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FACTORS MILITATING AGAINST FAMILY PLANNING AMONG WOMEN IN RURAL COMMUNITIES IN KADUNA STATE, NIGERIA

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ABSTRACT

Background: High fertility rate and inadequate spacing between births, can lead to high maternal and infant mortality. An estimated 600 000 maternal deaths occur worldwide each year; the vast majority of these take place in developing countries. WHO estimates that 13% of these deaths are due to unsafe abortion. Family planning is an important strategy in promoting maternal and child health. It improves health through adequate spacing of birth, avoiding pregnancy at high-risk maternal age and high parity. It is often used as a synonym for birth control, however. It does have a wider view, dealing with birth control, reproductive health, as well as premarital and pre conception counseling. There is relatively high fertility rate in suburban and rural Nigeria despite the efforts of government and other non-governmental family planning services providers. Even though the fertility rate is high, acceptance and utilization of modern family planning methods has been low due to various reasons. The objective of this study aims to determine the factors militating against family planning amongst women in rural communities in Kaduna state, Nigeria.

Method: It is a descriptive cross-sectional survey, conducted among 364 women of childbearing age (15 to 49 years), utilizing the multi- stage sampling technique.

Result: (37%) of the respondents were within the age group 15 to 24 years, all respondents were married (100%) and 135 (37%) had more than 5 children. About half of the respondents (48.7%) had no formal education.

Conclusion: Few were currently using a contraceptive method, however, the majority whom were not using any method had main reasons being



lack of appropriate knowledge on family planning, fear of side effects and availability. The most significant socio-demographic determinants of utilization of family planning services were religion (p-value 0.01), family setting (p-value <0.001), age (p-value 0.01) and male involvement (p-value <0.001). The utilization of family planning services among the rural women was poor, with religion, fear of side effect and husbands' disapproval among other reasons being the main reasons for non-use.

KEYWORDS: Family Planning, Militating, Communities, Rural, Birth, Reproduction

INTRODUCTION

Family planning is one of the most important components of reproductive health. As defined by the WHO, family planning is the ability of a couple to anticipate and attain their desired number of offspring with proper spacing and timing between their births. This can be achieved via taking proper precautions and birth control methods. It improves both maternal and child health, reduces the prevalence of unwanted pregnancy and unsafe abortions, prevent sexual transmitted infection and enhances economic wellbeing of families. In fact, family planning also promotes women's sense of autonomy and the ability to make health decisions.

Family planning refers to the use of modern contraception and other methods of birth control to regulate the number, timing, and spacing of human births. It allows parents, particularly mothers, to plan their lives without being overly subject to sexual and social imperatives.

As a result, the United Nations has prioritized it to increase and sustain the utilization of family planning because of its importance in the attainment of sustainable development goals. In particular, emphasis has been put on universal access to a full range of safe and reliable family planning methods to help couples realize their right to freely and responsibly decide the number and spacing

of their children. Family planning is an arena of contestation within broader social and political conflicts involving religious and cultural injunctions, patriarchal subordination of women, social-class formation, and global political and economic relations. Worldwide, nearly 100 million married women would prefer to avoid pregnancy but are not using any method of family planning, which means that they have an unmet need for family planning (Robey, et al., 1996). There is a discrepancy between their fertility goals and contraceptive practice (West off and Bankole, 1998).

Attempts to control human reproduction is not entirely a modern phenomenon. Throughout history, human beings have engaged in both pro-and antenatalist practices directed at enhancing social welfare. In many foraging and agricultural societies, a variety of methods such as prolonged breast-feeding was used to space births and maintain an equilibrium.

Family planning has been identified as a key intervention that not only contributes to reducing maternal, infant, and child mortality, but can also ensure states attain their demographic dividends. This means that in addition to reducing unintended pregnancies and ensuring healthy spacing between births, families that use contraception are likely to have healthier families. Also, young people are provided



with the opportunity to stay in school longer, have a clear life purpose and be able to achieve their dreams.

Family planning is an important preventive measure against maternal and child morbidity and mortality. It is an essential component of primary health care and reproductive health. It plays a major role in reducing maternal and neonatal morbidity and mortality. It confers important health and development benefits to individuals, families and communities and the nation at large. It helps women to prevent unwanted pregnancies and limit the number of children, thereby enhance reproductive health. By this, it contributes towards achievement of Millennium Development Goals (MDGs) and the Target of the Health for all Policy.

In general, child spacing provides greater opportunities for nurturing the individual child thereby providing the possibility of preventing complications such as gastrointestinal infections and malnutrition during infancy and early childhood. Family planning may also improve the quality of life and raise the standard of living by decreasing the number of dependents requiring intensive personal care, education, food, shelter, and clothing, among others. Nevertheless, where family planning services may be available, its use may be limited due to a number of factors such as low literacy levels, socio-cultural beliefs favoring large families, and unavailability in Nigeria, there is high rate of maternal mortality due to birth to pregnancy intervals of less than 18 months are associated with risk of low birth weight, preterm birth, small size for gestational age, and stillbirth eventually. Moreover, legally, politically and culturally access to abortion create internal dispute, therefore effective contraceptive programming should be the current and future approach to reduce the risk and

unwanted pregnancies which lead to abortion.

Contraceptive options not all of which are available in many developing countries; include a variety of hormonal regimens and modes of delivery for women (e.g., pills, injectable, implants, patches, vaginal rings, medicated intrauterine devices) as well as improved male and female condoms, spermicides, cervical caps and other vaginal barriers, post-coital (emergency) contraception, improved fertility awareness-based methods, and simpler and more effective surgical techniques for tubal ligations and vasectomies.

According to the World Health Organization almost 60% of women of child bearing age using family planning globally. Even though evidence shows a global increase in the use of family planning, especially in Asia (62%) and Latin America (67%), Sub-Saharan Africa; Nigeria inclusive, paints a different picture as there is average of less than 20% month use of family planning. Furthermore, less than 30% of women of childbearing age in Sub-Saharan Africa are using family planning with more than 200 million women wishing to prevent unwanted pregnancies yet not using these services. Both of these situations reflect, to variable degrees, program- and method-related inadequacies, including contraceptive failures due to a variety of reasons, as well as personal and situational factors such as partner's opposition or women's experiences or fears of side-effects that need to be addressed.

Before the current dramatic increase of about 10.2 percentage point in contraceptive prevalence rate (CPR), Kaduna State had recorded low CPR in the preceding two decades; and a preference for large family size, natural family planning methods and an aversion for



modern contraceptive methods (NPC & ICF Intl., 2014). Family planning offered by the public sector did not fulfill the demand for contraception, particularly among the urban poor, and rural dwellers. In the private sector, cost was a major constraint, Nigerian Urban Reproductive Health Initiative (NURHI, 2010:2015; MLE, 2013). It is therefore important to understand factors influencing the current rise in the CPR and influence of role in reproductive health decision.

Few published data exist concerning use of family planning services in Nigeria, especially northern part where we have recently observed high maternal morbidity and mortality. Thus, this study would show the factors militating against family planning and the level of awareness of family planning and lack of exposure to the use of family planning methods among women of child bearing age in Kaduna State.

Kaduna State, located in the North Western geopolitical zone in Nigeria has a population of 6.11 million and an annual population growth rate of 2.47 percent. The population of the state is young and growing, with 44 percent of the population under the age of 15, and about 5 percent of the population (1.44 million) are women in the reproductive age group (14 to 49 years) (NDHS, 2013). This means that the state is burdened with the challenge of providing for a growing population during a period of limited resources, while also ensuring that its citizenry enjoy quality health, education, employment, etc.

The goal of the activity was to help reinforce family planning activities in Kaduna through identifying opportunities and gaps and developing a consensus plan to apply corrective measures in the country, particularly in the Borgou/Alibori and Ouémé/Plateau regions, in the context of USAID support.

RESEARCH METHOD

Study setting: Kachia (Adara: Akhwee) is a Local Government Area in the southern part of Kaduna State, Nigeria. Its headquarters are in the town of Kachia. It has area of 4,570 km² and a population of 252,568 in the 2006 census. Most of the people of Kachia include the Adara, Tinor-Myamya, Gbaya, Ham. Others include the Bajju, Bakulu and the Hausa. Kachai town is also one of the Largest towns in southern Kaduna state where various small and medium scale business contribute to the economy of the state and country at large. Sabon Gari Local Government is a local government area in Kaduna State, Nigeria. It is one of the local government areas in the Zaria metropolis as well as being one of the districts of the Zazzu Emirate Council. The towns and villages are Dogarawa, Bomo, Basawa, Zabi, Samaru, Kwari, Barashi, Muchiya and Palladan. Chikun is a Local Government Area in central Kaduna state, Nigeria. It has an area of 4,466 km², and had a population of 372,272 as at the 2006 census. Its headquarters is in the town of Kujama. Chikun Local Government Area derives its name from a Gbagyi village named Chikun in the southeastern part of Kujama. The area was originally populated by the Gbagyi people but is now being subsumed by urbanization making it a cosmopolitan part of Kaduna. Chikun Local Government Area according to March 21, 2006 national population census was put at 372,272. Its population was projected by the National Population Commission of Nigeria and National Bureau of Statistics to be 502,500 by March 2016.

Study design: This study is a community based cross-sectional household study that was conducted to investigate use and



factors associated with utilization of family planning services in Chikun, Sabon gari, Kachia communities, Kaduna state.

Study population: The study population comprised of all married women of child-bearing age (15-49 years) residing in Chikun, Sabon gari, Kachia communities Kaduna state. The inclusion criteria encompassed; married woman at the time of the study, women of childbearing age (15-49 years) and women residing in Chikun, Sabon gari, Kachia communities, Kaduna state for at least one year. The exclusion criteria encompassed; women with coexisting premorbid condition such as cancer, HIV etc.

Sample size determination: minimum sample size for the respondents was determined using the formula for descriptive health studies;

$$n = (z\alpha + z\beta)^2 pq / d^2$$

$z\alpha$ = confidence level

$z\beta$ = power of the study (80%)

p = prevalence of contraceptive use in North-West Nigeria (4%) obtained from National

Demographic and Health Survey (NDHS)

2013 $q = 1 - p$

d = desired level of precision (5%)

Adjusting for non-response (NRR) - set at 10% $n = (z\alpha + z\beta)^2 pq / d^2$

$$n = (3.8421 + 0.8)^2 (0.04) (0.96) / 0.05^2$$
$$n = (21.55) (0.0384) / 0.0025$$
$$n = 0.82752 / 0.0025$$
$$n = 331$$

With non-response rate of 10%, $n = 364$

Therefore, the minimum sample size at 95% confidence interval and precision level of 0.05 is 364.

Study instrument: The instrument used was a semi-structured, interviewer-

administered questionnaire that was developed was used to seek information about socio-demographic characteristics, level of knowledge, attitudes and practice as well as determinants associated with utilization of family planning services.

Validity/ Reliability of the research instrument: The validity of the study instrument was established through interview and content validity criteria. The questionnaire was presented to the supervisor, who made the necessary correction.

Data collection: Six (6) research assistants were recruited and trained on the questionnaire administration. The questionnaire was shared among women that met the eligibility criteria residing within Kaduna metropolis. Relevant information was obtained through questionnaire was administered. During the period of data collection, the interviewers collected the information from the respondent using the questionnaire and these were submitted to the investigator daily. Questionnaires were checked for errors and omissions and corrected immediately.

Statistical analysis: Quantitative data was analyzed using SPSS software and MS Excel; uni-variate analysis (frequencies and proportions), bi-variate analysis (chi-square tests) and multi-variate analysis (regression analysis)

Ethical Consideration: The researchers got verbal consent of the participants. The participants were properly oriented on the research aims, those that consented were involved. No form of compulsion was employed.

RESULTS

Socio-Demographic Data

A large part of the respondents (38.2%) were aged 15 to 24 years. Women aged 45 to 49 years constituted only 8.0% of the respondents.



Table 1: Age distribution of child-bearing women in Chikun, Sabon gari, Kachia communities, Kaduna state, 2022

Age in years	Frequency	Percentage
15-24	139	38.2
25-29	78	21.4
30-34	57	15.7
35-39	38	10.4
40-44	23	6.3
45-49	29	8.0
Total	364	100

Distribution of respondents according to educational status depicts that a large part of the respondents (45.9%) had no formal education and a few (13.5%) had tertiary education.

Table 2: Educational status of child-bearing women in Chikun, Sabon gari, Kachia communities, Kaduna state, 2022

Age in years	Frequency	Percentage
No formal education	167	45.9
Primary	101	27.7
Secondary	47	12.9
Tertiary	49	13.5
Total	364	100

Majority of all the respondents had good knowledge of family planning, though there is a decline as age increases. There was no statistically significant association between age and knowledge of family planning (p value of 0.326).

Table 3: Age and knowledge of Family Planning Services

Age in years	Good knowledge of FPS count	Percentage
15-24	130	9
25-29	72	6
30-34	50	7
35-39	33	5
40-44	21	3
45-49	29	0
Total	364	29

$\chi^2 = 5.800, df = 5, p = 0.326$

The association between educational status and knowledge of family planning shows that a large part of the respondents with poor knowledge of family planning had no formal education (48.7%). 58.6% of the respondents with tertiary education had good knowledge of family planning. Association between educational status and knowledge of family planning is statistically significant (p value less than 0.0001).



From the focus group discussions (FGD) conducted, majority of the respondents knew about the existence of family planning but had some misconceptions. There was a clear lack of appropriate knowledge. A discussant said —family planning prevents us from getting pregnant by harming our wombs, so we may not be able to bear more children.

The source of information about family planning is mainly through media programs and friends. A discussant said —we hear much about it on radio and also discuss with friends when we meet at naming ceremonies. The family planning methods mentioned include oral contraceptive pills, injectables and male condoms. A few of the respondents knew about intrauterine contraceptive device (IUCD). A discussant said —there is one injection given every three (3) months to prevent one from getting pregnant. The respondents made it clear that the purpose of family planning is to prevent unplanned pregnancies.

Table 4: Educational status and knowledge of Family Planning Services

Educational status	Good knowledge of FPS count	Poor knowledge of FPS count
No formal education	4	163
Primary	5	96
Secondary	3	44
Tertiary	17	32
Total	29	335

$$\chi^2 = 43.104, df = 5, p < 0.0001$$

Age, religious misconception, male involvement and family setting are found to be statistically significant determinants. Those respondents whose husbands' are involved are 26 times more likely to utilize family planning services. Also those in monogamous setting are about 2.9 times more likely to use a family planning method.

Focus group discussions showed most of the discussants have never used any family planning method. Their non-usage is mostly due to husbands' non-approval, fear of side-effects and religion. One discussant said I have 7 children and would want to use a family planning method but my husband has refused. Another discussant said it is prohibited in my religion. Some linked religion misconception and husband non-approval. Distance to closest health facility was not found to be an important reason for non-utilization. Those using a method went to health facilities far from their homes (greater than 5 kilometers) in order to get the service. Most of the discussants using a method bought the pill or injection over the counter but admitted administration of the injection at health facilities was free. These suggest that the family planning commodities may not be readily available at the health centers.

Table 5: Factors associated with utilization of family planning services among child-bearing women in Chikun, Sabon gari, Kachia communities, Kaduna state, 2022

Determinants utilization of FPS	Adjusted Odds Ratio (AOR)	p value	95% Confidence level
Age	0.91	0.01	0.841 - 0.977
Educational status	1.76	0.73	0.069 - 44.785
Socio-economic status	0.964	0.895	0.557 - 1.667



Parity	1.118	0.062	0.995 - 1.257
Religion	0.033	0.034	0.001 - 0.767
Male involvement	26.058	<0.0001	7.400 - 91.763
Access to health facility	1.376	0.560	0.470 - 4.026
Family setting	2.877	0.007	1.344 - 6.159

DISCUSSION

This study sought to identify the determinants of utilization of family planning services amongst women of child-bearing age in rural areas of Kaduna state, Nigeria. This is very relevant given the high total fertility rate among Nigerian rural women (6.2/ woman) compared to women residing in urban areas (4.7/woman). Also the maternal mortality rate in Nigeria is unacceptably high (545/100,000 population).

Majority of the participants were in the 15-24-year age group. According to NDHS 2013, this is the age group that showed a steady rise in fertility rate. Majority of those not utilizing family planning services fall within this age group though no statistical significant association was found between age and family planning services utilization.

Most of the 364 participants had no formal education, whereas a small proportion had tertiary education. Of the women with no formal education, about half (48.7%) are not utilizing FPS. In this study, a good proportion of the respondents who had tertiary education were also not utilizing FPS. It would thus seem that higher education is not a predictor of utilizing FPS among these participants; however, a statistically significant association has been established between educational status and Family planning services utilization. In a study conducted by Moronkola in South-West Nigeria, knowledge about contraception was high though this pattern is expected in light of much enlighten that is on-going on the issue of family planning in the country;

more so majority of respondents' source of awareness was media.

Pregnancies have been well documented. However, many factors have been found to affect a woman's fertility regulation decisions; they include the status of the woman, the survival chances of her children and knowledge of, availability of, access to and quality of family planning services. The very low status of the women in the rural areas and cultural and religious aversion to family planning may be working in synergy with health services related factors to limit utilization of family planning services in the localities.

Findings from this study on source of family planning information revealed that media, friends and hospitals constituted their major sources. This is comparable to findings documented in studies conducted in Osogbo, Jos and Sokoto where health personnel, the media and friends accounts for their major of information while in Zaria, most respondents obtained their information from nurses and midwives also. This is a demonstration of the vital role played by health workers and the media in health information dissemination particularly concerning family planning. The variation in sources of information could be attributable to difference in age groups studied and marital status. Since the married if pregnant in the course of attending antenatal clinic or child immunization clinic at the health facilities may have opportunity to receive information regarding family planning.



CONCLUSION AND RECOMMENDATIONS

This study has established that women of child-bearing age in rural areas of Kaduna state have low level of knowledge on family planning and its methods. Attitude towards family planning is poor with cultural and religious misconceptions playing vital roles. Level of use of family planning methods is also low. Established determinants of utilization of family planning services include male non-involvement, family setting, age and religion.

Recommendations

A. State Government:

1. The State Ministry of Health in collaboration with the primary health care management board should roll out more programs such as organizing workshops and seminars to educate married couple on the benefits of family planning practices. This will bridge the gap between awareness and knowledge and practices of family planning.
2. Intensify advocacy to religious leaders in the communities as well as conduct interactive sessions so as to enlighten them on the benefits and urgent need to clarify issues on status of religion regarding family planning to their followers.
3. Health education of the people in the rural areas should be intensified by the health education unit of the primary health care management board.
4. Conduct research on causes on husband non –approval or male non-involvement as regards to utilizing FPS.

5. Promote community’s involvement in public health programs.
6. There should be concerted efforts to the policy makers to intensify awareness on utilization of modern methods of contraception.

B. Family planning service providers:

1. Traditional leaders, opinion leaders, religious leaders and the communities as a whole should be made part of the awareness and practice campaign. This will help reduce the negative perceptions society have about people who practice family planning.
2. Communities-based family planning clinics need to be expanded and strengthened in the rural areas so as to disseminate information and provide counseling on family planning practices and contraceptive usage. This will help married couple choose appropriate methods so as to reduce the fear of side effects associated with contraceptive usage.
3. Family planning services should be incorporated in all public hospitals and clinics within the rural areas with the view of increasing access to and supply of contraceptives. This will help reduce if not eliminate the accessibility constraint.

C. Clients:

1. Client orientation and empowerment with regards to family planning.
2. Clients should be encouraged to be committed users of family planning services.
3. Clients should be encouraged to give feedback on the service satisfaction.



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