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SOCIOECONOMIC FACTORS AFFECTING UTILIZATION OF FAMILY PLANNING SERVICES AMONG REPRODUCTIVE AGE WOMEN IN OWO, ONDO STATE

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ABSTRACT

The exponential growth rate of Nigeria population is a serious concern which must be checked in order to forestall population explosion from taking place in the country. The study therefore investigated the socioeconomic factors affecting utilization of family planning services among women of reproductive age in Owo local government area of Ondo state, Nigeria. It is a cross-sectional household survey which enlisted 401 women within the reproductive age (15-49 years) from four communities randomly selected from two wards of the eleven wards in the LGA. A structured questionnaire was used to obtain information from the respondents. Three levels of analyses (univariate, bivariate and multivariate) were carried out using descriptive statistics and logistic regression model. Considering the unadjusted model, maternal education, marital status, religion and cost of transportation to health centers were the significant predictors of contraceptive use. However, in the adjusted (multivariate) model only education significantly predicted the use of modern contraceptive. The study therefore concludes that a significant proportion of women with or without primary education were not using modern contraceptive, hence health information education is recommended for women in the LGA.

Keywords: Family planning, Contraceptive, Education, Unmet need, Health Belief Model

INTRODUCTION

Family planning (FP) refers to a conscious effort by a couple to limit the number of children they want to have through the use of contraceptive method (Nigeria Demographic and Health Survey, NDHS, 2013). The federal government of Nigeria, through the federal ministry of health (FMoH), is making all efforts at ensuring that there is remarkable increase in the use of contraceptive. In line with this, FMoH distributed contraceptives to states, and family planning and child spacing program in April, 2011. In spite of this effort, ability and willingness to pay for contraceptives have revealed that, to achieve the desired increase in contraceptive prevalence rate, cost barriers should be removed so that even the very poor can have unimpeded access to contraceptives (FMoH, 2013). Socio-economic factors have tremendous effect not only in deciding the utilization of family planning services among women of reproductive age (15-49 years) especially in developing economies but also whether to use any method at all (Undelikwo, Osonwa, Ushie, & Osonwa, 2013). Socio economic factors that can impact on utilization of family planning methods are overpopulation, poverty, corruption, education, religion, caste related violence, cost, partner involvement among others (Sumit, Badgaiyan & Sachin, 2016). Nigeria population was just about 45.2 million people at independence in 1960 and by 2015 it quadrupled to over 180 million people living within the country. It is expected that by 2050, Nigeria will be the third most populous country in the world with nearly 400 million people living in the country (World Health Organization, WHO, 2010). Therefore the main panacea for increasing population growth in Nigeria is utilization of

family planning services by women of reproductive age especially among the rural, less educated and low income families (Olaitan, 2011).

Globally, the utilization of modern contraception has risen somewhat, from 54% in 1990 to 57.4% in 2015, in Africa, it increased marginally from 23.6% to 28.5% (WHO, 2018). In Africa, 24.2% of women of reproductive age faced with an unmet need for modern family planning (WHO, 2018). Acceptance and utilization of family planning services and commodities remain abysmally low in sub-Sahara Africa (Tsuli, Brown, & Qingfeng, 2017). In spite of the huge amount of time, material, and human resources invested on it in the Sub-Region utilization of FP services is very low. For instance, the modern contraceptive prevalence rates in some sub- Sahara African countries such as Nigeria, Ghana, Uganda, Kenya and Ethiopia in 2013 were 15 %, 29.2%, 49.7%, 60% and 19.2% respectively (NDHS, 2013). An unmet need for family planning utilization is a probable issue of great concern. NDHS (2018) reports that 17% of married women age 15-49 use any method of family planning, 12% use modern method and 5% use traditional method. The use of FP has increased from 6% in 1990 to 17% in 2018. During the same period, modern method use increased from 4%in 1990 to 10% in 2008 and 2013 and then slightly increased to 12 % in 2018 (NDHS, 2018).

In Southwest, Ondo state has the lowest demand for FP (49.5%),with 29.4% unmet and 20.1% met need, unlike Legos, Ekiti, Osun, Oyo and Ogun states which have 65.9%, 56.7%, 55%, 53.2% and 49.8% demand for FP respectively (NDHS, 2018). Government also made efforts to meet the unmet need for family planning which led to the approval of distribution of free family planning supplies in public health facilities and an increased commitment by reproductive health programs (NDHS, 2013). One may wonder if these measures have achieved intended goal. Despite a high fertility rate of about 6 per women and a high population growth rate of 3.2 % Nigeria's contraceptive prevalence rate is 15% which is one of the lowest in the world (Tsuli et al.,2017).

Several studies have demonstrated that education, marital status, women's pay, and other demographic and socio-economic variables influence usage of family planning services (Alade, 2012., Anyanwu, Ezegle, & Eskay, 2013., Ekpenyoung, Nazute, Odejimi & Abdullaki, 2018., Olaitan, 2011., Omolase, Faturoti, & Omolase, 2009), the enormity of these factors have not been resolved for every definite area in the nation. Hence, the study investigated the factors that influenced utilization of FP among women of reproductive age in Owo local government area.

Theoretical Literature

The theoretical foundation for this study is the Health Belief Model (HBM). This was advanced in the 1950s by Social Psychologists to describe and predict health related behaviors, mainly regarding the uptake of health services (Uzobo & Abasiekong, 2019). The theory asserts that when people are faced with sickness, they are bound to take actions that will return them to good health again. This is heath behavior. Thus the HBM affirms that people's engagement in health behavior hinges on their belief about their health problems, perceived severity of the illness, perceived benefits of action and barriers to action as well as self efficacy (Uzobo & Abasiekong, 2019). A good example of the application of the HBM in this study is the use of modern contraceptive by women of reproductive age. A typical woman of reproductive age will use modern contraceptive if she perceives that using it will be effective and feasible in fertility control and prevent unwanted pregnancy, abortion and parenthood (perceived benefits), perceives unwanted pregnancy and other attendant problems such as having to stop schooling and other complications that may arise from abortion as threats to her health (perceived severity), believes she can be ill without using contraceptive (perceives

susceptibility). The model also believes that certain factors such as perceived side effects, weight gain or mood swing and cost of treatment etc. (perceived barriers) as well as age, sex, personality (modifying variables) may affect contraceptive utilization.

Hypotheses

1) All women of reproductive age that desire the use of FP have access and utilize FP in Owo local government area.
(2) No factor influences the utilization of FP services among women of reproductive age in Owo local government area.
(3) Only the women take decision regarding the use and non-use of FP services among couples in Owo local government area.

METHODS

A descriptive cross-sectional design was employed to determine factors affecting the utilization of family planning services among women of reproductive age (15-49 years) in Owo Local Government of Ondo State. The study was conducted in the rural communities of Owo local government where the dwellers were mostly low income earners. The local government which is located in the Northern senatorial district of Ondo state has about 222,262 inhabitants of which 110,206 are females (Nigeria census, 2006). Only women between ages 15-49 years were included in the study. It was aimed at eliciting information about demographic characteristics of participants, determining women of reproductive age who desire the use of FP but have access it, and to determine who takes decision about contraceptive use among couples in the local government area. 401 questionnaire were distributed, 384 (95.8 % response rate) respondents completed and returned same. Structured questionnaires were administered to participants by the researcher to collect information from respondents and the respondents willing completed the questionnaire after they were assured of the purpose and the confidentiality of the study. Aside from getting the consent of the respondents, ethical clearance was obtained from Federal Medical Centre, Owo. We used multi-stage sampling technique to select four communities randomly from two wards selected by means of simple balloting out of the eleven wards in the LGA. The four communities were, Emure, Ajegumo, Ipele and Ajagbale. Lastly, eligible participants were females of between ages 15-49 years who willingly participated.

The required sample size was 401. This was obtained by using the assumption used to estimate the sample size of single population proportion for prevalence studies (Kish, 1965). Thus,

$n= (Z_{1-\alpha})^2 (Ƥ (1-Ƥ) \div d^{2,}$ Where $Z_{1-\alpha}=Z_{0.95} = 1.96$ (For a normal distribution table for a CI 95%).

Ƥ = the proportion of targeted population estimated to have the characteristics (women of reproductive age 15-49 years) in Owo local government area. This is taken to be 46% because women within the reproductive age forms 46% of the total population of women in Owo local government area (Ondo State Department of Research and statistics Ministry of Economic, Planning and Budget, 2009)

ɗ =the absolute precision or degree of accuracy required is ±5%), ɗ = 5% = 0.05

n = sample size. Therefore, $n= (1.96)^2(0.46(1-0.46) \div 0.05^2)$

n = 3.8416× (0.46(0.54) ÷ 0.0025). n=382

Therefore, sample size for this study was 382. However, because of the likely attrition that might arise during questionnaire administration, 5% of 382 was added bringing the sample size to 401.

Data analysis

Descriptive statistics were used to determine the frequency distribution of the variables. This was done in order to present the background characteristics of the women in the sample. Bivariate analysis was employed to examine the relationships of the independent variables and contraceptive use while multivariate analysis was also undertaken to determine effect of more than one independent variables on contraceptive use. The study also estimated logistic regression to determine the variables that have effect on utilization of family planning services among women of reproductive age in Owo local government area. Data analysis was performed using Stata Version 12. Data collected from these participants were imputed into the computer using Stata software package, Version12 for data analysis.

Description of variables

The dependent variable is modern contraceptive use. It is coded '1' for respondents who reported they were using modern contraceptive and '0' otherwise. Drawing on the model of health service utilization and past studies on utilization of contraceptive, the following independent variables were considered: Monthly Income, Maternal Education, and Husband's Education, Employment status of respondents, Spousal attitude to contraceptive use, Religion, Availability of PHCS in communities of respondents, Time involved in walking to the nearest PHCS, Transport cost to health centers, Number of health talks attended, Mass Media exposure, Maternal Age and Marital status. Both maternal education and partner's education were categorized into no formal education, primary education, secondary education and higher education. Religion was categorized into Christianity, Catholic, Islam, African Traditional worshiper. Employment status was binary coded, 1 for working and 2 for not working. Income considered the following income brackets <10000, 10000-14,999, 15,000- 19,999 and ≥20,000. The transport cost refers to the amount of money respondents spent on movement to and from health center. There are four options: < 200, 200 – 499, 500 - 799 and ≥ 800. Exposure to media was binary coded, 2 for respondents who either listen to radio, watches TV and read news papers and 1 otherwise. Spousal attitude to contraceptive use is also binary and coded 2 for respondents who have spouse who supported contraceptive use and 1 otherwise. Availability of PHCS in communities was also binary and was coded 2 for residents who have PHCS in their resident's communities and 1 otherwise. Time involved in travelling to health center considers the minimum amount of time it will take the respondent to walk to the nearest center. There were three options < 30 minutes, 30 – 59 minutes and ≥ 60 minutes. Number of health talks attended is continuous and coded 1, 2, 3 and so on, depending on the number of talks the respondents had attended. Maternal age is continuous variable measured in current year of the respondents and marital status considered the following options married, cohabiting, divorced, widowed and separated.

RESULTS

Percentage distribution of the respondents

According to the table, teenage mothers constituted 15–19 (22.9%) while 77.1% were within the age group (20-49 years). A higher number of the women reported secondary educational qualification (46.6%). Majority of the women were not working (72.4%). While

72.7% (n=279) were married, the remaining numbers were among the marital status of widow, separated, divorced and single. Majority of the women belonged to other Christian religion (71.1%). While 265 (69%) earned less than ₦10, 000, roughly 12% (n-=44) earned between ₦ (20,000 –99,999). It is plausible that majority of the women earned less than ₦10, 000 because they have secondary education. Besides, most of them are only petty traders and farmers. Majority of the women pay less than ₦ 200 as fare to the nearest health center (87.2%). While 77.9% were in support of their wives using contraceptive 22.1% were not. From the analysis, (91.2%) of the respondents reported the availability of PHCS in their communities. Majority of the participants lived within 30 minutes' walk to the nearest primary health centers.

Table.1. Profile of Respondents

Variables		**Frequency**	**Percentage**
Age of Respondents	15 –19	88	22.9
	20 – 49	296	77.1
Maternal Education	No formal Education	20	5.2
	Primary	83	21.6
	Secondary	179	46.6
	Post-secondary Education	102	26.6
Employment Status	Working	86	22.4
	Not Working	298	72.4
Marital Status	Married/living together	278	72.4
	Widowed /separated/divorced	21	5.46
	Single	84	21.9
Religion	Catholic	19	4.9
	Other Christian	273	71.1
	Islam	92	23.9
Monthly Income	Less than ₦10,000	265	69.0
	10,000 – 14,999	41	10.7
	15,000 – 19,999	34	8.9
	20,000 – 99,999	44	11.5
Cost of Transportation to PHCS	< 200	334	81.2
	200 – 499	29	7.6
	500 – 799	08	2.1
	≥ 800	12	3.1
Spousal attitude to contraceptive	Support	299	77.9
	Non support	85	22.1
Availability of PHCS in communities	Yes	350	91.2
	No	34	8.9
Time involved in travelling to nearest PHCS	<30 min	289	75.3
	(30 – 59) min	70	18.2
	≥60	25	6.5

Source: Field Survey, 2020

Patterns of Contraceptive Use among Respondents

In table 2 below, we examined the contraceptive use among the study participants. As at the time of this study, 19.3% of the respondents reported they were using modern contraceptive while 40.2% reported they once used contraceptive, but they stopped. We also assessed the types of contraceptive used by the respondents and it was revealed that, the most commonly used method of contraceptives were injectable (26.2%), oral pills (24.6%) and

implant (14.8%). The percentage of participants who were using traditional method of FP was 21.4% with 9.8%, 8.2% and 3.3% using withdrawal method, safe period and breastfeeding respectively. Three of the contraceptive methods did not receive any responses. These are vasectomy, female sterilization, inter-uterine contraceptive device (IUCD).

Table 2: Patterns of Contraceptive Use among Study Participants

Variables		Frequency	Percentage
Current use of contraceptive/Family planning	Yes	74	19.3
	No	310	80.7
Once used contraceptive/ FP but stopped	Yes	122	31.8
	No	262	68.2
Method of contraceptive/FP	Male condom	10	8.2
	Female condom	02	1.6
	Oral Pills	30	24.6
	IUCD	0	0
	Implant	18	14.8
	Injectable	32	26.2
	BTL	04	3.3
	Breast feeding	04	3.3
	Safe Period	10	8.2
	Withdrawal	12	9.8
	Female sterilization	0	0
	Vasectomy	0	0

Source: Author's compilation, 2020

Use and Non - use of Contraceptive among Study Participants

In Table 3, we examined the proportion of respondents that used contraceptive and those who did not use, taking into consideration the various socio-demographic factors. It is shown that the use of modern contraceptive is more pronounced among participants within age 20 – 49 (68.6%), those who reported post-secondary education qualification (44.1%), Catholic Christians faith (52.6%), those who were divorced but still used contraceptive (62.5%) and participants who belonged to the income bracket, ₦ (20,000– 99,999)(40.9%). Furthermore, the use of modern contraceptive is higher among respondents who reported transport cost to the nearest facility as ₦(500 –799)(62.5%), respondents whose partners had primary school educational qualification (41.2%), those whose partners were in support that they should use modern contraceptive(32.1%) and those whose distance to the nearest health center is less than 30 minutes' walk(33.2%). In comparison with respondents living in communities without PHCS, those in communities with PHCS were more likely to use modern contraceptive (32.6% vs. 7.32%). Women who reported they attended health talks twice were more likely to use modern contraceptive (33.9%). Finally, higher proportion of women who reported media exposure utilized modern contraceptives (33.8%)

Table 3: Socioeconomic factors associated with family planning

Socio-demographic factors	Non- use (%)	Use (%)
Marital Age:		
15 – 19	58 (65.9)	30 (34.1)
20 – 49	203 (68.6)	93 (31.4)
Maternal Education:		
No formal education	16 (80)	04 (20)
Primary Education	65 (78.3)	18 (21.7)
Secondary Education	123 (68.7)	56 (31.3)
Post – secondary	57 (55.9)	45 (44.1)
Religion:		
Catholic	09 (47.4)	10 (52.6)
Other Christians	191(69.9)	82 (30.1)
Others	61(66.3)	31(33.7)
Marital Status:		
Married	192(68.8)	87(31.2)
Widow	06(60)	04(40)
Separated	02(66.7)	01(33.3)
Divorced	03(37.5)	05(62.5)
Single	58(69.0)	26(31.0)
Monthly Income:		
Less than ₦10, 000	182(68.9)	83(31.1)
10,000 – 14,999	30(73.2)	11(26.8)
15,000 – 19,999	23(67.6)	11(32.4)
20,000 – 99,999	26(59.1)	18(40.9)
Cost of Transportation to PHC:		
< 200	224(69.1)	110(32.9)
200 – 499	25(86.2)	04(13.8)
500 – 799	3(37.5)	05(62.5)
≥800	9(75)	05(25.0)
Partner's Education:		
No partner	75(70.8)	31(29.2)
No formal education	06(60)	04(40)
Primary education	20(58.8)	14(41.2)
Secondary education	81(65,9)	42(34.1)
Higher education	79(71.8)	31(28.2)
Spousal Support for Contraceptive use:		
Yes	203(67.9)	96(32.1)
No	58(68.2)	27(31.8)
Time Involved in Travelling to PHCS:		
< 30 min	193(66.8)	96(33.2)
30 – 59 min	52(74.3)	18(25.7)
≥ 1 hr	16(64.0)	09(36.0)
Availability of PHC in Community:		
Yes	236(67.4)	25(32.6)
No	114(92.7)	09(7.32)
Number of Health Talks:		
1	55(67.9)	26(32.1)
2	128(66.1)	65(33.9)
3	43(69.4)	19(30.6)
4	20(71.4)	08(28.6)
≥5	15(75.0)	05(25.0)
Media Exposure:		
No	216(68.4)	100(31.6)
Yes	45(66.2)	23(33.8)

Source: Field Survey, 2020

Unadjusted and adjusted analyses of use of contraceptive

In Table 4 calculated the unadjusted (bivariate) odds ratio using logistic regression analysis to consider the effect of one single predictor (independent) variable (for example, maternal education) on the dependent variable, which is family planning utilization proxy by contraceptive utilization. We also went further to calculate the adjusted (multivariate) odds ratio by adding other independent variables (respondent age, marital status, religion, etc) which took into account the effect due to the additional variables on the dependent variable.

For the unadjusted, maternal education, marital status, religion and cost of transportation to primary health centers were the significant predictors of contraceptive use. In reference to respondents who had no formal educational qualification, those with post-secondary education were approximately three times (AOR: 3.158, 95% CI: 0.987 10.107) significantly more likely to use modern contraceptive. The odds ratio increses as the educational level of women increases indicating that the likelihood of using contraceptives increases as the educational level increases. In reference to respondents who were married, the ones that were single (AOR: 1.103 95% CI: 0.099 – 12.332) were 10.3% significantly more likely to use contraceptive. In reference to Christianity, respondents that practiced Islam (AOR: 0.386 95% CI: 0.159 – 0.986) were 61.4% significantly less likely to use contraceptive. In response to those who require less than ₦200 to travel to the nearest health center, those who need ₦ (200 – 499) (AOR: 0.326, 95% CI; 0.76 – 14.461) were 61.4% significantly less likely to use contraceptive, while those who need ₦ (500 – 799) were 239.4% significantly more likely to use contraceptive. When the model was adjusted only maternal education was found to be a significant predictor of contraceptive use. Women who reported at least secondary educational qualifications (AOR: 3.091, CI: 0.933-10.234) reported threefold-increase in the odds for using modern contraceptive.

Table 4: Bivariate and Multivariate Analysis of use of Contraceptive

Variable	Unadjusted Odds Ratio (95% CI)	Adjusted Odds Ratio (95% CI)
Age of Respondents:		
15 – 19(ref)	1.0	
20 – 49	0.886(0.535-1.467)	-
Maternal Education:		
No formal education(ref)	1.0	1.0
Primary education	1.108(0.329 – 3.728)	0.831(0.237 – 2.906)
Secondary education	1.821(0.582 – 5.696)	1.456(0.450 – 4.706)
Post – secondary Education	3.158(0.987 – 10.107) ***	3.091(0.933 – 10.236)
Employment Status:		
Working(ref)	1.0	
Not working	1.262(0.762 – 2.089)	-
Marital Status:		
Married(ref)	1.0	1.0
Single	1.103 (0.099 – 12.332)***	2.341 (0.185 – 29.681)
Separated	3.678 (0.859 – 15. 737)	3.586 (0.766 – 16.778)
Widowed	0.989 (0.584 – 1.676)	1.100 (0.629 – 1.922)
Religion:		
Christianity(ref)	1.0	1.0
Islam	0.386 (0.151 – 0.986)***	0.328 (0.114 – 0.938)
Pagan	0.457 (0.168 -1.242)	0.400 (0.133 – 1.213)
Monthly Income:		
Less than ₦10,000(ref)	1.0	
10,000 – 14,999	0.804 (0.384 – 1.682)	-
15,000 – 19,999	1.048 (0.489 – 2.251)	-
20,000 – 99,999	1.518 (0.789 – 2.921)	-
Spousal Support for Contraceptive:		
Support(ref)		
No support	1.0	-
	0.984 (0.581 – 1.651)	-
Time Involved in Travelling to the Nearest PHC:		
< 30 mins(ref)	1.0	-
30 – 59	0.696 (0.386 – 1.254)	-
≥60	1.131 (0.482 – 2.653)	-
Number of Health Talks:		
1x(ref)	1.0	-
2x	1.083 (0.622 – 1.884)	-
3x	0.935 (0.458 – 1.908)	-
4x	0.846 (0.329 – 2.173)	-
≥5x	0.705 (0.231 – 2.149)	-
Media Exposure:		
Yes(ref)	1.0	-
No	1.104 (0.633 – 1.924)	-
Partner's Education:		
No partner(ref)	1.612 (0.425 – 6.114	-
No formal education	1.694 (0.760 – 3.773)	-
Primary education	1.254 (0.716 – 2.197)	-
Higher education	0.949 (0.526 – 1.712)	-
Availability of PHC:		
Yes(ref)	1.0	-
No	0.745 (0.337 – 1.649)	-
Cost of Transportation to PHC:		
<₦200(ref)		
200 499	1.0	1.0
500 – 799	0.326 (0.111 – 0.959)***	0.295 (0.097 – 0.902)
≥ 800	3.394 (0.767 – 14. 461)***	4.141 (0.930 – 18. 429)
	0.679 (0.180 – 2. 557)	0.665 (0.165 – 2.680)

*p<0.01 **p<0.05 ***p<0.10.ref: reference category.

Source: Field Survey, 2020

DISCUSSION OF THE FINDINGS

The introduction of modern family planning methods during the recent decades and with increasing availability of effective techniques used in preventing unwanted pregnancy, have granted people the privilege to exercise their decision, prevent unwanted pregnancy, make responsible choices with respect to their reproduction and enjoy the dividend of family planning(Gazali et al., 2001). Currently, worldwide, it is estimated that only 60% of women use modern contraceptive method and in developing countries over 53% of couples are using some form of contraceptive (Huezo,1998). In this study, evidence shows that only 19.3% of women are using modern contraceptive. A good number of the participants had knowledge of at least one place where to obtain information on family planning and one place where to access it. 91.2% of the respondents live in communities with PHCS and 95.3% reported that PHC in their communities offer family planning services, hence availability and accessibility were not barriers to the utilization of modern contraceptive among study group.

The study examined the various barriers to modern contraceptive use. Approximately 40% of the respondents reported side effects as the major reason why they gave up on the use of modern contraceptive. Decisions to use contraceptives was influenced by the side effects of the methods, dislike of existing methods, inconveniencies associated with the usage and the desire to have more children. Side effect is the most cited reasons for discontinuation or reluctance to use modern contraceptive.

Furthermore, the desire to space children and avoid unplanned pregnancy were the two major reasons given by some women who were using modern contraceptive. These set of practitioners have changed their attitude and they are now aware of the benefits the use modern contraceptive has on their personal health, the health of their children and the overall quality of life of their families (UNICEF, 2005). It can be deduced from the findings of the study that women are likely to desire few number of offspring in order to stay healthy, free up more time for participation in economic activities and more time to look after their children.

The present study revealed a statistically significant relationship between maternal education and attitude towards the use of modern contraceptive. Women who reported high educational qualification were almost three times likely to adopt modern contraceptive. Several other studies reported that education and decision making are reliable predictors of modern contraceptive use (Alade, 2012; Bandura, 2002; Beekle, 2006). It has been argued that educated women are often incorporated into family planning programmes and counselling via various communication links including mass media. Education may result in increased acceptance and utilization of family planning in rural part of Nigeria.
A study by UNICEF (2005) revealed that 96% of women with secondary and high educational qualifications and 47% of those without any form of formal education sought family planning services in the last two years before the survey. A large number of couples take FP decision together. The respondents opined that many men consented to non-use of FP services when it is discussed because of the fear that the health of their wives might be affected due to the perceived negative effects of FP. Other women argued that since the responsibility for the care of the family falls upon the couple, it is only reasonable to take the decision together. Women who take the decision alone believe that it is the women who are saddled with the responsibility of taking care of the children, suffer during pregnancy and labour. Women whose husbands insist on non-use decision alone probably do so for the fear of promiscuity on the part of the women

CONCLUSION AND RECOMMENDATION

The study concludes that a significant proportion of the participants were not using modern contraceptive. The attitude towards modern contraceptive is poor and unimpressive. Fear of side effects of contraception and women wanting more children are significant reasons for poor practice, socio-demographic factor like education was found to influence the use of contraceptive methods among respondents.

In addition, the adoption of FP by women depends on many factors and commonly factors given by respondents are avoiding unwanted pregnancy or spacing of children and the side effects of the methods. Women who wanted more children or were unable to tolerate the side effects of the method would not practice family planning. Side effects were the biggest concern for non-users. In all, everyone involved in the formulation and implementation of family planning policy programmes should begin to intensify awareness campaigns on specific methods of contraception and how to handle or manage likely side effects and improve private, public and individual attitudes towards utilization of family planning services provision to improve uptake and reproductive health outcomes.

Since the study reveals that maternal education significantly and positively influence the uptake of modern contraceptive, we therefore recommend for the expansion of educational opportunities for women especially for primary and secondary education. This can be achieved by making enrolment compulsory for females and setting preferential cut-off marks for them. Free tuition fee should be implemented for female children in order to encourage female educational enrolment rate.

Also, within the context of this study, women who refrained from using modern contraceptives reported side effects as one of the reasons why they don't use. Therefore, there is need for reproductive health information to reduce knowledge gap about contraception. This can be achieved with the use of radio, television, social media platforms and health workers. Thirdly, about 68% of religious followers (Christians and Muslims) did not use contraceptives in this study. Therefore, adequate Counselling should evolve in religious organizations and communities to spread the knowledge and importance of family planning.

Community leaders should dampen the negative habit of not having family planning choice in their cultural norms since people's cultural and social environment influence decisions on family planning utilization.

REFERENCE

Alade, F., A. (2012). Determinants of family planning among married people in Lagos State. *Arabian Journal of Business and Management Review 2*(5), 101-125.

Anyanwu, J. I., Ezegbe, B.N., & Eskay, M. (2013). Family planning in Nigeria: A myth or reality? Implications for education. *Journal of Education and Practice*, *4 (*15), 201-358.

Badura, A. (2002). Environmental sustainability by Socio – cognitive deceleferation of population growth in the psychology of sustainable development, Pp.209 -238

Beekle, A., & Mccabe, C. (2006). Awareness and determinants of family planning practice in Jumma, Ethiopia. *Journal of International Council of Nurses*, 53, 269 -276.

Ekpenyong, M.S., Nzute, A.I., Odejimi, O., & Abdullahi, A.D. (2018). Factor influencing family planning services and female of reproductive age (15-45 years) in Bauci local government area, Bauchi State. *Nursing and Palliative Care, 3*(2), 1-6. Doi:10.15761/NPC.1000180.

Federal Ministry of Health, Nigeria (2013). *National reproductive health working group meeting report*. Abuja, Nigeria: Federal Ministry of Health.

Kish, L. (1965). Sampling organizations and group of unequal sizes. *America Sociological Review, 30* (4), 564-572.

National Population Commission (Nigeria) & ICF International (2014). *Nigeria demographic and health survey 2013*. Abuja, Nigeria, and Rockville, Maryland, USA: National Population Commission and ICF International.

National Population Commission (Nigeria) & ICF International (2019). *Nigeria demographic and health survey 2018.* Abuja, Nigeria, and Rockville, Maryland, USA: National Population Commision and ICF International.

National Population Commission (NPC), *2006 Population Census of the Federal Republic of Nigeria (*Abuja, Nigeria: NPC, 2007):5.

Olaitan, O.L. (2011) Factors influencing the choice of family planning among couples in Southwest Nigeria. *International Journal of Medicine and Medical Sciences,* 3(7), 227-232.

Omolase C.O., Faturoti, S.O.,& Omolase B.O. (2009). Aawareness of Family Planning amongst Antenatal Patients in a Nigerian community: An Exploratory Study. *Annals of Ibadan Postgraduate Medicine. 7*(1), 107-124.

Ondo State Department of Research and statistics Ministry of Economic, Planning and Budget. (2009). *Demographic and Vital Statistics for Ondo State*.

Sumit, D, Badgaiyan, Y. D., & Sachin, P. (2016) A study of economic factors affecting family planning services in an urban area. *Internaltional Journal of Scientific Research*. *l5* {6), 618-620

Tsuli, A.O., Brown, W., & Qingfeng, L. (2017) Contraceptive practice in Sub-Saharan Africa. *Population Dev Rev*. *43*(1), 166-191. Doi:10.1111/padr.12051.

Undelikwo, V.A., Osonwa, O. K., Ushie, M. A., & Osonwa (2013). Family Planning Behaviours and Decision –Making among Couples in Cross River State, Nigeria. *International Journal on Learning and Development, 3*(1). 00-120.

UNICEF (2005). Analysis of the situation of children and women in Nigeria Lagos and New York, UNICEF

Uzobo, E., & Abasiekong, M.E. (2019). Determinants, types and patterns of complementary and alternative medicine use among pregnant women in the South-South Region of Nigeria. *International Journal of Pregnancy & Child Birth. 5*(1), 36-43.

World Health Organization (2010). The optimal duration of exclusive breast feeding available at : www.who.int/inf-pr-2001/er/note2010-07.html. Accessd September, 24th, 2019