

Jurnal Sains Kesihatan Malaysia 16(1) 2018: 71-79
DOI : <http://dx.doi.org/10.17576/JSKM-2018-1601-09>

Artikel Asli/Original Article

Socio-demographic Factors Associated with Knowledge and Uptake of Family Planning Among Women of Reproductive Age in a Rural Community of Abuja, Nigeria

(Faktor Sosioekonomi yang Berkait Rapat dengan Pengetahuan dan Pengambilan Perancangan Keluarga dalam Kalangan Wanita pada Umur Reproduksi di Komuniti Luar Bandar Abuja, Nigeria)

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ABSTRACT

Nigeria has a population of about 180 million, estimated to double in 22 years due to low uptake of family planning services. Low utilization of family planning is the major factor associated with high fertility pattern in Nigeria. This trend is higher among rural women in Northern Nigeria. Without a thorough understanding of, and due attention to the local context, utilization of family planning may continue to be low. Identification of correlates of family planning would be invaluable in designing strategies for ultimately improving uptake of family planning services. This study became relevant as no previous study on family planning has been carried out in Ushafa Community. The study was conducted at Ushafa community, a rural community, located in Bwari Area Council on the northern axis of the Federal Capital Territory (FCT) of Nigeria. The study was a descriptive cross-sectional study, conducted among women of reproductive age (15-49 years) who were permanent resident of Ushafa Community. Using proportion of contraceptive usage of 16% from a previous study, 240 women were recruited into the study by systematic sampling technique. Data was collected by means of a structured interviewer administered questionnaire, data was entered and analysed using statistical package for social sciences (SPSS) version 20. All tests were conducted using 2 tails while level of significance was set at 0.05. About a quarter of respondents (26.3%) knew that amenorrhoea could be a side effect of oral contraceptive pills, 51.1% knew that oral contraceptive pills must be taken daily, 58% were not using any form of family planning. Age ($\chi^2 = 8.382$, $p = 0.01$) and marital status ($\chi^2 = 8.915$, $p = 0.01$) were significantly associated with family planning knowledge. Level of education was significantly associated with current use of family planning ($\chi^2 = 10.78$, $p = 0.03$). Educational status was significantly associated with likelihood of using family planning in the future ($\chi^2 = 8.64$, $p = 0.04$). Although the respondents had fairly good knowledge of family planning, the study observed some misconceptions especially with respect to side effects and methodology of use of the commodities. Low uptake of family planning was observed among the respondents. Age and marital status were significantly associated with family planning knowledge; level of education was significantly associated with current use of family planning. There is need for incorporation of facts on usage and side effects of family planning in message disseminated by health workers in health facilities in Ushafa Community so as to correct misconceptions.

Keywords: Knowledge; utilization; family planning; rural community

ABSTRAK

Nigeria mempunyai kira-kira 180 juta populasi, dijangka bertambah dua kali ganda dalam 22 tahun kerana tahap perancangan keluarga yang rendah. Tahap perancangan yang rendah merupakan faktor utama yang berkait rapat dengan corak kesuburan yang tinggi di Nigeria. Trend ini adalah lebih tinggi dalam kalangan wanita di kawasan luar bandar utara Nigeria. Tanpa pemahaman yang mendalam dan minat setempat, kadar penggunaan perancangan keluarga akan terus menjadi rendah. Pengenalpastian kolerasi perancangan keluarga sangat berguna bagi melakar strategi untuk menambah baik penggunaan perkhidmatan perancangan keluarga secara menyeluruh. Kajian ini adalah relevan kerana tiada kajian lepas yang berkenaan dijalankan dalam komuniti Ushafa. Kajian ini dijalankan dalam komuniti Ushafa, sebuah komuniti luar bandar yang bertempat di Bwari Area Council yang terletak di bahagian utara Federal Capital Territory (FCT), Nigeria. Kajian ini dilakukan secara keratan rentas deskriptif dan dalam kalangan wanita pada umur reproduktif (15-49 tahun) yang merupakan penduduk kekal komuniti Ushafa. Berdasarkan kadar penggunaan kontraseptif setinggi 16% dalam kajian lepas 240 wanita telah disampel dengan teknik persampelan sistematik. Data dikumpul menerusi soal selidik berstruktur di bawah administrasi penemu duga, disusun atur dan dianalisa dengan perisian Statistical Package for Social Sciences (SPSS) versi 20. Kesemua ujian dijalankan secara dua hujung dan aras signifikan ditentukan pada 0.05. Kira-kira satu suku daripada responden (26.3%) sedar bahawa amenorrhoea adalah

antara kesan sampingan pengambilan pil pencegah hamil, 51.1% mengetahui pil pencegah hamil perlu diambil pada setiap hari, 58% tidak mengambil sebarang langkah perancangan keluarga. Faktor umur ($\chi^2 = 8.382, p = 0.01$) dan status perkahwinan ($\chi^2 = 8.915, p = 0.01$) didapati berkait rapat secara signifikan dengan pengetahuan perancangan keluarga. Tahap pendidikan turut berkait rapat secara signifikan dengan penggunaan perancangan keluarga semasa ($\chi^2 = 10.78, p = 0.03$). Taraf pendidikan berkait rapat secara signifikan dengan kebarangkalian penggunaan perancangan keluarga pada masa depan ($\chi^2 = 8.64, p = 0.04$). Biarpun responden mempunyai tahap pengetahuan yang sederhana berkenaan perancangan keluarga, kajian ini mendapati wujudnya salah konsep terutamanya dari segi kesan sampingan dan cara penggunaan komoditi. Kadar penggunaan perancangan keluarga yang rendah telah diperhatikan dalam kalangan responden. Faktor umur dan taraf perkahwinan berkait rapat secara signifikan dengan pengetahuan perancangan keluarga; tahap pendidikan juga didapati berkait rapat dengan penggunaan perkhidmatan perancangan keluarga semasa. Terdapat keperluan untuk menggabungkan fakta penggunaan dan kesan sampingan perancangan keluarga dalam mesej yang disebarkan oleh pekerja kesihatan di kemudahan kesihatan dalam komuniti Ushafa bagi membetulkan salah konsep yang wujud.

Kata kunci: Pengetahuan; penggunaan; perancangan keluarga; komuniti luar bandar

INTRODUCTION

The population of the world is growing by nearly 80 million a year, one and a half million a week, a quarter of a million a day and ten thousand an hour (United Nations 2015). Similarly, Nigeria is experiencing a population explosion due to very high fertility rates, quadrupling its population in the last 40-50 years, with a projected population of about 182 million in 2016 compared to about 37 million in 1950 (National Population Commission & Macro 2014).

Family planning also helps individuals or couples to avoid unwanted births, achieve wanted births, regulate intervals between pregnancies, control the time at which births occur in relation to the ages of the parents and determine the number of children in the family. This is achieved through the use of contraceptive methods and treatment of involuntary infertility. A woman's ability to space and limit her pregnancies has direct impact on her health and wellbeing as well as on the outcome of each pregnancy (World Health Organisation 2016).

Current evidence indicates that globally there is an increase in contraceptive prevalence especially in Asia and Latin America, but contraceptive prevalence continues to be low in Sub-Saharan Africa (United Nations 2015). Globally, the use of modern contraceptive has risen slightly from 54% in 1990 to 57% in 2012 (United Nations 2015). In Africa, it went from 23% in 1990 to 24% 2012. In Asia, it has remained at 62% and in Latin America and the Caribbean it rose slightly from 64% to 67%. There is significant variation among countries in these regions (United Nations 2015).

The United Nations Population Fund (UNFPA), the United States Agency for International Development (USAID), Pathfinder International, the Planned Parenthood Federation of Nigeria (PPFN) and other stakeholders in population and family planning services have been providing information, education and counselling (IEC) services and facilities in Nigeria for over two decades. In 2001, the Federal Ministry of Health (FMOH) developed a National Reproductive Health Policy and Strategy as a commitment to the provision of quality – integrated

family planning programmes (Federal Ministry of Health 2001). Again, in 2003, the FMOH and its partners developed the National Strategic Plan for Reproductive Health Commodity Security to support the National Policy objectives geared towards strengthening the contraceptive logistics management system (CLMS) (Federal Ministry of Health 2003).

However, the level of utilization of family planning still remains very low in Nigeria. According to 1990 NDHS, 6% of women of child bearing age were reported as using any contraceptive method, while only 4% were using a modern method (National Population Commission and Macro 1990). By 1999, 15% of women of child bearing age reported using contraceptive method, only 9% were using a modern method (National Population Commission & Macro 2000). As at 2003, only 8% were reported to use a modern method among married women of child bearing age (National Population Commission & Macro 2004). The proportion of married women of child bearing age using modern contraceptives slightly increased to 9.7% in 2008 (National Population Commission & Macro 2009) and 10% in 2013. (National Population Commission & Macro 2014) According to 2013 National Demographic and Health Survey (NDHS), the use of modern contraceptive was 10% and the level of unmet need for family planning was 16.1% (National Population Commission and Macro 2014). Fertility rate in Nigeria is 6 per woman and this is the highest in Africa (National Population Commission & Macro 2014).

In spite of efforts by Federal and state Governments, international agencies, Non-Governmental Organization (NGO), uptake of family planning remains very low and unmet need of family planning high (16.1%) in Nigeria (National Population Commission & Macro 2014). The low uptake of family planning and high unmet need of family planning are associated with high fertility pattern and population growth rate in Nigeria (National Population Commission & Macro 2014). As a result, there is a high rate of unwanted child bearing (28%) and unsafe induced abortion which accounts for 20 to 40% of maternal death (Monjok et al. 2010).

Both demographers and family planners have long recognized that without a thorough understanding of, and due attention to the local context, family planning will have little chance of being well accepted (Dehne 2003). Identification of factors associated with family planning knowledge and uptake among the study subjects would be invaluable in designing strategies for ultimately improving uptake of family planning services. This study was thus conducted to determine the knowledge of family planning, uptake of family planning and socio-demographic factors associated with knowledge and uptake of family planning among residents of Ushafa Community.

MATERIALS AND METHODS

The study was conducted at Ushafa community, a rural community, with a population of about 6000 people, located in Bwari Area Council on the northern axis of the Federal Capital Territory (FCT) of Nigeria, majority of the natives who are predominantly farmers and hunters belong to the Gbagyi ethnic group (Omoniyi & Mukaila 2011; Igbokwe 2016).

The study was a descriptive cross-sectional study and the study population comprised of women of reproductive age (15-49 years) who are permanent resident of Ushafa Community. Using proportion of contraceptive usage of 16% from a previous study (National Population Commission & Macro 2014), 240 women were recruited into the study. The eligible study subjects were selected by systematic sampling technique. All the houses in the community were numbered with the first house determined by spinning of a bottle top. The houses were numbered in a clock wise direction until all the houses in the community (720) were numbered and this number constituted the sampling frame. The sampling frame was divided by the sample size, 240, to arrive at the sampling interval ($720/240 \approx 3$). The 1st house was chosen randomly among numbers 1 to 3 by simple random sampling (balloting). Every third house was then selected and included in the sample. In each of the house, simple random sampling (balloting) was done to pick a woman of reproductive age group. Where there was more than one eligible woman in the household, simple random sampling (balloting) was used to select one of them to participate in the study. Where the selected woman in the selected house declined participation in the study, and she was the only eligible woman in the house, the immediate next house was selected, and the woman in the house invited to participate in the study, sampling subsequently continued with the initial sampling interval.

Data was collected by administering a structured questionnaire prepared in English and translated to Hausa Language for respondents who did not understand English Language. The questionnaire which was administered by research assistants contained 3 sections which sought to obtain information on respondents' socio-demographic characteristics, knowledge, and uptake of family planning. Only respondents who had ever heard of family planning

were asked questions on knowledge and uptake of family planning. After assessing respondent's uptake of family planning, the respondents were further asked if they will be willing to use using family planning in the future. Knowledge and uptake were assessed using 18 and 6 questions respectively. The instrument was adapted from previous studies (Onwuzurike & Uzochukwu 2001; Olaitan 2011) A pre-test of the survey instruments was carried out and the questionnaire was pretested among 15 women of reproductive age in Bwari, another community in the area council. Appropriate corrections were made based on the deficiencies detected in the instrument during pre-test. Temporal stability of the instrument was assessed by administering the questionnaire to women of reproductive age group (not part of those recruited for the study) the questions were re-administered 2 weeks later. This was done to ascertain correlation between initial response and second set of responses. Internal consistency was assessed for knowledge and uptake questions using Cronbach's alpha and a score of 0.82 and 0.80 respectively were obtained.

Data collation and sorting was done manually. A score was awarded for every correct answer and any wrong or non-response was not given any score. The total score was determined by calculating the total correct responses divided by the total number of expected correct responses multiplied by hundred. A score of 50% and above was regarded as adequate knowledge while a score below 50% was regarded as inadequate knowledge. Data was subsequently entered and analysed using statistical package for social sciences (SPSS) version 20. Data analysis started with descriptive statistics followed by inferential statistics. Quantitative variables were summarized using mean and standard deviation while qualitative variables were summarized using frequency and percentages. Inferential statistics (chi square test) was used to determine factors associated with respondents' family planning knowledge and uptake. All tests were conducted using 2 tails while level of significance was set at 0.05.

Permission to conduct the study was obtained from Bwari Area Council Health Department, ethical approval was obtained from Health Research Ethics Committee, Federal Capital Territory, Abuja, Nigeria. Informed written consent was obtained from the study participants after explaining the objectives of the study to them. Confidentiality was maintained throughout the course of the study and the respondents were assured that all the provided information would be confidential. Data was stored in a password-protected personal computer.

Many of the respondents were business women, as such it was a bit difficult to get their attention. Some respondents refused to respond to certain questions despite assurance of confidentiality, possibility of misreporting cannot be completely ruled out. This study is the first to be conducted in the study population, Findings from this study would provide baseline data for future reference and intervention measures.

RESULTS

Two hundred and forty respondents participated in the study, however knowledge and uptake of family planning was assessed for 226 respondents who had awareness of family planning. Slightly less than half (46.8%) of the respondents were aged 30-39 years with mean age of 31.4 ± 6.7 years. Most of the respondents were married (91.1%), Christians (67.9%), and work as traders (73.4%). Very few of the respondents (11%) had no formal education. (Table 1). Most (94%) of the respondents have heard about family planning, respondents identified healthcare workers (90%) as their main source of family planning information. (Table 2)

Most of the respondents had good knowledge of the use of family planning; 93.2% knew that family planning is used to space children, 91.95% knew that family planning can be used to prevent unwanted pregnancies. Knowledge of side effects of family planning was not as good as knowledge of use of family planning as about a quarter of respondents (23.3%) knew that amenorrhoea could be a side effect of oral contraceptive pills, 75.42% knew that family planning commodities could alter menstrual pattern of users, 49.58% knew that family planning commodities cannot destroy the uterus. Less than half of the respondents (47.88%) knew that oral contraceptive pills must be taken daily, 73.72% knew the timing of taking injectable, 52.12% knew the use of vasectomy and 59.32% knew the use of tubal ligation in family planning, 49.58% and 55.93% knew site for insertion of IUCD and Norplant respectively. (Table 3)

More than half (58%) of the respondents were not using any form of family planning. Almost all the respondents (97%) currently using family planning were using modern method. Of the women currently using modern methods, more than half (52%) were on injectable, 21% were using implant, 9% were using condom, and 8.3% were on pills. (Table 4)

About one-third of those not using family planning methods they wanted, reported health contra-indication (31.3%), decision of health worker (31.3%), not having husband's consent (12.5%), method of choice was temporarily out of stock (6.3%) as their main reasons. Several reasons were given for not being on family planning, some of the reasons giving include wanting to get pregnant (33.6%), already pregnant (23.4%) side effects of contraceptives (17.2%), husbands disapproval (16.4%). (Table 5)

Two-fifth of the respondents who had adequate knowledge were less than 30 years. Age ($\chi^2 = 8.382, p = 0.01$) and marital status of respondents ($\chi^2 = 8.915, p = 0.01$) were significantly associated with family planning knowledge score. Occupation ($\chi^2 = 2.641, p = 0.34$) and educational status of respondents ($\chi^2 = 7.63, p = 0.07$) were not found to be associated with their knowledge of family planning (Table 6).

TABLE 1. Socio-demographic characteristics of respondents

Variables	n (%)
Age Group (yrs) (n = 237)	
Less than 30	98 (41.4)
30-39	111 (46.8)
40-49	28 (11.8)
Marital status (n = 237)	
Single	7 (3.0)
Married	216 (91.1)
Others (Separated, Divorced or Widowed)	14 (5.9)
Type of Marriage (n = 210)	
Monogamous	177 (74.3)
Polygamous	33 (15.7)
Religion (n = 232)	
Islam	71 (30.6)
Christianity	161 (69.4)
Level of Education (n = 237)	
None	18 (7.6)
Qur'anic only	8 (3.4)
Primary	67 (28.3)
Secondary	113 (47.7)
Tertiary	31 (13.1)
Occupational Status (n = 233)	
Full Housewife	30 (12.9)
Trader	174 (74.7)
Civil Servant	21 (9.0)
Others (Farmer, students and other occupations)	8 (3.4)

TABLE 2. Respondents awareness of family planning and their main source of information

Variables	n (%)
Ever heard of family planning (n = 236)	
Yes	222 (94)
No	14 (6)
Source of Information (n = 221)	n (%)
Healthcare workers	199 (90.0)
Family and Friends	16 (7.2)
Community Leaders	3 (1.4)
Media	3 (1.4)

Level of education was significantly associated with respondent's current use of family planning ($\chi^2 = 10.78, p = 0.03$). there was no significant association between age ($\chi^2 = 4.168, p = 0.12$), marital status ($\chi^2 = 5.396, p = 0.06$), occupational status ($\chi^2 = 4.744, p = 0.19$), type of marriage ($\chi^2 = 0.77, p = 0.38$) and respondent current use of family planning (Table 7).

Educational status was significantly associated with likelihood of using family planning in the future ($\chi^2 = 8.64, p = 0.04$). Age ($\chi^2 = 3.049, p = 0.20$) and marital status ($\chi^2 = 2.701, p = 0.28$) were not found to be significantly associated with likelihood to use family planning in the future (Table 8).

TABLE 3. Respondents knowledge of family planning

Variables	Response (<i>n</i> = 236)	
	Appropriate <i>n</i> (%)	Inappropriate <i>n</i> (%)
Knowledge of the Use of Family Planning		
Family planning is used to space children	220 (93.2)	16 (6.78)
Family planning is used to delay pregnancy	215 (91.1)	21 (8.89)
Family planning is to prevent unwanted pregnancy	217 (91.95)	19 (8.05)
Knowledge of Side Effects of Family Planning		
Amenorrhea is a side effect of contraceptive pills	55 (23.3)	181 (76.69)
Family planning can alter menstrual pattern	178 (75.42)	58 (24.57)
Family planning can lead to cancer	163 (69.07)	73 (30.93)
Family planning can destroy the uterus	117 (49.58)	119 (50.42)
Family planning can cause loss of weight	123 (52.12)	113 (47.88)
Knowledge of Methods of Family Planning		
Combined contraceptive pill can be used for family planning	196 (83.05)	40 (16.95)
Pills must be taken everyday	113 (47.88)	123 (52.12)
Injections can be used for family planning	213 (90.25)	23 (9.75)
Timing of taking injectable contraceptives	174 (73.72)	62 (26.27)
Condoms can be used for family planning	207 (87.71)	29 (12.29)
Female condoms can be used for family planning	187 (79.24)	49 (20.76)
Use of vasectomy in family planning	123 (52.12)	113 (47.88)
Use of tubal ligation in family planning	140 (59.32)	96 (40.68)
Site for IUCD insertion	117 (49.58)	119 (50.42)
Site for Norplant insertion	132 (55.93)	104 (44.07)

TABLE 4. Respondents uptake of family planning and type of commodities being used

Variables	<i>n</i> (%)
Currently using family planning (<i>n</i> = 237)	
Yes	100 (42)
No	137 (58)
Method being used (<i>n</i> = 100)	
Modern	96 (96)
Traditional	4 (4)
Types of Traditional method being used (<i>n</i> = 4)	
Herbs	2 (50)
Beads	1 (25)
Safe Period	1 (25)
Modern (<i>n</i> = 96)	
Injectable	52 (53.6)
Implant	21 (21.6)
Condoms	9 (9.3)
Pills	8 (8.3)
IUCD	5 (5.2)
Sterilization	1 (1.0)

TABLE 5. Respondents' main reasons for not being on family planning and not using their methods of choice

Variables	<i>n</i> (%)
Reason for Non-use of family planning (<i>n</i> = 128)	
Want to get pregnant	43 (33.6)
Already Pregnant	30 (23.4)
Side effects of contraceptive	22 (17.2)
Husband's disapproval	21 (16.4)
Have not completed family size	6 (4.7)
Lack of awareness	3 (2.3)
Religious belief	2 (1.6)
Searching for a particular gender	1 (0.8)
Reason for Non-use of method of choice (<i>n</i> = 15)	
Health contra-indication	5 (31.3)
Health worker determine another method more suitable	5 (31.3)
Do not have husband's consent	2 (12.5)
Don't know	2 (12.5)
Method temporarily out of stock	1 (6.3)

DISCUSSION

The study found a high level of awareness of family planning with majority of the respondents (94%) having heard about family planning. This was slightly higher than 79% reported in the 2013 NDHS for North Central Zone (National Population Commission & Macro 2014). This high level of awareness of family planning is important because awareness is the first critical step to adoption

of healthy practices. Majority of the respondents got information about family planning from health workers while only very few respondents got their information from the media. This finding agrees with previous studies which identified health workers as contributing significantly to dissemination of family planning information (Utoo et al. 2010; Anyebe et al. 2014). The result of our study may signify the effectiveness of primary healthcare system in Ushafa community. Ushafa, being a rural community

TABLE 6. Relationship between socio-demographic characteristics and respondents' knowledge of family planning

Variables	Knowledge Score (<i>n</i> = 236)		Test statistics and <i>p</i> -value
	Adequate <i>n</i> (%)	Inadequate <i>n</i> (%)	
Age group (yrs.)			
Less than 30	89 (39.7)	9 (75.0)	$\chi^2 = 8.382$ (Fisher's Exact Test), <i>p</i> -value = 0.01
30-39	109 (48.7)	1 (8.3)	
40-49	26 (11.6)	2 (16.7)	
Marital Status			
Single	5 (2.2)	2 (16.7)	$\chi^2 = 8.915$ (Fisher's Exact Test), <i>p</i> -value = 0.01
Married	207 (92.4)	8 (66.7)	
Others	12 (5.4)	2 (16.7)	
Religion			
Islam	63 (28.8)	7 (58.3)	$\chi^2 = 4.7$, <i>p</i> -value = 0.04
Christianity	156 (71.2)	5 (41.6)	
Level of education			
None	15 (6.9)	3 (25.0)	$\chi^2 = 7.63$ (Fisher's Exact Test), <i>p</i> -value = 0.07
Qur'anic only	6 (2.9)	1 (8.3)	
Primary	63 (29.2)	4 (33.4)	
Secondary	104 (48.1)	3 (25.0)	
Tertiary	30 (13.9)	1 (8.3)	
Occupation			
Housewife	28 (12.7)	2 (18.2)	$\chi^2 = 2.641$ (Fisher's Exact Test), <i>p</i> -value = 0.34
Business	166 (75.0)	7 (63.6)	
Civil Servant	20 (9.0)	1 (9.1)	
Others	7 (3.2)	1 (9.1)	
Type of Marriage			
Monogamous	171 (85.5)	5 (55.6)	$\chi^2 = 5.81$, <i>p</i> -value = 0.02
Polygamous	29 (14.5)	4 (44.4)	

TABLE 7. Relationship between socio-demographic characteristics of respondents and current use of family planning

Variables	Are you currently using family planning? (<i>n</i> = 222)		Test statistics and <i>p</i> -value
	Yes <i>n</i> (%)	No <i>n</i> (%)	
Age group			
Less than 30	29 (33.0)	61 (45.5)	$\chi^2 = 4.168$ (Fisher's Exact Test), <i>p</i> = 0.12
30-39	46 (52.3)	61 (45.5)	
40-49	13 (14.7)	12 (9.0)	
Marital status			
Single	1 (1.1)	4 (3.0)	$\chi^2 = 5.396$ (Fisher's Exact Test), <i>p</i> -value = 0.06
Married	86 (97.8)	120 (89.5)	
Others	1 (1.1)	10 (7.5)	
Religion			
Islam	14 (15.9)	50 (78.1)	$\chi^2 = 12.87$, <i>p</i> = 0.00, OR = 0.302
Christianity	74 (84.1)	80 (51.9)	
Level of education			
None	2 (2.3)	10 (7.5)	$\chi^2 = 10.78$ (Fisher's Exact Test), <i>p</i> = 0.03
Qur'anic only	0 (0.0)	6 (4.5)	
Primary	31 (36.0)	34 (25.4)	
Secondary	47 (54.7)	62 (46.2)	
Tertiary	6 (7.0)	22 (16.4)	
Occupational Status			
Unemployed	13 (14.7)	15 (11.5)	$\chi^2 = 4.744$ (Fisher's Exact Test), <i>p</i> = 0.19
Business	68 (77.3)	97 (74.0)	
Civil Servant	7 (8.0)	13 (9.9)	
Others	0 (0.0)	6 (4.6)	
Type of Marriage			
Monogamous	73 (88.0)	96 (83.5)	$\chi^2 = 0.77$, <i>p</i> = 0.38, OR = 1.41
Polygamous	10 (12.0)	19 (16.5)	

TABLE 8. Relationship between socio-demographic characteristics of the respondents and likelihood of using family planning in future

Variables	Are you likely to use family planning in future? (n = 214)		Test statistics and p-value
	n (%)	n (%)	
Age group			
Less than 30	78 (39.0)	9 (64.3)	$\chi^2 = 3.049$ (Fisher's Exact Test), <i>p</i> -value = 0.20
30-39	97 (48.5)	4 (28.6)	
40-49	25 (12.5)	1 (7.1)	
Marital status			
Single	4 (2.0)	1 (7.1)	$\chi^2 = 2.701$ (Fisher's Exact Test), <i>p</i> -value = 0.28
Married	186 (93.0)	12 (85.7)	
Others	10 (5.0)	1 (7.1)	
Religion			
Islam	60 (30.6)	3 (23.1)	$\chi^2 = 0.33$, <i>p</i> -value = 0.76
Christianity	136 (69.4)	10 (76.9)	
Level of education			
None	10 (5.0)	3 (21.4)	$\chi^2 = 8.64$ (Fisher's Exact Test) <i>p</i> -value = 0.04
Qur'anic only	4 (2.0)	1 (7.1)	
Primary	58 (29.0)	3 (21.4)	
Secondary	98 (49.0)	7 (50.0)	
Tertiary	30 (15.0)	0 (0.0)	
Occupational Status			
Housewife	25 (12.7)	1 (7.1)	$\chi^2 = 2.728$ (Fisher's Exact Test) <i>p</i> -value = 0.36
Others	5 (2.5)	1 (7.1)	
Business	147 (74.6)	12 (85.7)	
Civil Servant	20 (10.2)	0 (0.0)	
Type of Marriage			
Monogamous	152 (84.9)	11 (84.6)	$\chi^2 = 0.67$, <i>p</i> -value = 0.98
Polygamous	27 (15.1)	2 (15.4)	

without regular power supply, has a limited access to mass media and hence, the reduced role of mass media in family planning publicity.

Similarly, majority of the respondents had adequate knowledge of family planning with 95% demonstrating overall general knowledge of family planning. This finding is consistent with other studies in Nigeria which showed high level of knowledge among women of reproductive age group (Monjok et al. 2010; National Population Commission & Macro 2014). However, variation in level of knowledge on different aspects of family planning existed among the respondents. While over 95% of the respondents had knowledge of general use of family planning such as child spacing and family size control, 77% did not know amenorrhea could be a side-effect of family planning and almost half of the respondents (49.6%) thought family planning can destroy the womb. Misconceptions and incorrect knowledge of side effects may discourage individuals from accepting family planning (Monjok et al. 2010; National Population Commission and Macro 2014). Knowledge of individual method of family planning was also poor with less than half of the respondents, knowing where IUCD is inserted and not knowing that oral contraceptive pills are taken daily. Adequate knowledge of individual methods of family planning empowers a woman to make an informed choice (Monjok et al. 2010).

It will be difficult to choose an appropriate method without adequate knowledge.

The adequate level of knowledge of family planning in this study was however not reflected in the use of family planning. Family planning uptake was only 42% among the respondents. This is however higher than the national average of 15% and FCT average of 25% reported in the last NDHS (National Population Commission & Macro 2014). Most of the respondents using family planning were using modern methods. Higher use of modern family planning method was also reported in 2013 NDHS (10% vs. 5%) (National Population Commission & Macro 2014). Surprisingly, the commonest methods of family planning used by respondents in this study were injectable (52.3%) and implant (22.0%) in contrast to condoms and oral contraceptive pills reported in previous studies (Aninyei et al. 2008; Utoo et al. 2010). The main reason for uptake among current users was child spacing (85.8%) which was consistent with the result of previous studies (Onwuzurike & Uzochukwu 2001; Aninyei et al. 2008). The low uptake of family planning in Ushafa may expose the community to accompanying negative consequences such increased growth rate, high level of poverty and high maternal mortality rate.

About Seventeen percent using family planning did not experience any side effect, almost 20% of the respondents

not using family planning cited fear of side effects as their reason for not using family planning. Low uptake of family planning due to fear of side effects may be associated with widespread misconceptions discussed earlier such as the believe that family planning destroys the womb. Without correct information about possible side effects of family planning, the fear of side effects will continue to discourage uptake of family planning services in the community. The results of this study are similar to the results of previous studies conducted among women of reproductive age in Nigeria (Utoo et al. 2010; Anyebe et al. 2014).

Husband's disapproval was similarly reported by about 20% of the respondent as a reason for non-uptake of family planning. Even among those using family planning in this study, the husband solely took decision on family planning in about half of the respondents. Previous studies also identified husband disapproval as one of the main reasons for non-uptake of family planning. Decision making in African culture is often the husband's responsibility as the head of the family. Thus, health promotion interventions on family planning should not exclude men. A study which explores attitudes of men in this community to family planning should be considered in the future research.

The results obtained in this study may in part be attributed to the socio-demographic characteristics of the respondents. Majority of the respondents who had adequate knowledge of family planning were found to be married. It is socially unacceptable for unmarried women to use family planning in Nigeria as unmarried women using contraceptives may be regarded as morally loose. Family planning services are often targeted at married individuals and often delivered with post-natal services.

Surprisingly, there was no association between respondents' knowledge of family planning and their level of education. The uptake of family planning reported in this study might be explained by the religion of the respondents. Respondents who were Christians were three times more likely to use family planning than the Muslims. This may also partially explain a higher uptake in this study than the national average as the proportion of Christians were higher in the community (Almost 70% of the respondents were Christians). Previous studies in Nigeria have also reported higher uptake of family planning among Christians (Nwachukwu et al. 2008; Olugbenga-Bello et al. 2011). Therefore, promotion of family planning services in the community may be achieved through religious leaders.

CONCLUSION

Although the respondents had fairly good knowledge of family planning, the study observed some misconceptions especially with respect to side effects and methodology of use of the commodities. Low uptake of family planning was observed among the respondents. Age and marital status were significantly associated with family planning knowledge; level of education was significantly associated

with current use of family planning. There is a need for incorporation of facts on usage and side effects of family planning in message disseminated by health workers in health facilities in Ushafa Community so as to correct misconceptions.

ACKNOWLEDGEMENT

We are grateful to Leaders of Ushafa Community for facilitating the conduct of this study.

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Received: April 2017
Accepted for publication: November 2017