population to double. The population increased from 88.5 million in 1991 to 140 million in 2006 and projected to 167 million in 2012 (NPC, 2006) Fertility and mortality patterns have also resulted in a young population structure, with children under age 15 accounting for more than two-fifths of the population (Federal office of statistics, Federal Republic of Nigeria Official Gazette, 2009).

Maternal mortality which incidentally is one of the biggest problems facing the developing areas of the continent, including Nigeria (Lindroos and Luukkainen, 2004). Maternal mortality is estimated to about 800 - 1100/100 000 in Nigeria and the population which is over 120 million, it translate to about 54 000 deaths every year. This is about only 10% of all maternal mortality cases in the world per year. Raphael (2008) corroborates the foregoing statistics as he asserts that Nigeria's maternal mortality rate is the second highest in the world, after India - 1,100 maternal deaths per 100,000 live births. The country is home to 2% of the global population, but 10% of all maternal deaths take place there. Only about 60% of pregnant women have access to prenatal care in Nigeria and 16% have access to family planning (NDHS, 2013). These scary statistics have been blamed on women's inability to access information on family planning and contraception, two issues very closely related to maternal death (Centre for Reproductive Rights, (CRR), Women Advocates Research and Documentation Centre, WARDC 2008).Clearly, the health benefits of family planning associated with child spacing and the use of specific methods can play a major role in protecting the lives of infants, children, women and the family as a whole on the continent of Africa.

However, Nigeria is the most populous country on the continent and among the ten most populated nations of the world. Its national population is about 120 million and has been projected to reach 250 million by the year 2015 (Population Reference Bureau, 2004 & NPC 2006). The large increase in size of the population is mostly a function of past and present levels of fertility and mortality in the country. In Nigeria, child spacing or the timing of every birth including the first and last can improve the likelihood of survival and of good physical and emotional health for the entire family at all stages of life.

Statement of the problem

Lindroos and Lukkainen (2004) contend that Nigeria is a country where modern family planning usage is one of the lowest in the world. This may be due to lack of useful information to those who really need the information as a majority of the Nigerian populace live in the rural areas where there is poor access to modern means of communication including the mass media. Family planning provides the society with some socio-economic and health benefits (Odaman, 2005). Awareness of such benefits can significantly enhance the use of contraceptives, which in turn, will reduce population growth and overtime have positive effects on national development. In this connection, Ugoji (2008) observes that family planning programmes strive to prevent unwanted pregnancies, help achieve birth spacing and help couples limit family size so as to reduce maternal/infant mortality. Oladeji (2008) explained that

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communication and decision making play a vital role in ensuring informed choice of family planning and reproductive health behaviour. Effective communication/ decision making allows people to seek what is best for their own health and to exercise their right to good quality health care (Rimal et al, 2002). In the same vein, it has been argued that the mass media, especially radio and television have been quite effective in creating family planning awareness in urban Nigeria. Perhaps, this is because the urban dwellers have greater access to the mass media. According to a survey of predominantly urban areas, about 90% of all urban house-holds have radios and about 60% own televisions in Nigeria (Information, Education and Communication, IEC, July 1996) and the likelihood that people living in urban areas would readily have access to family planning information as purveyed through radio and television media is high. But to make this level of family planning awareness effective among the generality of Nigerians, the mass media should have a hold in the rural areas where a larger number of the people live. The spread of television and radio, the rise of an independent press, and increasing literacy rates in many countries offer new opportunities for family planners and other health care organizations to inform the public and reach opinion leaders (Piotrow et al, 2004). Making the most of these opportunities requires skill in helping the news media cover family planning. While examining the knowledge and practice of family planning methods among the currently married adolescent women (CMAW) in India, Narsary (2009) observed that exposure to mass media and husband-wife communication play a significant role in family planning decisions.

Since 1972, the average family size in developing countries has dropped from about six or seven children per woman to about three children. This trend has saved millions of lives and provided additional benefits to women and children who when healthy can achieve greater levels of education and empowerment (PPF 2002). Despite the gain, contraceptive use is still low and needs high usage in some of the world's poorest and most populous places including Nigeria.

Despite all endeavours to reduce the number of birth through family planning in Nigeria, there are a lot of problems still emanating considering the population of Nigeria which was estimated at 167 million in 2013 (NDHS, 2013) It is, however, projected that there may be as many as 174 million heads in the country by the year 2020 and the repercussion of such growth in the nation's economic development and social services calls for great concern (Federal Ministry of Women Affairs, 2004). Oladeji (2008) states that African from time of their ancestors is known to bear many children. It was believed that having many children was a pride and a way of boosting one's ego and also providing enough labour and increasing the productivity on the farms. Another major problem hindering modern family planning in Nigeria is illiteracy. Majority of the married people in the rural areas of are illiterates and they are ignorant of the importance and necessity of the modern family planning programme and alternatively, they rather prefer to ask their children to stay or live with other family members who are financially capable than themselves. US Department of Agriculture Centre for Nutrition Policy and Promotion (2007) have pointed out various ways of controlling birth before the modern family planning came into existence and natural traditional method of family planning have been in use before the introduction of contraceptives. Family planning is a vital issue to investigate considering the rapid increase of Nigeria's population. The population of Nigeria today increases tremendously thus, posing problem of survival to the members of individual families.

Nigerian culture has respect for the human family. The size of the family in the Nigerian cultural setup is of importance to the community because of some of its advantages. For instance, the African tradition have much regard for lineage continuity; thus, women are married to procreate on behalf of the dead as barrenness is viewed as a curse. In spite of the importance of population growth to the society, cultural resistance to child-spacing has brought about numerous social problems like indiscriminate child bearing, unwanted pregnancies, high rate of infant and maternal deaths/ morbidity, drop-out from schools and the low standard of living which has been on the increase with poverty also contributing to the incidence where families continue to reproduce uncontrollably because of the belief that, it is a taboo to regulate fertility or determine the number of children one should have as procreation and provision are up to God; thus, the more children they have the more opportunity they might have in life, due to such children could be used as sources of labour such as scavenging, street hawking and begging as well as other practices which in itself constitute serious abuse of children's right. With the recognition and consideration of the consequences of population explosion, it is obvious that birth-

control remains the only acceptable and practicable option for the reduction of incessant population growth.

Despite the enormous benefits of family planning services, the uptake of the service still remains low in Nigeria. This has resulted into high rates of unwanted pregnancies, unplanned deliveries, unsafe abortions and maternal mortalities in Nigeria the low uptake of family planning is largely blamed on many factors.

Justification of the study

Despite these initial findings in recent studies, less is known regarding the full range of factors hindering the uptake of contraception services. However, there are still gaps on health provider's perspectives on enabling factors and barriers to contraceptive use. Program managers and policy makers in the delivery of contraception services will require more information on how to bridge the gap between the increasing need for effective contraception services and the current low utilization of Modern contraception services.

The results of this study are potentially useful as base line information for designing family planning programme, aimed at increasing uptake of modern contraceptive services in Nigeria with special reference to the study area. The results could also help to throw light on issues which needs to be taken into consideration while formulating policies relating to the modern contraception.

General objective

To determine the factors affecting the coverage and uptake of modern contraception services among women of reproductive age in urban areas in Oyo state.

Specific objectives

- 1. To assess the knowledge of family planning methods among women of reproductive age in urban areas in Ibadan.
- 2. To describe the pattern of uptake of contraceptive commodities and services among women of reproductive age.
- 3. To ascertain the factors affecting the uptake of modern contraception services among women of reproductive age in urban areas in Ibadan.

Research question

- 1. What is their level of knowledge of family planning methods?
- 2. What are the patterns of uptake of modern contraceptives associating women of reproductive age from using contraceptives?
- 3. What is their Perception towards the use of family planning methods?

Research hypothesis

- 1. There is no difference in the level of awareness of family planning methods and uptake of contraception services women of reproductive age.
- 2. There is no association between the uptake of family planning and socio demographical characteristics.
- 3. There is no association between the level of knowledge and uptake of family planning.

Methods

Study design: This was a descriptive cross sectional study design using interviewer-administered questionnaires and observational checklist.

Brief description of the study area: Ibadan North-West is a Local Government Area in Oyo State, Nigeria. The local government has its headquarters are at Dugbe/Onireke. Ibadan Southwest Local Government was carved out of the defunct Ibadan Municipal Government (IMG) on August 27, 1991 by the regime of former military President, retired General Ibrahim Babaginda. The federal Government created more local governments within the states to ensure equity among the nation, state and five out of Ibadan Municipal Government (IMG). It land mass extends to about 244.55km². This feature makes it one of the largest local government in the state. Ibadan. Ibadan Southwest Local Government is

approximately 150km from Lagos by the most direct route and 659km from Abuja, Federal Capital Territory (FCT). It is bounded by Ibadan North West and Ido local government in the North, by Oluyole Local Government in the South, by Ido Local Government in the West and by Ibadan North and South East Local Government in the East. The Local Government has a population figure of 283,098 according to the final results of 2006 census released by the National Population commission.

Study population: The study population consists of women of reproductive age between 15 -49 years including married adolescents and adults.

Inclusion criteria: Women of reproductive age between ages 15 - 49 years who gave informed consent and resides at the six randomly selected communities for at least one year.

Exclusion criteria: Women of reproductive age between 15- 49 years who are too ill to be interviewed or within the enumerated area were not considered. Women below 15 years of age as at this time of the study were not considered.

Sample size determination

 $N=\underline{DZ^{2}Pq}{d^{2}}$ Where N= sample size D= design effect = 2 Z= a constant at 95% precision = 1.96 d= desired precision at 5 % q = 1 - p (1 - 0.219 = 0.781) P = Contraceptive Prevalence Rate (CPR) in Oyo state = 21.9 (NDHS, 2008)Therefore, $N= \underbrace{2x1.96 \ x \ 1.96 \ x \ 21.9x \ 0.781}_{0.05x0.05}$

N= 526

Sampling technique: A Multistage sampling technique involving two stages were used to obtain representative participant in urban slum are of Ibadan North West local government area in Ibadan, Oyo state.

- **STAGE 1**: Five wards were randomly selected out of 11 wards in Ibadan North West Local Government Area in Ibadan, Oyo state.
- **STAGE 2**: Simple random sampling was used to select 530 women of reproductive age in the five selected wards in Ibadan North West Local Government Area in Ibadan, Oyo State.

The sample size assigned to each selected communities/wards was calculated based on the number of women of reproductive age (15- 49) in each community using proportionate sampling.

LGA's	No of wards in each LGA	No of Randomly selected wards	Names of communities and no of women of reproductive age	Sample size based on proportion to size (no of respondents in each community)
Ibadan North West	11	5	Beere/Ayeye	Beere/Ayeye
			556 Agbaje/Idikan 356 Oritamerin/ orieru 742 Opoyeosa/asukuna 356	93 Agbaje/Idikan 60 Oritamerin/ orieru 125 Opoyeosa/asukuna

Table 1.1. Showing sample size calculation for each community

Abebi	60
1,134	Abebi
Total	192
3,144	Total

Ethical considerations: Ethical clearance and approval was obtained from the Oyo State Ethical Review Committee and permission to enter the community was taken from the LGA and traditional head/community leaders.

Informed consent: Before the administration of the questionnaire, verbal informed consent was obtained from the interviewee.

Confidentiality of information: Confidentiality was ensured as no identifiers were included in the questionnaire. Interviews was conducted away from the hearing distance of other people while the collected data was stored in a secured place.

Results

Socio-demographic characteristics of the respondents

As shown in Table 1, 20.2% (n=107) of the respondents were 20-24 years age group, 19.6% (n=104) of respondents were 30-34 years, 19.4% (n=103) of respondents were 35-39 years of age, 19.2% (n=102) of respondents were 25-29 years of age, 11.1% (n=59) of respondents were 40-44 years age group, 7.7% (n=41) of respondents were 15-19 years age group and the lowest proportion of 2.6% (n=14) was noted among respondents aged 45-49 years. The total mean age of respondents (Table 2) was 30.29 ± 7.82 years. The study show that the predominant religion of respondent is Islam 59.8% (n=317) while the proportion of Christians is 39.6% (n=210) and the lowest proportion is traditional religion with 0.6% (n=3) Table 4.1 shows the summary statistics of respondents religion.

Most of the respondents were married 73.0% (n=387), Never married 20.4% (n=108), 5.1% (n=27) were either divorced or separated at the time of data collection and 1.5% (n=8) were reported to be widowed. Table 1 shows the summary statistics of respondent's religion.

As shown in table 4.1, 80.2 %(n=425) were mother at the time of data collection while 19.8% (n=105) were children still living with their parent in the household.

According to Table1, 48.7% (n=258) of respondents were Traders, 24.0% (n=127) were Artisans, 10.9% (n=58) were civil servants, 9.8% (n=52) were students, 5.1% (n=27) were unemployed at the time of data collection and the lowest proportion is 1.5% (n=8) were housewives.

Of the 530 respondents 34.5% (n=183) had secondary education, 34.5% primary education, 22.3% (n=118) had tertiary education, 7.5% (n=40) had no formal education and 1.1% or respondents had quaranic education. Table 1 shows the summary statistics of respondent's Educational Status

As show in table 1, 67% (n=355) of the respondents has been working or living in the selected area for three years and above, 22.3% (n=118) has been working for two years and above and the lowest proportion was 10.8% (n=57) has been working for more than one year and above.

As shown in Table 1, 28.9% (n=153) of the respondents were 25-29 age groups, 28.7 % (n=152) were 20-24 age group, 16.2% (n=86) were 15-19, 5.5% (n=29) were 35-39 years age group. The total mean age of respondents (Table 2) was 30.29 ± 7.82 years and mean age at marriage was 29.37 ± 112.45 .

	Variable	Frequency	Percent (%)
		(n)	
Age (years)	15-19	41	7.8
	20-24	107	20.2
	25-29	102	19.2
	30-34	104	19.6
	35-39	103	19.4
	40-44	59	11.1
	45-49	14	2.6
Age at marriage	15-19	86	20.4
6 6	20-24	152	36.1
	25-29	153	36.3
	30-34	29	6.9
	35-39	1	0.2
Religion	Christianity	210	39.6
6	Islam	217	59.8
	Never married	108	20.4
	Married	387	73
	Divorced	11	2.1
	Separated	16	3
	Widowed	8	1.5
Position in House	Mother	302	57
	Wife	123	23.2
	Daughter	105	19.8
	Unemployed	27	5.1
	Student	52	9.8
	Housewife	8	1.5
	Trading	258	48.7
	Artisan	127	24
	Civil Servants	58	10.9
	No formal		- • • •
Educational Status	education	40	7.5
	Ouaranic	6	1.1
	Primary	183	34.5
	Secondary	183	34.5
	Tertiary	118	22.3
	One year and		
How long working	above	57	10.8
iong working	Two years and	2.	
	above	118	22.3
	Three years		
	and above	355	67

Table 1. Socio-demographic characteristics of the respondents

Level of awareness of the respondents

According to table 3, 97% (n=516) of the participants in this study had heard about contraceptives, Majority 76% (n= 406) were aware of family planning methods which are used to space birth. The most common first source of information about contraceptives and family planning was through mass media 72% (n=386), while the internet was the least source of information 9% (n=51) among the participants of this study. Other sources are health workers/hospital, classroom, friends and relatives. 59% (n=151) of respondents knew about contraceptives while they were in the secondary school level of education while 35% (n=90) were aware at tertiary level of education and a very few knew about it at primary

school level 3% (n=15). Fifty one percent (n=274) had no formal education on contraceptives throughout their schooling years.

	Variable	Frequency	Percent (%)
		(n=530)	
Heard about			
contraceptives	Yes	516	97.4
	No	14	2.6
Aware of family			
planning	Yes	406	76.6
	No	124	23.4
Family planning methods	Yes	457	89.6
	No	55	10.4
Sources of information	Hospital/health worker	310	58.5
	Mass media	386	72.8
	Internet	51	9.6
	Friends/relatives	386	72.8
	Class room	102	19.2
Formal teaching on			
family planning			
throughout years of			
schooling		256	48.3
School Level where			
Family Planning were			
taught	Primary	15	2.8
	Secondary	151	59
	Tertiary	90	17

Table 3. Awareness of contraceptives and family planning

Knowledge of family planning methods

As shown in table 4, 43.8% (n=232) agreed that the ideal time to have a first child was between 25-29 years, 42.8% (n=227) believed that between 20-24 year is the ideal age to have a first child. 13.0% (n=69) of the respondents were of the opinion that the ideal age to have a first child is 15-19 years while the lowest 0.4% (n=2) believed that 30-34 is the ideal age group to have a first child.

Majority 52.5% (n=278) of the respondents agreed that the ideal age space between children is 2 years, 27.2% (n=144) believed that the ideal age space between children is between 3-5 years while minority 17.9% (n=95) and 2.1% (n=11) agreed that the ideal age space between children should be 1 year and 1 year and 6 months respectively.

Fifty one percent (n=270) did not have any education on sexual health and contraceptive methods before marriage while 49.1% (n=260) has education on sexual health and contraceptives before marriage. Most of the respondent in this study had good knowledge of the use of contraceptives 83.9% (n=429). Eleven percent (n=58) agreed that contraceptives are drugs used for abortion while 5.6% (n=29) believed that contraceptives are devices that destroys reproductive organs of women.

Variable	Frequency (n=530)	Percent (%)
Ideal time to have first child (years)		
15-19	69	13
20-24	227	42.8
25-29	232	43.8
30-34	2	0.4
1 year	11	2.1
1 year and half	95	17.9
2 years	278	52.5
3-5 years	144	27.2
Education about sexual		
health and contraceptive		
methods before Marriage		
Yes	260	49.1
No	270	50.9
What are contraceptives?		
Drugs used for abortion	58	11.2
Used to prevent pregnancy	429	83.9
Device that destroys	29	5.6
Women's reproductive organs		

Table 4. Respondents knowledge of family planning and modern contraceptive methods.

Factors affecting the uptake of modern contraceptives

According to table 5, 56.8% (n=259) planned their pregnancies before giving birth to their child. 43.6% (n=200) were not prepared for pregnancy before having their child. Majority 74.5% (n=395) had never requested for abortion of pregnancies while 25.5% (n=135) had requested for abortion due to non-use of modern contraceptives. Forty two percent (n=56) requested for abortion because they are not ready for pregnancies or pregnancy was not planned as at the time of requesting for abortion. Sixteen percent (n=22) had requested for abortion because they are too young to have a first child, 14.8% (n=20) of the respondents requested for abortion because of economic reasons, 12.6% (n=17) had complication during pregnancy, 10.4% (n=14) had little birth space between children while minority 3% (n=4) and 1.5% (n=2) of the respondents had requested for abortion because of social cause and career respectively.

Majority 72.2% (n=358) had barriers seeking for medical services on contraception while 27.8% (n=138) had no barrier seeking for contraception services. Myths and misconception 43.9% (n=202) was the major reason that stops respondents of this study from getting family planning advices or services. Twenty two percent (n=99) claimed that service provider's attitude are reason for not getting family planning services. Nineteen percent (n=85) agreed that societal norms and prejudice are factors that stops them from getting family planning advice and services while 16.1% (n=74) did not get contraception services because of long distance to health facilities.

Seventy five percent (n=132) did not use contraceptives due to fear of side effects, 17.6% (n=31) want to be pregnant. A small proportion did not use modern contraceptives because of their preference for traditional methods (0.9%) and singlehood (2.8%) while 1.7% (n=3) did not use modern contraception because of Gods instructions.

Variable	Frequency (n)	Percent (%)
Pregnancy was not planned	56	41.5
Complication during pregnancy	17	12.6
Too young to have first child	22	16.3
Little birth space between children	14	10.4
Economic reasons	20	14.8
Social cause	4	3
Career/Study	2	1.5
What stops you from getting family planning		
advices or services		
Long distance to facilities	74	16.1
Societal norms or prejudices	85	18.5
Myths and misconception	202	38.1
Service provider's attitude	99	18.7
Any barrier seeking for medical service		
Yes	138	27.8
No	358	72.2
Reasons for not using contraceptives		
I want to be pregnant	31	17.6
Fear of side effect	132	75.0
Prefer traditional method	5	0.9
Not yet married	5	2.8
Gods Instruction		

 Table 5. Factors affecting the usage of modern contraceptives

Barrier to use of contraception

As shown in table 6, some of the respondent in this study have had bad experiences using modern contraception methods. Some of the experiences include changes in menstrual patterns 58.9% (n=53), inability to get pregnant 17.8% (n=16), weight gain 7.8% (n=7), Prolonged heavy bleeding 7.8% (n=7), dizziness and headaches 7.8% (n=7).

Majority, 84.5% (n=332) had family planning centres close to their residence while a minority of 15.5% (n=61) did not have a family planning centre close to their house. A large proportion of respondents had family planning centres a walking distance 45.1% (n=30.9) from their residence, 41.8% (n=28.7) had family planning centres using a taxi or two taxi drops away from their residence while 13.2% (n=48) did not have centres close to their residence.

Seventy four percent (n=54) of the respondents significantly gained their husbands approval to use contraception while 26.1% (n=101) respondents did not have husbands approval for the use of contraception. 82.8% (n= 385) agreed that their religious believe did not act as a barrier to the use of contraception while 17.2% (n=80) believed that their religion would not allow them use contraceptive methods.

Variable	Frequency (n)	Percent (%)				
Bad experiences with contraceptive methods						
N=90						
Weight gain	7	7.8				
Inability to get pregnant	16	17.8				
Changes in menstrual patterns	53	58.9				
Prolonged heavy bleeding	7	7.8				
Dizziness and headaches	7	7.8				
Family planning service centre That is close to						
your house N=393						
Yes No	332 61	84.5 15.5				
How close is the nearest centre N=364						
Within walking distance	164	45.1				
A taxi drop or two taxi drops	152	41.8				
Outside your place of residence	48	13.2				
Spousal agreement to use contraceptives N=387						
Yes	286	73.9				
No	101	26.1				
Does religion act as a barrier N= 465 Yes	80	17.2				
No	385	82.8				

Table 6. Reasons for not using modern contraceptives

As shown in Fig 1, majority (71.5% n=397) of the respondents prefers health centre for contraception services, 14.3% (n=76) prefers a general practitioner, 4.0% (n=21) visits Patent Medicine Vendors (PMV's), traditional attendant 2% (n=11), pharmacy 1.7 % (n=9) and 6.4% (n=34) will prefer not to go anywhere for contraception services.





Current use of contraception

According to table 7, 72.8% (n=284) never used contraceptives before having their first child while 27.2% (n=106) used contraception before having their first child. 83.4% (n=166) are currently using contraceptive method and 16.6% (n=33) are not currently using contraceptives at the time of this study. The most common family planning methods currently used by respondents was condom 49.9% (n=153), Injectables 14.7% (n=46), calendar method 13.8% (n=11) Intra Uterine Device (IUD) 11.5% (n=36), oral pills 4.5% (n=14), withdrawal method 3.5% (n=11), Implants 2.2% (n=7) and exclusive breast feeding 0.6% (n=2).

Variable		Frequency (n)	Percent (%)				
Ever used any							
contraceptives							
before	Yes	106	27.2				
Having your							
first child	No	284	72.8				
Current use of							
contraceptives	Yes	166	83.4				
-	No	33	16.6				
Current methods							
of contraception							
Condom	153	49	Condom				
Oral			Oral				
contraceptive	14	4.5	contraceptive				
Intra Uterine			Intra Uterine				
Device	36	11.5	Device				
Injection	46	14.7	Injection				
Calendar							
method	43	13.8	Calendar method				
Withdrawal			Withdrawal				
method	11	3.5	method				
Exclusive breast			Exclusive breast				
feeding	2	0.6	feeding				
Implant	7	2.2	Implant				

Table 7. Respondents' current use of contraception

Socio-demographic characteristics and ever use contraceptives

From table 8 below, age of respondent statistically influence the uptake of contraception among respondents (P>0.05). Marital status (P=0.000), Position in household (P=0.000), occupation (P=0.039) and highest level of education (P=0.028) shows a significant statistical difference with respect to ever use contraceptives. However, religion do not significantly influence the use of contraceptives among respondents.

Factors affecting uptake of contraceptives and ever use contraceptives

As shown in table 9, association between ever requested for abortion, husband's attitude when discussed contraception, reasons for not getting family planning services, husband's approval to use contraception, religious believe acting as a barrier and ever use contraceptives is statistically significant.

Characteristics		Ever used contraceptives		N=530(%)	P-value
		Yes (%) N = 322	No (%) N=208		
Age	15-24 25-34 ≥35	47.1 65.4 66.2	52.7 34.6 33.3	100 100 100	0.0001
Religion	Christian ity Islam Tradition al	62.4 59.3 100	37.6 40.7 0	100 100 100	0.2941
Marital Status	Never Married Married Divorced Separate d Widowe d	34.3 70.3 54.5 31.3 25.0	65.7 29.7 45.5 68.8 75.0	100 100 100 100	0.0001
Position in househol d	Mother Wife Child	68.2 67.5 31.4	31.8 32.5 68.8	100 100 100	0.0001
Occupat ion	Unemplo yed Student Housewi fe Trading Artisan Civil servants	48.1 44.2 62.5 60.5 66.1 70.7	51.9 55.8 37.5 39.5 33.9 29.3	100 100 100 100 100 100	0.0391
Highest level of educatio n	None Quaranic Primary Secondar y Tertiary	82.5 33.3 57.4 59.6 61.9	17.5 66.7 42.6 40.4 38.1	100 100 100 100 100	0.0281

Table 8. Association between socio-demographic characteristics and ever used modern contraceptive methods

Variables		Ever used contraceptives		N=530(%)	P-value
		Yes (%) N = 322	No (%) N=208		
Ever done or	Yes	77.8	22.2	100	0.0001
requested for abortion	No	54.9	45.1	100	
Husband's	Embarrassed	80.0	20.0	100	0.0001
attitude when	Positive	80.1	19.9	100	
discus	Never discussed	37.0	63.0	100	
contraceptive					
Reasons for	Long distance	75.7	24.3	100	0.0111
not getting	Societal norms	57.6	42.4	100	
family	Myths and	54.5	44.6	100	
planning	misconception	66.7	33.3	100	
advices or	Service provider				
services	attitude				
How close	Walking distance	58.5	41.5	100	0.0001
family	A taxi or two taxi	78.9	21.1	100	
planning	drop	75.0	25.0	100	
centre	Outside your				
	residence				
Husbands	Yes	55.6	44.4	100	0.0021
approval to	No	73.3	26.7	100	
use					
contraceptives					
Religious	Yes	42.5	57.5	100	0.0001
believe act a s	No	64.9	35.1	100	
a barrier to					
use of					
contraceptives					

Table 9. Association between	perception and ever u	used modern con	traceptive method
	perception and ever a		daeoptive method

Logistics regression of demographic characteristics and ever used contraception

As shown in table 10, respondents who were married at the time of this study are two times less likely to use contraceptives (OR=0.462, 95%CI=0.230-0.927). Also, respondents who were mothers are less likely to use contraceptives (OR=0.565, 95%CI=0.571-2.795)

Husband's attitude when discussing modern contraceptives are six times more likely to influence the use of contraceptives (OR=6.506, 95%CI=2.314-18.291). Also, respondents who had never discussed modern contraceptives with their husbands are five times more likely to use modern contraception.

Variables	Odd Ratio	95%CI	p-value
Respondents			
marital status	0.462	0.230- 0.927	0.030
Married	1		
Divorced/separated/widowed			
Respondents			
position in household	0.565	0.571-2.795	0.840
Mother	0.687	0.505-2.818	0.565
Wife	1		
Daughter			
Husbands attitude when			
discussed contraception	6.506	2.314-18.291	0.000
Embarrassed/Avoid to discuss	5.069	3.307-7.767	0.000
Never discussed	1		
Positive			

Table 10. Logistic regression analysis of selected demographic factors and ever used contraceptives methods

Discussion

The findings suggest that although majority of the women were generally aware of modern contraception services in the selected communities but the usage was low. Major reasons cited for not using the services included husbands not giving approval for their wives to use modern contraception services, this argument is in line with the observation made by Allen et al. (2014) that husband's consent is a major constraint as women cannot take decisions for themselves without the approval of their husbands, who are regarded as the head of the family. Therefore it makes women more unlikely to use contraceptives if their husbands disagree. Another major reason that was reported were some perceived misconceptions about family planning services. Some of these misconceptions included respondents who did not go for family planning services because they perceived that it was meant for only married people while others perceived that contraceptives were harmful and can cause changes in menstrual patterns, prolonged heavy bleeding, dizziness and headaches, weight gain and inability to get pregnant. These findings were consistent with studies reported by Meka et al. (2013) in Nigeria and Gebremariam and Addissie (2014) in Ethiopia respectively. Another reasons for the non-use of contraception services was due to long distance to health facility, service providers poor attitude, fear of side effect were reasons why they did not significantly use the services.

These current findings have demonstrated that there is an appreciable level of awareness about modern contraception services through its educational campaign programmes and support from Non-governmental Organizations (NGOs). Hence, there is the need for the Federal Ministry of Health to revisit the methods currently adopted to deliver family planning messages most especially to dispel myths and misconception in the communities and the government to take full ownership of family planning program for sustainability even when there are reduced or no counterpart funding from donors. Family planning messages should be integrated into existing health education programmes as it could help increase awareness, access and utilisation of modern contraception services. Also, family planning educational messages should focus on the involvement of male partners in delivering the service as well as the benefits of family planning services as it will help reduce misconceptions about family planning services.

On the other hand, the high awareness of family planning services coupled with low usage of the service compares favourably with Hamid and Stephenson (2006) study in Pakistan which observed that despite the high awareness of family planning services in the community, very few people used the service. However, the high awareness of family planning services in Ibadan North West Local Government Areas of Oyo state may be attributed to social mobilization and clinical outreaches that exist through the activities of NGOs working in the communities which has made modern contraceptive services more accessible to the communities as well as empowering them to have greater control of their own health and building capacity of service providers to provide family planning services.

In this study, it was found that those who had to take transportation to health facilities did was positively associated with non-use of modern contraception services. This finding suggests that people who had family planning centers not more than five kilometre (5km) to their residence were more likely to go for family planning services than their counterparts who had to take transportation to service venues. This agrees with other studies that revealed that women who stay close to family planning centres use *modern* contraceptive services (Gaetano et al, 2014). Findings of this study are very useful as it can inform policy and decision making at the Nigeria health sector to help increase the family planning acceptor rate in oyo state and Nigeria as a whole. However, some weakness in the study design limits the generalisation of findings to entire population of Ibadan North West Local Government as participants were randomly selected from households rather than adopting the total sampling of women of reproductive age which may not be representative of the general population. However, we ensured that participants were recruited randomly from households to address any problem of selection bias. Also, husbands should be involved in further research to investigate their perceptions about usage of family planning services.

Conclusion

From the obtained result of this study, Majority of the women in Ibadan North West were knowledgeable and aware of contraception services but husband's approval on the use of modern contraceptives remains poor. Programmes that enhance husbands' approval of modern contraception are thus recommended.

An organized comprehensive family planning and sex education programme that is responsive to the need of women of reproductive age may become a necessity for these challenges to be overcome. Male involvement in contraceptive use will also play a fundamental role in of the uptake of contraceptive services.

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