Original Article

Access this article online

Quick Response Code:

Website: www.jmwan.org

DOI: 10.4103/jmwa.jmwa_3_23

Socioeconomic and Sociocultural Predictors of Family Planning Uptake amongst Females (15–49 Years) in Delta State Central Senatorial District

Precious Seyitan Amaki Tettehfio, Mamodesan Tudjegbe Okumagba[1], Patrick Gold Oyibo[2], Maureen Ntaji[1], Nyemike Simeon Awunor[1]

Abstract:

BACKGROUND: The Southern part of Nigeria, where Delta State's Central Senatorial District lies, has continued to record low levels of family planning (FP) service uptake despite their high level of awareness. This situation has led to poor health outcomes amongst women, children and the general population. Thus, poor progress towards achieving Sustainable Development Goal 3 which aims to ensure healthy lives and promotes well-being for all at all ages, with specific targets related to promoting family planning services.

AIM: This study aims to assess the level of awareness of FP uptake, the socioeconomic and sociocultural predictors of FP uptake and the major barriers influencing the uptake of FP services in the Central Senatorial District of Delta State.

METHODS: The study employed a cross-sectional descriptive design. Multistage sampling method was used to obtain a sample of 407 respondents drawn from females of reproductive age in suburban and rural communities. Data were collected through a researcher-administered questionnaire and analysed using SPSS version 26. Chi-square test was used to determine significant associations, and logistic regression analysis was used to determine the predictors.

RESULTS: Findings from this study revealed that awareness about FP amongst females was high (69.3%), but only two-fifths (42.3%) were using FP. The socioeconomic predictors of FP uptake were marital status (P = 0.004) and the type of community lived in (P = 0.010). The sociocultural predictors of FP uptake were spousal approval (P = 0.02), social groups' approval (P = 0.053), belief in the effect of curses (P = 0.001), prayers (P = 0.016) and traditional practises (P = 0.000).

CONCLUSION: This study revealed high awareness about FP but low uptake amongst females of reproductive age due to identified socioeconomic and sociocultural factors. Therefore, the local and state governments should increase health education and promotion in rural areas to improve health knowledge. Furthermore, non-governmental organisations associated with reproductive health should extend their programmes into rural areas and promote the creation of more FP advocacy social groups, to channel FP messages to the communities.

Keywords:

Family planning uptake, predictors, reproductive health, sociocultural, socioeconomic

Department of Community Medicine, Faculty of Clinical Medicine, College of Health Sciences, Delta State University, Abraka, [1]Department of Community Medicine, Delta State University Teaching Hospital, Oghara, Delta State, Nigeria, [2]Health Services Research and Management Division, School of Health and Psychological Sciences, University of London, London, United Kingdom

Address for correspondence:
Dr. Precious Seyitan Amaki Tettehfio, 3, Oludegun Avenue, Lagos, Nigeria.
E-mail: preciousseyitan@gmail.com

Submitted: 06-May-2023
Revised: 21-Jul-2023
Accepted: 04-Aug-2023
Published: 04-Sep-2023

Introduction

Family planning (FP) is amongst the most popular birth control practises worldwide, and individuals and couples can attain the desired number and spacing of their children through contraceptive use.[1]

It is one of the most economical public health measures essential for lowering the childbearing rate.[1] The rate of childbirth decline is a means of achieving

How to cite this article: Tettehfio PS, Okumagba MT, Oyibo PG, Ntaji M, Awunor NS. Socioeconomic and sociocultural predictors of family planning uptake amongst females (15–49 years) in Delta State Central Senatorial District. J Med Womens Assoc Niger 2022;7:48-54.

a demographic dividend with the potential to reduce poverty, boost economic growth and contribute to the overall well-being of families and societies.[1]

Statistics based on the global situation suggest that FP could play a critical role in improving the outcomes of pregnancy and childbirth. Out of 180–200 million pregnancies yearly, 75 million are unwanted. This resulted from method failure or the lack of use of any contraceptive. Out of the 50 million induced abortions in the world, 20 million abortions were unsafe. The consequences of unsafe abortions included undesired fertility, morbidity and mortality.[2]

In 2021, the United States Agency for International Development (USAID) reported that almost 923 million women worldwide wish to avoid or delay pregnancy.[2] This USAID report indicated that about three-quarters of these women use modern contraceptives. However, more than 218 million women still have an unmet need for FP globally.[2] Most African countries, including Nigeria, have the lowest rates of contraceptive use, maternal, infant, child mortality and fertility rates. According to data from the National Demographic and Health Survey in 2018, Delta State had the highest (44.8%) unmet FP needs in Nigeria and also recorded a 4.41% total fertility rate.[3]

In Delta State's Central Senatorial District, FP service uptake needs to be higher and far above the national target. This is mirrored in the low contraceptive prevalence rate of 12% and high fertility rate of 4.9 and the state's maternal mortality of 189/100,000 live births in 2020.[4] This worrying situation is attributed to various socioeconomic and cultural factors. Therefore, empirical evidence from this study will help policymakers, government and non-governmental organisations develop strategies to promote FP service uptake. Such evidence-based interventions will improve accessibility and utilisation of FP services, reduce maternal and infant mortality rates, improve maternal health and control population growth for economic development that is responsive to the unique context and needs of Delta State Central Senatorial District residents. In addition, it will enhance progress towards achieving the goals in the 2030 Agenda for Sustainable Development, precisely target 3.7, which supports universal access to reproductive healthcare, and target 5.6, which supports individuals' ability to exercise their reproductive rights.[1] This study uses the health belief model and the information motivation and behaviour theoretical framework Fisher developed.[5] This study aims to assess the socioeconomic and sociocultural factors that influence the uptake of FP amongst females of reproductive age in the Delta Central Senatorial District.

Methods

Study area

Delta State's Central Senatorial District is located in Delta State. It lies between latitude 5°9 and 6°3 North of the Equator and longitudes 5°30 and 6°12 East of the Greenwich Meridian. It is bounded in the North by Edo State, South by Bomadi and Patani, in the East by Warri South West, Warri South, Warri North and Burutu and West by Ukwuani, Ndokwa West, Isoko North and Isoko South. The size of the region is about 3700 km^2. The population is estimated to be 2 million people, and the region has eight local governments.[6] The study was conducted in a suburban community, i.e. Jesse, and two rural communities, i.e. Ovade and Ijomi, in the Delta State Central Senatorial District.[6]

Study design

This study employed a cross-sectional descriptive design between July and October 2022. The study population comprised females of reproductive age (15–49 years). A sample size of 407 was estimated using Fisher's formula.[5]

The communities were designated as rural or suburban based on population size, housing unit density, census, population density and developmental activities.[3]

This study employed the multistage sampling technique: For the first stage, from a pool of eight local governments in the Delta State Central Senatorial District, the Ethiope West Local Government Area (LGA) was selected by simple random sampling technique through balloting. For the second stage, the communities in Ethiope West LGA were stratified into suburban and rural communities using the stratified sampling technique. For the third stage, Jesse Town (a suburban community), Ovade and Ijomi rural communities in Ethiope West LGA were selected by simple random sampling technique through balloting. Finally, for the fourth stage, the houses in each community were systematically selected using even numbers (nth = 2); females within the inclusion criteria participated after giving informed consent. The palace of the community chief in each location was the starting point for data collection.

Data collection instruments

The instrument for data collection was a researcher-administered questionnaire developed by the authors. The questions were clear and concise. The respondents' details were anonymised, and the respondents' confidentiality was assured. This study was piloted using 15 questionnaires at Sapele LGA. Data checking and cleaning were done simultaneously during data collection. Data were checked for completeness and

consistency at the end of every field day. Data were analyzed using the Statistical Package for the Social Sciences (SPSS) version 26 software (IBM Corporation, Armonk, New York, USA). Descriptive and inferential statistics were used for data analysis. Chi-square analysis was adopted to explore the relationship between dependent and independent variables for categorical data. In addition, binary logistic regression analysis was used to examine the likelihood of the independent variables affecting the dependent variables. $P < 0.05$ was considered statistically significant.

Study population

The study population comprised females of reproductive age (15–49 years) of age seeking health services.

Inclusion and exclusion criteria

Females of reproductive age (15–49 years), females willing to participate and females who gave informed consent were included in this study. However, reverend sisters, females who were sick and those of non-reproductive age were excluded from the study.

Study variables

Independent variables

In this study, the independent variables under the socioeconomic factors were marital status and type of community. At the same time, independent variables under the sociocultural factors were spousal approval, social group approval, belief in prayers, belief in curses and belief in traditional practices.

Dependent variables

This study's dependent variable of interest was the uptake of FP services. Uptake of Family Planning services is described as the use of any Family Planning method and services.

Ethical considerations

Ethical approval to conduct this study was obtained from the Health Research and Ethics Committee, Delta State University Teaching Hospital, Oghara, Delta State, Nigeria (HREC/PAN/2022/055/0496). Permission was also obtained from the chiefs of communities to carry out the study. Consent was obtained from the study participants after they had been informed about the purpose of the study.

Results

Sociodemographic characteristics of the respondents

Most respondents were females between 20 and 29 years (31.9%: $n = 130$), followed by 30–39 years (26.8%: $n = 109$). Respondents were predominantly Christians (84.3%: $n = 343$), while 8.1% ($n = 33$) and 7.6% ($n = 31$) practised traditional and Muslim religions, respectively. In addition, most respondents were married (57.2%: $n = 233$), while 27.0% ($n = 110$) were single [Table 1]. In this study, the highest proportion of ethnic group was the Urhobo (68.3%: $n = 277$). Regarding employment status, most respondents were self-employed (50.1%: $n = 204$), and most lived in rental apartments (54.3%: $n = 221$). Table 1 summarises these findings.

Level of awareness and utilisation of family planning services

Out of 407 respondents, 69.3% ($n = 282$) had heard about FP, while 30.5% ($n = 124$) had not heard about FP. On the source of information about FP, 26.9% ($n = 76$) heard about it from family members, 23.8% ($n = 67$) heard about it from the health centre, while 20.9% ($n = 59$) and 17.4% ($n = 49$) heard about FP from the television and radio, respectively.

Table 1: Sociodemographic characteristics of respondents

Characteristics	Frequency (%)
Age (range)	
15–19	39 (9.6)
20–29	130 (31.9)
30–39	109 (26.8)
40–49	82 (20.1)
50–59	36 (8.8)
>59	11 (2.8)
Religion	
Christian	343 (84.3)
Traditional	33 (8.1)
Muslim	31 (7.6)
Marital status	
Married	233 (57.0)
single	110 (27.0)
Widow	32 (7.9)
Engaged	12 (2.9)
Divorced	11 (2.7)
Separated	9 (2.2)
Type of community	
Urban	264 (64.9)
Rural	143 (35.1)
Employment status	
Self-employed	204 (50.1)
Employed by someone	155 (38.1)
Unemployed	48 (11.8)
Ethnicity	
Urhobo	277 (68.1)
Others	63 (15.5)
Igbo	22 (5.4)
Itsekiri	20 (4.9)
Isoko	19 (4.7)
Ijaw	6 (1.5)
Place of residence	
Rental	221 (54.3)
Self-owned	186 (45.7)
Total	407 (100)

Regarding the utilisation of FP services, out of 407 respondents, only 172 (42.3%) currently use FP, while 235 (57.7%) do not. However, out of 407 respondents, 57.5% (n = 234) had previously used FP service, while 42.5% (n = 173) had not.

Concerning the decision to use FP services, 82% (n = 191) used FP services based on individual decision, 17.9% (n = 73) used it based on a joint spousal decision and 15.7% (n = 64) used it based on their partners' sole decision. In contrast, 19.1% (n = 78) did not indicate who took the decision. With regard to the place of childbirth, 54.5% (n = 222) had their last delivery in the health centre, while 28.9% (n = 118) had theirs at home, and 10.3% (n = 42) had theirs in a church or mission house.

Socioeconomic predictors influencing family planning uptake

Marital status (χ^2 = 17.289; df = 5; P = 0.004) and the type of community respondents lived in (χ^2 = 6.583; df = 1; P = 0.010) showed a statistically significant association with FP uptake [Table 2].

In addition, single status is 16 times more likely to use FP services (adjusted odds ratio [AOR] =15.874; 95% confidence interval CI: 1.845–136.436) than other marital statuses; likewise, respondents residing in suburban communities (AOR = 0.525; 95% CI: 0.325–0.835) were one time more likely to use FP services than those in the rural communities [Table 3].

Sociocultural predictors influencing family planning uptake

Concerning the sociocultural factors, there is a significant relationship between spousal approval (χ^2 = 7.219; df = 2; P = 0.027), social group approval (χ^2 = 5.862; df = 2; P = 0.043), belief in curses (χ^2 = 13.904; df = 2; P = 0.001), belief in prayers (χ^2 = 8.246; df = 2; P = 0.016), belief in traditional practises (χ^2 = 21.822; df = 2; P = 0.000) and FP service uptake [Table 4].

In addition, respondents whose spouses approved of FP uptake are more likely to use FP services (AOR = 0.770; 95% CI: 0.534–1.109) than respondents whose spouses disapproved. Second, respondents whose social group approves FP uptake were more likely to utilise FP services (AOR = 0.655; 95% CI: 0.421–1.021). Table 5 summarises these findings.

Furthermore, this study showed that respondents who do not believe in curses were three times more likely to use FP (AOR = 2.718; 95% CI: 0.344–21.469) than those who believe in curses. The likelihood of FP uptake was two times more (AOR = 2.064; 95% CI: 0.706–6.038) for respondents who believe in prayers than those who do not, and respondents who do not believe

Table 2: Socioeconomic factors influencing family planning uptake

Variables	FP uptake, frequency (%)		χ^2	df	P
	Yes	No			
Marital status					
Single	51 (46.4)	59 (53.6)	17.289	5	0.004*
Married	136 (58.4)	97 (41.6)			
Widow	21 (65.6)	11 (34.4)			
Divorced	10 (90.9)	1 (09.1)			
Separated	5 (55.6)	4 (44.4)			
Engaged	11 (91.7)	1 (08.3)			
Type of community					
Urban	164 (62.1)	100 (37.9)	6.583	1	0.010*
Rural	70 (49.0)	73 (51.0)			

*Statistically significant. FP: Family planning

Table 3: Regression analysis of independent socioeconomic factors influencing family planning uptake

Variables	AOR	df	P	95% CI	
				Lower bound	Upper bound
Marital status (no reference)					
Single	15.874	1	0.012	1.845	136.436
Married	9.115	1	0.042	1.087	76.409
Widow	6.934	1	0.095	0.715	67.227
Divorced	0.744	1	0.845	0.037	14.889
Type of community (reference=Rural)					
Urban	0.525	1	0.010	0.325	0.835

AOR: Adjusted odds ratio, CI: Confidence interval

Table 4: Sociocultural factors influencing family planning uptake

Variables	FP uptake		χ^2	df	P
	Yes, n (%)	No, n (%)			
Spouse approval					
Yes	112 (64.4)	62 (35.6)	7.219	2	0.027*
No	112 (51.4)	106 (48.6)			
Do not know					
Social groups approval					
Yes	83 (65.4)	44 (34.6)	5.862	2	0.043*
No	151 (54.1)	128 (45.9)			
Do not know	0	1 (0.2)			
Believe on curses					
Yes	166 (63.6)	95 (36.4)	13.904	2	0.001*
No	62 (44.9)	76 (55.1)			
Do not know	6 (75.0)	2 (25.0)			
Believe in traditional practises					
Yes	140 (69.0)	63 (31.0)	21.822	2	0.000*
No	93 (46.0)	109 (54.0)			
Do not know	1 (50.0)	1 (50.0)			
Believe in prayers					
Yes	184 (59.0)	128 (41.0)	8.246	2	0.016*
No	31 (44.9)	38 (55.1)			
Do not know	19 (76.0)	6 (24.0)			

*P<0.05 for significantly associated variables. FP: Family planning

in traditional practises are more likely to utilise FP services (AOR = 1.166; 95% CI: 0.054–25.129) [Table 5].

Major barriers influencing family planning service uptake

The major barriers influencing FP uptake, i.e., the distance of the health centre, side effects from the contraceptives, chemicals used in making contraceptives, health-related issues from the respondents, lack of adequate information and health workers' attitude towards patients, showed a statistically significant association with the uptake of FP (P = 0.0009) [Table 6].

Furthermore, this study showed that health-related issues caused by contraceptives were two times more likely to be a major barrier (AOR = 1.984; 95% CI: 0.589–6.681), lack of adequate information about FP uptake was also two times more likely to be a major barrier (AOR = 1.557; 95% CI: 0.476–5.092), health workers' attitude towards patient is one time more likely to be a major barrier on FP uptake (AOR = 1.426; 95% CI: 0.342–5.950) and side effects from the contraceptives were two times more likely to be a major barrier in FP uptake (AOR = 1.754; 95% CI: 0.580–2.956) [Table 7].

Discussion

Level of awareness on family planning uptake

A recent study in Nigeria revealed a high awareness of FP methods and services.[7] Similarly, this study revealed that most respondents have heard about FP, half have used it before and less than half are presently not. This corroborates another study which suggested that although there is a high awareness amongst females of reproductive age, utilisation of FP is still relatively low.[8] The source of information about FP for most respondents was from other family members; a few respondents heard about FP from health personnel. However, information obtained through friends and relatives could be incorrect. This is in line with another study that revealed that sources of information were mostly from friends and relatives.[9] It is also similar to a study on fertility intentions, contraceptive awareness and contraceptive use amongst women in three communities in Northern Nigeria, where family members and health facilities were the primary sources of information. This study also revealed that most had their last delivery in the health centre, while few had theirs at home.[7] This is similar to a study done in Calabar, Nigeria, on awareness, attitude and practise of contraception amongst secondary school girls, where most respondents had their last delivery in the health centre.[10]

Influence of socioeconomic factors on family planning uptake

This study revealed that marital status has a significant influence on FP uptake because women with single status tend to utilise FP more than other marital statuses; this may be because they want to protect themselves from unwanted pregnancies and sexually transmitted diseases; this finding is similar to a study which showed the significance of marital status on the utilisation of FP

Table 5: Regression analysis of sociocultural factors influencing family planning uptake

Variables	AOR	df	*P*	95% CI	
				Lower bound	Upper bound
Spouse approval (reference=No)					
Yes	0.770	1	0.160	0.534	1.109
Social group approval (reference=No)					
Yes	0.655	1	0.061	0.421	1.021
Belief in curses (reference=None)					
Yes	1.718	1	0.604	0.222	13.314
No	2.718	1	0.343	0.344	21.469
Belief in prayers (reference=None)					
Yes	2.064	1	0.186	0.706	6.038
No	1.996	1	0.269	0.586	6.799

AOR: Adjusted odds ratio, CI: Confidence interval

Table 6: Major barriers influencing family planning uptake

Major barriers	FP uptake		χ^2	df	*P*
	Yes, *n* (%)	No, *n* (%)			
Distance from the health centre	55 (74.3)	19 (25.7)	18.901	7	0.009*
Side effects of contraceptives	57 (48.7)	60 (51.3)			
Chemicals used in making contraceptives	30 (61.2)	19 (38.8)			
Health-related issues	33 (54.1)	28 (45.9)			
Lack of information	11 (55.6)	9 (45.0)			
Health worker's attitude towards patients	13 (81.3)	3 (18.8)			
Unaware	10 (58.8)	7 (41.2)			
No reason	25 (47.2)	28 (52.8)			

*Statistically significant. FP: Family planning

Table 7: Regression analysis of major barriers and predictors influencing family planning uptake

Variables	AOR	df	*P*	95% CI	
				Lower bound	Upper bound
Major barriers (no reference)					
Distance of the health centre	0.611	1	0.412	0.189	1.982
Side effects of the contraceptives	1.754	1	0.319	0.580	5.300
Chemicals used in making contraceptives	0.867	1	0.820	0.254	2.956
Health issues from respondents	1.984	1	0.269	0.589	6.681
Lack of information	1.557	1	0.464	0.476	5.092
Health worker's attitude to patients	1.426	1	0.627	0.342	5.950
Unaware	0.406	1	0.294	0.075	2.186

AOR: Adjusted odds ratio, CI: Confidence interval

services which may be related to shared cultural values amongst most communities in Africa concerning who should use FP services. There is a high premium on virginity from these cultural systems, especially amongst females before marriage, so most adolescents and the unmarried avoid going to primary health centre facilities to get help with FP.[11]

This study also revealed that the type of community the respondents lived in influenced FP uptake. Suburban respondents tend to utilise FP more than those in rural communities. This may imply that those in the suburban community have more access to health centres, good roads and more awareness of FP uptake. These findings are similar to another study which showed a higher utilisation of FP services in the suburban communities compared to the rural due to the greater availability of health providers.[11] Another study revealed that a possible explanation for the higher utilisation of FP services in suburban communities compared to rural communities is the greater availability of health providers, good roads and transportation systems. In contrast, women in rural areas are most likely to be far from health facilities, poor, less educated with poor knowledge and least aware of FP services.[12]

Influence of sociocultural factors on family planning uptake

The key sociocultural factors influencing the uptake of FP in this study are spousal approval, social group approval, belief in curses, prayers and traditional practises. The influence of spousal approval for FP uptake may imply that men or husbands dominate decision-making regarding family reproductive issues. This suggests that the higher the partners' favourable attitude and involvement in FP, the higher the likelihood of their utilisation of FP. Therefore, the respondents whose partners approved contraceptive use will likely be optimistic about their attitude towards using FP services. This is consistent with the studies conducted in Northern Nigeria and Malawi, which indicated that women who got support from their husbands utilised FP services more.[13,14] This finding is similar to a study where many women relied on their partners to make decisions on FP and may highlight the patriarchal nature of the communities.[15] It also highlights the need to involve partners in FP counselling.

These husbands tend to make decisions about women's health and reproductive choices due to society's cultural norms that place men as superior.[13] The implication is that women's health decisions about when to seek medical attention depend on their husbands, which can lead to unnecessary delays. This study also revealed that women whose spouses support FP uptake used contraceptives more. This study also showed that women who belonged to social groups that approve of FP uptake were likelier to use FP than those who belonged to social groups that disapprove of FP uptake. This supports another study which indicates that if a woman perceives that most women in her social group are using contraceptives, she is more likely to use them.[8] This underscores the influence of social groups and networks in FP uptake decisions amongst the respondents, as implied by other studies.[16]

Major barriers influencing family planning uptake

In general, there are barriers to FP uptake in different societies. However, the barriers in the rural community could be different from the urban setting. A study identified cost, prior counselling and difficulty accessing services, procurement difficulties, long distances of sources, misconceptions, fear of side effects, low education, uncertainty about its need and ignorance of FP as barriers to FP uptake.[17] This study showed that the major barriers to the uptake of FP are fear of side effects, health issues, lack of information, health workers' attitudes, distance to the health centre and chemicals used in making the contraceptives.

Fear of FP side effects is also a major barrier in this study. Many of these fears are due to authentic experiences. Unfortunately, the fear of side effects has become a persistent challenge for FP methods. Side effects of contraception may be tackled by adequately screening patients for pre-existing health risk factors before the choice of contraceptive method is made. This is why couples using contraception should consult qualified health personnel at a healthcare facility for screening through history taking, physical examination and simple tests.[18] The attitude of health workers was another major barrier in this study. Women who had a bad experience with health personnel were less likely to use FP services in this study; this might be due to negative experiences encountered by the respondents in the health centres. In addition, the distance of the health centre influenced FP uptake, as women in the urban communities tend to utilise FP more than those in the rural communities because those in the rural communities will have to walk long distances or use a means of transportation before they can get to a health centre. Another reason is that there may be transportation challenges such as bad roads, increased transport fares or fuel scarcity. This study's findings agree with a previous study showing that healthcare services were far from many residents' districts, and the district health facility grappled with staff absenteeism.[19]

Conclusion

Most of the females were aware of FP uptake, but very few were using FP; these were due to socioeconomic

predictors such as marital status and the type of communities they lived. Likewise, sociocultural predictors such as spousal approval, social group approval, belief in curses, belief in prayers and belief in traditional practises also influenced FP uptake. However, the major barriers to the uptake of FP services were fear of side effects from contraceptives, health-related issues, lack of adequate information, health workers' attitudes, distance from the health centre and concerns about chemicals used in contraceptives.

Recommendations

Based on the findings from this study, the following recommendations are given: health policymakers should leverage on the high level of awareness to drive demand for FP services. The local and state governments should initiate adult learning on FP services in the villages to raise literacy levels in rural areas. Health education should be targeted at social influencers, such as religious leaders and traditional leaders in the state, to help educate their members towards the uptake of FP. Non-governmental organisations should promote the formation of FP advocacy groups and utilise existing social groups for channelling FP messages to the community. Non-governmental organisations working in reproductive health should extend their programme into rural areas instead of concentrating more on urban areas. Finally, health workers in the community should work with FP providers and workers to address side effects and health-related issues associated with contraceptives use, so as to enable the use of FP method amongst the females in the community.

Limitations of the study

Most respondents gave incorrect responses about their income; therefore, the study could not include the analysis and result from income. In addition, some women were sick and were not included in the study.

Acknowledgement

The authors wish to acknowledge all the women who participated in the study.

Financial support and sponsorship

This was a self-funded study.

Conflicts of interest

There are no conflicts of interest.

References

1. World Health Organization, Contraception. Available from: https://www.who.int/health-topics/contraception. [Last accessed on 2022 Dec 02].
2. United States Agency for International Development. Family Planning and Reproductive Health; 2021. Available from: https://www.usaid.gov/global-health/health-areas/family-planning. [Last accessed on 2023 April 23].
3. National Population Commission (NPC) [Nigeria] and ICF International Nigeria. Demographic and Health Survey. Abuja, Nigeria and Rockville, Maryland, USA: NPC and ICF International; 2018.
4. Lasisi CJ, Bassey TI, Ita AE, Awoyemi OK. Awareness and utilization of family planning among married women in the traditional core areas of Ibadan, Oyo State. N J Humanit Soc Sci 2014;3:1-8.
5. Fisher AA, Laing JE, Strocker JE. Handbook for Family Planning, Operation Research Design and Sampling. New York: Population Council. 1998. p. 40-5.
6. Ejemeyovwi OD. Geographic information system assessment of the accessibility of public and private hospitals in delta state: A study of delta central senatorial district. Int J Dev Sustain 2019;8:768-84.
7. Bolarinwa OA, Tessema ZT, Frimpong JB, Seidu AA, Ahinkorah BO. Spatial distribution and factors associated with modern contraceptive use among women of reproductive age in Nigeria: A multilevel analysis. PLoSONE.2021;16:e0258844. doi:10.1371/journal.pone.0258844.
8. Igbodekwe FC, Oladimeji O, Oladimeji KE, Adeoye IA, Akpa MO, Lawson L. Utilisation of modern contraceptive among women of childbearing age in resource constraint setting: Evidence from 2008 national demographic and health survey in Nigeria. J Health Sci 2014;4:72-8.
9. Chirdan OO, Akosu JT, Ejembi CL, Bassi AP, Zoakah AI. Perceptions of working conditions amongst health workers in state-owned facilities in Northeastern Nigeria. Ann Afr Med 2009;8:243-9.
10. Bassey EA, Abasiattai AM, Asuquo EE, Udoma EJ, Oyo-lta A. Awareness, attitude and practice of contraception among secondary school girls in Calabar, Nigeria. Niger J Med 2005;14:146-50.
11. Alenoghena IO, Isah EC, Isara AR, Ameh SS, Adam VY. Uptake of family planning services among women of reproductive age in Edo North senatorial District, Edo State, Nigeria. Sub-Saharan Afr J Med 2015;2:154-9.
12. Federal Ministry of Health Nigeria. Essential Obstetric Care Facilities in Nigeria. Abuja: Federal Ministry of Health, Abuja; 2013. p. 1-66.
13. Azuh D, Fayomi O, Ajayi L. Sociocultural factors of gender roles in women's healthcare utilization in Southwest Nigeria. Open J Soc Sci 2015;3:105-17.
14. Oye-Adeniran BA, Adewole IF, Odeyemi KA, Ekanem EE, Umoh AV. Contraceptive prevalence among young women in Nigeria. J Obstet Gynaecol 2005;25:182-5.
15. Samandari G, Speizer IS, O'Connell K. The role of social support and parity in contraceptive use in Cambodia. Int Perspect Sex Reprod Health 2010;36:122-31.
16. Shattuck D, Kerner B, Gilles K, Hartmann M, Ng'ombe T, Guest G. Encouraging contraceptive uptake by motivating men to communicate about family planning: The Malawi male motivator project. Am J Public Health 2011;101:1089-95.
17. United Nations. World Population Prospects, the 2012 Revisions: Key Findings and Advance Tables. New York: United Nations; 2013.
18. Hyeladi A, Gyang, JD, Chuwang N. Family planning practice and factors influencing family size among Mwaghavul ethnic group of Plateau state. Int J Humanit Soc Stud 2020;2;106-9.
19. Akamike IC, Okedo-Alex IN, Eze II, Ezeanosike OB, Uneke CJ. Why does uptake of family planning services remain sub-optimal among Nigerian women? A systematic review of challenges and implications for policy. Contracept Reprod Med 2020;5:30.