

# FAMILY PLANNING USE; PREVALENCE, PATTERN AND PREDICTORS AMONG WOMEN IN AN URBAN SLUM IN ENUGU, NIGERIA

Aniwada, Elias Chikee<sup>1</sup>, Okpoko Chinwe Catherine<sup>2</sup>, Uleanya Nwachinemere<sup>3</sup>, Umeobieri Ancilla Kate<sup>1</sup>, Okechi Uchenna Chukwuemeka<sup>4</sup>

<sup>1</sup>Department of Community Medicine, University of Nigeria, Enugu Campus, Enugu state, Nigeria

<sup>2</sup>Department of Mass Communication, University of Nigeria, Nsukka, Enugu State, Nigeria

<sup>3</sup>Department of Paediatrics, Enugu State University Teaching Hospital, Enugu, Nigeria

<sup>4</sup>Oral and Maxillofacial Surgery Department, Faculty of Dentistry, College of Medicine, University of Nigeria

## ABSTRACT

**INTRODUCTION:** High fertility, high birth rates and low family planning prevalence rate is a common feature in developing countries with consequent rapid population growth. Family planning has saved the lives and protected the health of millions of women and children. This study aims to ascertain prevalence, pattern and predictors of family planning use among women living in an urban slum.

**METHODOLOGY:** It was a Community based, descriptive cross sectional study using questionnaire. Chi square test was used to assess associations of socio-demographics characteristics with ever used and currently using family planning. Binary logistic regression was used to determine the predictors of family planning use.

**RESULT:** Of the 281 women studied, 50.5% of respondents have used family planning method before and 35.6% still using. Commonly used methods include; withdrawal (30.2%), condom (26.7%) and abstinence (26.7%) while the least used were sterilization (1.1%) and BTL (1.4%). About 79.7% of non-users cited fear of side effects as the major reason and 9.3% discontinued due to side effects. There were statistically significant association of age, marital status, occupation and number of children with ever used family planning (all  $p < 0.001$ ). Those aged 25-34 years were 0.22 (95% CI: 0.10-0.48) times likely and those aged  $\geq 35$  years 0.32 (95% CI: 0.122-0.83) likely to have ever used family planning than those aged 24 years and below. Equally those with 1-3 children were 0.25 (95% CI: 0.08-0.80) likely and those that had  $> 3$  children 0.22 (95% CI: 0.06-0.81) likely to have ever used family planning than those with no children.

**CONCLUSION:** Prevalence of family planning is poor. Fear of side effects, inconvenience and religion played a major role in the reduction of use of family planning. Identified predictors were age and number of children. There is need to increase access, reduce cost and improve promotion on services like counselling to enable informed choices which will ultimately increase family planning uptake.

**KEYWORDS;** Prevalence, pattern, predictors, family planning, urban slum

NigerJMed2017: 59-67

© 2017. Nigerian Journal of Medicine

## INTRODUCTION

Developing countries are characterized by rapid population growth which is usually due to high fertility, high birth rates and low contraceptive prevalence rate.<sup>1</sup> This is high in Sub-Saharan Africa compared to the rest of the world.<sup>2</sup> Family planning (FP) is regarded as a basic human right to attain the highest standard of sexual and reproductive health, free of discrimination, coercion and violence.<sup>3</sup> It is an essential element of reproductive health care and have saved the lives and protected the health of millions of women and

children.<sup>3</sup> According to the WHO fact sheet on FP, "it is achieved mainly through use of various contraceptive methods and treatment of involuntary infertility".<sup>4</sup> Among the major benefits of a woman's ability to space and limit pregnancies comprise: a direct impact on their health and well-being as well as outcome of pregnancies.<sup>5</sup> Family planning use plays a significant role in controlling fertility, particularly in reaching the replacement level of fertility.

Unplanned pregnancy poses a significant health problem to both the mother and the unborn child. Globally the use of modern contraceptives has risen slightly from 54 percent in the 20th century to 57.4 percent in the 21st century.<sup>6</sup> In Africa it has gone from 23.6 percent to 27.6 percent.<sup>6</sup> However, out of 225

**Corresponding Author:** Aniwada Elias Chikee  
Department of Community Medicine, University of Nigeria, Enugu  
Campus, Enugu State Nigeria  
eaniwada@gmail.com  
+234(0)8038722391

million women in the world with unmet needs of modern contraceptives, 23.2 percent dwell in Africa.<sup>6</sup> Of the 211 million pregnancies that occur annually in the world a population of about 87 million are unwanted pregnancies.<sup>7</sup> Thus, a WHO report that an estimated 222 million women in developing countries who want to space or prevent child bearing lack access to modern contraceptive methods is not surprising. Nigeria with its population of about 174 million individuals contributes about 6.8 million of the annual pregnancies with 4 percent of it being unwanted and 7 percent being mistimed.<sup>6</sup>

Projection statistics shows that if all women with an unmet need for modern contraceptives were able to use modern methods; 24 million induced abortions, 6 million miscarriages, 70,000 maternal deaths and 500,000 infant mortality could be avoided.<sup>9</sup> This gives a lucid view of why the prevalence, pattern and predictors of a cost effective practice like family planning in a developing Nigeria is an area requiring critical analysis and further supportive data. Unwanted pregnancies could avert yearly the loss of 4.7 million Disability Adjusted Life Years (DALYs).<sup>9</sup>

Globally maternal mortality rate is 216 per 100000 live births<sup>10</sup> and in Nigeria is 545 per 100000 live births.<sup>11</sup> In Nigeria, the most recent National Demographic and Health Survey estimates that the national total fertility rate is still very high at 5.5%. The Contraceptive Prevalence Rate (CPR) for modern methods of family planning among married women is 10%.<sup>12</sup> About 16 million women within the ages of 15-19 give birth yearly and one in two of these occur in just seven countries which includes Nigeria.<sup>13</sup> However, due to the socio cultural implications like stigma associated with pregnancy before marriage in our environment, unsafe abortion practices are very common among this age group, with consequent long term health implications, financial burden on the nation, infant and maternal mortality. Conversely, the low prevalence of family planning practice further affects the rate of HIV transmission, gender inequality, leads to overcrowding and slum growth.<sup>6</sup> Nigeria approved about 11.3 million US dollars for family planning commodities, conversely the achievements so far does not reflect this.<sup>14</sup> These are indications that a lot is yet to be done on how to get the individuals willing and actively involved in family planning.

Among other factors, poor health infrastructure and transportation facilities also hinder access to family planning services.<sup>15-17</sup> The situation is worsened by the high level of unmet need for family planning in these countries.<sup>18</sup> Studies further reveal that the preferred long-lasting methods of family planning are not always readily available in these countries. The low uptake of

family planning is largely blamed on many factors. It has been observed that the awareness of the availability of family planning services has a great influence on the uptake of family planning services.<sup>19</sup> Additionally, even though some women are aware of the availability of family planning services, they are not properly informed about the various forms of family planning methods and how they work.<sup>20</sup> Similarly some of the women who went for family planning services stated that there were poor access to a full range of modern family planning methods, dearth of convincing information on family planning as well as fear of side effects and therefore the reproductive health needs of these women were not met.<sup>20</sup> Women's age, residence, number of living children, women's education, religion, desire for more children, visited by family planning worker, and husband's view on family planning had significant relationships with modern method use.<sup>21</sup> According to study of couples in Nigeria, women tend to use contraceptives when their husbands are satisfied with the number of children they have.<sup>22</sup> A focus on improving family planning in Nigeria will not only facilitate reduction in the costs of meeting these needs but also to achieving the Sustainable Development Goal three.

Over the last 50 years Nigeria has witnessed a rapid migration from rural to urban areas with more than 50 percent in the urban area. The implication of this is a state of insufficiency of infrastructures and resources in these urban areas leading to creation of slums and semi urban areas. Statistics have shown that 75 percent of urban dwellers in Nigeria live in semi urban areas.<sup>23</sup> Considering the low socio economic status, overcrowding and population density of the people in these areas, their practice of family planning is highly contributory in achieving national and global goal on population control.

## METHODS

### 3.1 Study area

The study area was at Ngenevu an urban slum in Enugu north Local Government Areas (LGA) of Enugu state. Enugu Metropolis is made up of Enugu North, Enugu South and Enugu East LGAs. Ngenevu shares boundary with coal camp and university of Nigeria teaching hospital, Enugu (old site). It is located on top of Onyeama coal mine. The predominant occupation of inhabitants are artisan, petty trading with few civil/public servants. There are 3 primary schools and no primary health facility in the area. The houses are scattered in nature making the area not to have clear cut streets or zones.

### 3.2 Study design and instrument

A community based quantitative descriptive cross sectional study was done. It involved use of pretested,

interviewer administered questionnaire divided into sections including social demographics, perception and practice of family planning.

### 3.3 Data collection

Instrument was pre-tested in a similar urban slum in another location of Enugu metropolis after which observed gaps were filled. Four research assistants who were medical students were trained for 3 hours on the tool and data collection. Data collection was between September and November 2016.

### 3.4 Study population

Women aged 15-49 years resident in the area that gave consent were included in the study. However, women who are celibates like Reverend sisters, postmenopausal, and those that were not sexually active were excluded from the study.

### 3.5 Sample size determination

The minimum sample size formula for descriptive study involving proportion was used.<sup>24</sup>

$$n = \frac{Z^2 P (1-P)}{d^2}$$

Where  $Z$  is two sided confidence level at 95% (taken as 1.96),  $d$  is margin of error tolerated taken as 5%,  $p$  is prevalence of family planning use amongst women in low income and high density area=20%.<sup>25</sup> An addition of 10% was added to make for the non-response. A total of 281 women were studied.

### 3.6 Sampling technique

Cluster sampling was used. Due to the scattered nature of the houses, the researcher roughly grouped the area into six (6) clusters to ensure approximately equal representation. Three clusters were randomly selected and all respondents that met the inclusion criteria in the clusters were studied. Respondents were recruited consecutively house to house. In a situation where more than one person is qualified, all eligible persons were studied as most houses had multiple families.

### 3.7 Data Management

Data were analyzed using IBM Statistical Package for Social Science (SPSS) version 20.0. Data were summarized using proportion and percentages as well as presented in tables. Chi square test was used to assess associations between socio-demographic characteristics and ever used as well as currently using family planning. Further analysis to determine predictors was done using binary Logistic regression. The level of significance was at  $p < 0.05$ .

### 3.8 Ethical considerations

Ethical clearance was from Health research and Ethics Committee, University of Nigeria Teaching Hospital

(UNTH), Ituku/Ozalla, Verbal informed Consent was obtained from each participant after explanation of what the research is all about. Participants were informed that they must not participate in the study. Confidentiality was maintained throughout the study even beyond.

### 3.9 Limitations of the study

It would have been better if random sampling technique was used involving all household as respondents would have had equal chance of being selected. This will increase generalizability of the study.

## RESULTS

Table 1: Socio-demographics of respondents

Variables	Frequency (n =281)	Percent (100%)
<b>Age in category(years)</b>		
15-24	98	34.9
25-34	107	38.1
>35	76	27.0
<b>Denomination</b>		
Catholic	188	66.9
Anglican	42	14.9
Pentecostal	51	18.1
<b>Marital status</b>		
Single	113	40.2
Married	168	59.8
<b>Educational level</b>		
primary & below	47	16.7
Secondary	169	60.1
Tertiary	65	23.1
<b>Occupation</b>		
Civil/public servant	41	14.6
Trading	108	38.4
Student	59	21.0
Others	73	26.0
<b>Number of children</b>		
None	120	42.7
1-3	92	32.7
>3	69	24.6

Table 1 shows that 38.1% of the respondents were aged between 25-34 years, 66.9% of the respondents were Catholics, 59.8% were married, 60.1% have secondary level of education as their highest level of education, 38.4% were traders by occupation, 24.6% have more than 3 children and 42.7% have no child.

**Table 2: Ever used, method, reasons for use and non-use of family planning**

VARIABLES	Yes n(%)	No n(%)
Have you used family planning before	142(50.5)	139(49.5)
	Frequency(n=281)	Percent (100%)
<b>Duration of use</b>		
<1-5	104	37.0
6-10	26	9.25
>10	5	1.78
<b>If yes, which method did you use</b>		
Condom	75(26.7)	206(73.3)
Withdrawal	85(30.2)	196(69.8)
Abstinence	75(26.7)	206(73.3)
Contraceptive pills	30(10.7)	251(89.3)
Breastfeeding	43(15.3)	238(84.7)
IUCD	10(3.6)	271(96.4)
Implant	10(3.6)	271(96.4)
Sterilization	3(1.1)	278(98.9)
Billings method	25(8.9)	256(91.1)
BTL	4(1.4)	277(98.6)
<b>If no, reason</b>		
Predisposes one to infertility	44(15.7)	237(84.3)
Affects my general well being	38(13.5)	243(86.5)
Makes people promiscuous	34(12.1)	247(87.9)
Affects ones' relationship with my husband/his family	26(9.3)	255(90.7)
Scared it will make me gain weight	36(12.8)	245(87.2)
Scared it will increased my appetite	25(8.9)	256(91.1)
Make my menses irregular	32(11.4)	248(88.6)
Make me experience mood swings	19(6.8)	262(93.2)
Not acceptable by my religion(a sin)	31(11.0)	250(89.0)
<b>Person/source of recommendation</b>		
Hospital/medical personnel	94(33.5)	187(66.5)
Chemist	18(6.4)	263(93.6)
friends /relatives	117(41.6)	164(58.4)
Internet source	28(10.0)	253(90.0)
Radio/TV	37(13.2)	244(86.8)

**Table 2 shows ever used, method, reasons for use and non-use of family planning. About 50.5% have ever used family planning before, 37% have used it for less than 5years and 1.78% have used it for greater than 10 years. Methods used includes; withdrawal 30,2% condom 26.7%, abstinence 26.7%, contraceptive pills 10.7%, IUCD 3.6%, and BTL 1.4%. Reasons for non-use includes; predispose them to infertility 15.7%, makes one gain weight 12.8%, makes menses irregular 11.4% and not acceptable by their religion 11.0%. Recommendation was by hospital/medical personnel 33.5%, friends/relatives 41.6% and internet source 10.0%.**

**Table 3: Currently using, challenges and reasons for non-use of family planning**

VARIABLES	Yes n(%)	No n(%)
Still using family method	100(35.6)	181(64.4)
<b>Challenges encountered while using the contraceptives</b>		
Poor accessibility of service in their area	31(11.0)	250(89.0)
It was not convenient	51(18.1)	230(81.9)
Unavailability of family planning commodities	28(10.0)	253(90.0)
Financial challenges/affordability	28(10.0)	253(90.0)
Disapproval from family	27(9.6)	254(90.4)
<b>Reasons for not currently using it</b>		
Experienced unpleasant side effects	26(9.3)	255(90.7)
Ready for a planned pregnancy	36(12.8)	245(87.2)
My husband was against it	30(10.7)	251(89.3)
Sociocultural/religious beliefs	20(7.1)	261(92.9)
<b>Any dedicated centre around you offering family planning services</b>	110(39.1)	171(60.9)

**Table 3 shows currently using, challenges and reasons for non-use of family planning. About 35.6% are still using contraceptive methods. The challenges the women encountered includes; poor accessibility service in their area (11.0%), inconvenience (18.1%), unavailability of family planning commodities (10.0%), financial/ challenges/affordability (10.0%) and disapproval from family 9.6%. Reasons for not currently using it were; experienced unpleasant side effects 9.3%, ready for planned pregnancy 12.8%, their husband were against it 10.7% and sociocultural/religious beliefs 7.1%. However 39.1% have dedicated centers around them offering family planning services.**

**Table 4: Associations between Socio-demographics and ever used family planning**

Socio-Demographics	Yes n(%)	No n(%)	Bivariate analysis <sup>2</sup> (p value)	Multivariate analysis AOR(95%CI for AOR)
<b>Age in cat(years)</b>				
24 and below	23(23.5)	75(76.5)		
25-34	68(63.6)	39(36.4)	44.32 (0.000)	0.22(0.10-0.48)
35 and above	51(67.1)	25(32.9)		0.32(0.12-0.83)
<b>Denomination</b>				
Catholic	91(48.4)	97(51.6)		
Anglican	23(54.8)	19(45.2)	1.03 (0.597)	0.81(0.37-1.80)
Pentecostal	28(54.9)	23(45.1)		0.91(0.43-1.91)
<b>Marital status</b>				
Single	31(27.4)	82(72.6)	40.35 (0.000)	
Married	111(66.1)	57(33.9)		0.99(0.31-3.14)
<b>Educational level</b>				
Primary & Below	20(42.6)	27(57.4)		
Secondary	95(56.2)	74(43.8)	5.48 (0.065)	0.93(0.42-2.04)
Tertiary	27(41.5)	38(58.5)		1.40(0.55-3.55)

Occupation				
Civil/Public Servant	20(48.8)	21(51.2)		
Trading	74(68.5)	34(31.5)	28.28(0.000)	0.67(0.28-1.64)
Student	16(27.1)	43(72.9)		0.64(0.22-1.89)
Others	32(43.8)	41(56.2)		2.02(0.81-5.07)
Number of children				
None	32(26.7)	88(73.3)		
1-3	59(64.1)	33(35.9)	49.24 (0.000)	0.25(0.08-0.80)
>3	51(73.9)	18(26.1)		0.22(0.06-0.81)

**Table 4 shows associations between socio-demographics and ever used family planning. There were statistically significant association between age in category (p <0.001), marital status (p <0.001), occupation (p <0.001) and number of children (p <0.001). Those that were aged 25-34 years were about 0.22 times (95% CI: 0.10-0.48) and those aged 35 years 0.32 times (95% CI: 0.122-0.83) likely not to have used family planning than those aged 24 years and below. Those that had 1-3 children were about 0.25 times (95% CI: 0.08-0.80) and those that had > 3 children were about 0.22 times (95% CI: 0.06-0.81) likely not to have used family planning than those that had no child.**

**Table 5: Associations between Socio-demographics and currently using of family planning**

Sociodemographics	Yes n(%)	No n(%)	Bivariate analysis <sup>2</sup> (p value)	Multivariate analysis AOR(95% C.I forAOR)
<b>Age in cat(years)</b>				
24 and below	24(24.5)	74(75.5)		1
25-34	43(40.2)	64(59.8)	8.29(0.016)	0.80(0.37-1.73)
35 and above	33(43.4)	43(56.6)		0.96(0.37-2.46)
<b>Denomination</b>				
Catholic	63(33.5)	125(66.5)		1
Anglican	20(47.6)	22(52.4)	3.12(0.210)	0.55(0.26-1.15)
Pentecostal	17(33.3)	34(66.7)		1.23(0.60-2.53)
<b>Marital status</b>				
Single	24(21.2)	89(78.8)	16.98(0.000)	1
Married	76(45.2)	92(54.8)		2.24(0.55-9.06)
<b>Educational Level</b>				
Primary & Below	13(27.7)	34(72.3)		1
Secondary	70(41.4)	99(58.6)	6.32(0.042)	0.84(0.38-1.85)
Tertiary	17(26.2)	48(73.8)		1.31(0.50-3.45)
<b>Occupation</b>				
Civil/Public Servant	15(36.6)	26(63.4)		1
Trading	55(50.9)	53(49.1)	22.18(0.000)	0.76(0.33-1.77)
Student	10(16.9)	49(83.1)		1.45(0.48-4.38)
Others	20(27.4)	53(72.6)		2.32(0.92-5.88)
<b>Number of children</b>				
None	22(18.3)	98(81.7)		1
1-3	46(50.0)	46(50.0)	27.43(0.000)	0.12(0.03-0.49)
>3	32(46.4)	37(53.6)		0.17(0.04-0.78)

Table 5 shows associations between socio-demographics and currently using family planning. There were statistically significant association of age in category (p = 0.016), marital status (p <0.001), educational level (p = 0.042), occupation (p <0.001) and number of children (p <0.001) with currently using family planning. Those that had 1-3 children were about 0.12 times (95% CI: 0.03-0.49) and those that had > 3 children were about 0.17 times (95% CI: 0.04-0.78) likely not to be currently using family planning than those that had no child.

## DISCUSSION

The International Conference on Population and Development acknowledged the importance of providing family planning as part of a comprehensive set of services to meet individual reproductive health needs that would also address broader development concerns.<sup>28</sup> Nigeria and other developing countries are confronted with rapid population growth which is usually due to high fertility, high birth rates, and low contraceptive prevalence rate.<sup>27</sup> The National Policy on Population for Sustainable Development targets to reduce the national population growth rate to 2 percent or lower, reduce the total fertility rate by encouraging child spacing and increase the contraceptive prevalence rate for modern methods through the use of family planning.<sup>28</sup>

This study documented that about half of the respondents agreed to have used a family planning method before and a third still using contraceptive methods. This is poor considering the far reaching effect on population growth and society at large. The implication is that the number of persons in need of social amenities like health facilities, education and basic infrastructure, among other public benefits, is enormous. This increases the burden on our limited resources and personnel. Similarly a study documented that only 49.7% (271) had ever used any method, while 25.4% (69) of the number who had ever used contraception were currently using a method.<sup>31</sup> In another study in Ogbomoso, Oyo state only 18% (50/280) of respondents had used family planning services in the past.<sup>30</sup> Contraceptive prevalence rate has been found to be low at 13% in 2008<sup>32</sup> and with a minimal increase of 3% in 2013.<sup>32</sup> A previous study done in Enugu, reported current use prevalence of 20%.<sup>7</sup>

The common family planning methods used by the respondents from this study include; withdrawal, condom, abstinence and breast feeding. The least used methods were sterilization, Bilateral Tubal Ligation, implant and IUCD. The implication is that due to the high failure rate of abstinence this may not achieve the desired objective. This contrasts with a study among

urban poor women from six cities of Uttar Pradesh, India in which sterilization was the commonest method of contraception.<sup>33</sup> This could be explained by India's effort to curtail population explosion. The socioeconomic status of the respondents may offer explanations to why withdrawal method is the commonest method used by the respondents. In other studies the choice of family planning are widely varied.<sup>34-38</sup> In Egypt the most commonly used modern method was the IUD, followed by the pill and then injectable.<sup>34</sup> In Ibadan Nigeria frequently selected methods were IUDs (66.2%), Oral Contraceptives (10.4%), injectables (7.9%), and sterilization (5.8%). However, IUDs were common choice among women who had not obtained their husbands' support.<sup>35</sup> Studies in Southeastern Nigeria, while one reported that majority of the clients (71.8%) accepted injectable hormonal contraceptives followed by the IUDs (14.4%), implants (6.9%) and female sterilization (3.2%) while pills and condom were the least accepted,<sup>36</sup> another documented condom as the commonest contraceptive method used.<sup>37</sup> The percentages of different contraceptive methods used by women in Shire town were as follows: pill 10%, Depo-Provera 76%, Norplant 6%, IUD 1% and male condom 7%.<sup>38</sup>

A very high proportion of non-users in this study cited fear of side effects as the major reason for non-use and 9.3% respondents that used before discontinued because they experienced unpleasant side effects. This is comparable to the research in post-conflict Gulu district of Uganda, where 88.2% of non-users also cited fear of side effect as a reason for non-use.<sup>39</sup> Current study reported that challenges the women encountered include; inconvenience associated with family planning, poor accessibility, afford ability and disapproval from family especially husband or religion. The commonest reasons for discontinuation of family planning methods were: predisposition to infertility, weight gain, husbands being against it as well as sociocultural or religious beliefs. Documented barriers from other studies includes; lack of access to a full range of modern family planning methods, dearth of convincing information on family planning and fear of side effects,<sup>21</sup> poor health infrastructure and transportation facilities,<sup>15-17</sup> past experience of failure of method used or the presence of side-effects.<sup>40,41</sup>

Worldwide, religion has played a major role in hampering dissemination of information on FP use. Catholics especially have a restriction on contraceptive use.<sup>42</sup> In countries like Brazil that are predominantly Catholic, the church plays a major role in influencing government policies on family planning.<sup>43</sup> Inequity in distribution of health facilities and services is likely the reason for poor access. This is because FP clinics are in most cases located in urban areas. This evidence is

supported by studies in Uganda.<sup>44</sup> Ironically, modern contraceptive methods have cost implications, such that fees for contraceptive methods deter poor people from using the services.<sup>45</sup> A study of wealth status and family planning reveals that modern contraceptive use is more than twice as high among the wealthiest women when compared to the poorest women.<sup>46</sup> Women empowerment is another issue. Married women depend on their spouses for approval of family planning. Thus, husband's non approval was cited as the major reason for non-use therefore the low utilization of modern contraceptive services among married women in many developing countries especially in Nigeria is not surprising.<sup>47</sup> This is supported by finding that major reasons for not accessing family planning services were opposition from husbands, 90% (207/230) and misconceptions about family planning, 83% (191/230).<sup>31</sup>

There were statistical significant association of ever used family planning with age, marital status, occupation and number of children while identified predictors were age and number of children. Equally there were statistically significant association between currently using family planning and age, marital status, education, occupation and number of children while identified predictors were age and number of children. This agrees with a host of other studies. Previous studies have documented associations between demographic and socioeconomic factors.<sup>21,28,29</sup> The predictors of contraception use included the age group, marital status, level of education.<sup>30</sup> Another study reported age, religion, residence, education, ethnicity, and media exposure to family planning as significant predictors of current use of any contraceptive method.<sup>28</sup> Women's age, residence, number of living children, women's education, religion, desire for more children, visit by family planning worker and husband's view on family planning had significant relationships with modern method use.<sup>21</sup> In Malawi, the major determinants of contraceptive use were age, respondents' and partners' approval of family planning, family planning discussion with partner, number of living children, work status, education and visit to a health centre.<sup>48</sup> In contrast to most reports, a study revealed that socioeconomic status, religious factors and cultural norms do not influence couples' choice, whereas educational background of the couples and involvement of partners toward the choice of family planning significantly influenced the choice of family planning among couples.<sup>49</sup>

## CONCLUSION

Prevalence of family planning is poor. Fear of side effects, cost, access barriers, inconvenience, disapproval from husband and religion played a major

role in the reduction of use of family planning. Identified predictors were age and number of children. There is need for culturally appropriate counseling which can mobilize the presumably latent demand for family planning use by reassuring potential clients of the social acceptability and by allaying their fears about side effects of contraceptive methods. Moreover, there is need to reduce cost and increase access by making family planning readily available especially at the primary health care level where women should be educated on family planning and its importance.

#### CONFLICT OF INTEREST

Authors declare no conflict of interest

#### REFERENCES

1. Oyedokun AO. Determinants of contraceptive usage: lessons from women in Osun State, Nigeria. *J Humanit Soc Sci.* 2007;1(2):1-14.
2. USAID/HPI. Achieving Equity for the Poor in Kenya: Understanding Level of Inequities and Barriers to Family Planning Services. Futures Group International, Nairobi: 2007.
3. United Nations Population Fund The State of World Population 2003. Making 1 Billion Count: Investing in Adolescents' Health and Rights. Geneva, 2003.
4. World Health Organization. Updates fact sheet on Family Planning/ Contraception 2013.
5. World Health Organization World Health Statistics Report. Geneva: 2014
6. World Health Organization. Family planning/contraception world health organization fact sheet N351 may 2015, Available at : <http://who.int/mediacentre/factsheets/fs351/en/> Accessed on 24/2/17
7. World Health Organization. Not every pregnancy is welcome. World health report chapter 2005 3. P4. Available at: <http://www.who.int/whr/2005/chapter3/en/index3.html> Accessed on 24/2/17
8. World Health Organization. Population data. Available at : <http://data.worldbank.org/indicator/> Accessed on 24/2/17
9. Susheela S. Jacqueline ED. Lori SA. Adding it up, the cost and benefits of investing in sexual and reproductive health 2014, Guttmacher institute 2014, 2:14
10. World Health Organization Maternal mortality ratio data accessed Available at <http://data.worldbank.org/indicator/> Accessed on 24/2/17
11. Obionu, C. N. Primary health care for developing countries. 2nd ed. 2007: 249
12. National Population Commission (NPC) [Nigeria] and ICF International. Nigeria Demographic and Health Survey 2013. NPC, Abuja: 2014
13. World Health Organization. Adolescence pregnancy fact sheet, September 2014 Available at: [http://www.who.int/maternal\\_child\\_adolescent/](http://www.who.int/maternal_child_adolescent/) Accessed on 24/2/17
14. Olusola B. USAID spending on family planning, health Space intervention in Nigeria. Available at <https://www.google.com.ng/amp/punchng.com/usaids-spends-n9-12bn-family-planning-health-interventions-nigeria/amp> Accessed on 24/2/17
15. Cleland J, Bernstein S, Ezeh A, Faundes A, Glasier A, Innis J. Family Planning: The Unfinished Agenda. *The Lancet* 2006.;368(9549): 1810-1827.
16. United Nations Population Fund. State of the World Population; By Choice not by Chance, Family Planning, Human Rights and Development. New York 2012.
17. Yeakey, M.P., Muntifering, C.J., Ramachandran, D.V., Myint, Y., Creanga, A.A., and Tsui, A.O. How Contraceptive Use Affects Birth Intervals: Results of a Literature Review. *Studies in Family Planning.* 2009;40(3): 205-214.
18. World Health Organization. Family Planning Fact Sheet No. 351. Geneva: 2012.
19. Lauria L, Donati S, Spinelli A, Bonciani M, Grandolfo ME. The effect of contraceptive counselling in the pre and post-natal period on contraceptive use at three months after delivery among Italian and immigrant women. *Ann Ist Super Sanita.* 2014;50(1):54-61.
20. Malini B, Narayanan E. Unmet need for family planning among married women of reproductive age group in urban Tamil Nadu. *Journal of Family & Community Medicine.* 2014;21(1): 53-5
21. Rahayu R. Contraceptive Use Pattern among Married Women in Indonesia Paper presented at the International Conference on Family Planning: Research and Best Practices, November 15-18, 2009, Kampala, Uganda.
22. Ogunjuyigbe PO, Ojofeitimi EO, Liasu A. Spousal communication, changes in partner attitude, and contraceptive use among the Yorubas of southwest Nigeria, *Indian Journal of Community Medicine,* 2009;34(2):112-116
23. World bank statistics, population of Nigerians living in slum, (% of urban population) accessed at <http://data.worldbank.org/indicator>

24. Onwasigwe C. Principles and Method of Epidemiology. 2nd ed. Enugu: El Damak Publications. 2010:pg35
25. Onwuzurike BK, Uzochukwu BSC. Knowledge attitude and practice of family planning amongst women in a high density low income urban of Enugu Nigeria. African journal of Reproductive Health 2001;5[2]:83-89.
26. Okech TC, Wawire NW, Mburu TK. Contraceptive use among women of reproductive age in Kenya's city slums. Int J Bus Soc Sci. 2011;2:22-43.
27. Oyedokun AO. Determinants of contraceptive usage: lessons from women in Osun State, Nigeria. J Humanit Soc Sci. 2007;1(2):1-14
28. Adebowale SA, Adeoye IA, Palamuleni ME. Contraceptive use among Nigerian women with no fertility intention: interaction amid potential causative factors. African Popul Stud. 2013;27:127-139.
29. Health Policy Initiatives (HPI). Inequalities in the Use of Family Planning and Reproductive Health Services: Implications for Policies and Programs. USAID/HPI Task Order 1, Washington DC: 2007.
30. Adeyemi AS, Olugbenga-Bello AI, Adeoye OA, Salawu MO, Aderinoye AA, Agbaje MA. Contraceptive prevalence and determinants among women of reproductive age group in Ogbomoso, Oyo State, Nigeria. Open Access Journal of Contraception. 2016; 7:33-41
31. Apanga PA, Adam MA. Factors influencing the uptake of family planning services in the Talensi District, Ghana. The Pan African Medical Journal. 2015; 20:10. doi:10.11604/pamj.2015.20.10.5301
32. National Population Commission (NPC). Nigeria Demographic and Health Survey 2003. NPC, Abuja: 2004.
33. Shaikh S, Dwivedi S. Predictors to use of family planning methods among women of Allahabad district, Uttar Pradesh. Health and Population Perspectives and Issues. 2014;37(3&4):118-127
34. Amin TT. Trend and Pattern of Use and Barriers to Family Planning in Egypt. International Public Health Forum. 2014;4(1):1-8
35. Konje JC, Oladini F, Otolurin EO, Ladipo OO. Factors determining the choice of contraceptive methods at the Family Planning Clinic, University College Hospital, Ibadan, Nigeria. Br J Fam Plann. 1998;24(3):107-10
36. Chigbu B, Onwere S, Aluka C, Kamanu C, Okoro O, Feyi-Waboso P. Contraceptive choices of women in rural Southeastern Nigeria. Niger J Clin Pract. 2010;13(2):195-9
37. Adogu P, Udigwe I, Udigwe G, Nwabueze A, Onwasigwe C. Pattern, Types and Predictors of Contraception among Female In-School and Out-of-School Adolescents in Onitsha, Anambra State, Nigeria. Advances in Sexual Medicine. 2014;4(3):33-41.
38. Tsehaye WT, Mengistu D, Birhanu E, Berhe KK. Assessment of Preference and Its Determinant Factors to Ward Modern Contraceptive Methods among Women of Reproductive Age Group in Shire Indaselassie Town, Northern Ethiopia, 2011. International Journal of Family Medicine Volume 2013, Article ID 317609, 8 pages. <http://dx.doi.org/10.1155/2013/317609>
39. Orach CG, Otim, Apromon JF, Amone R, Okello SA, Odongkara B, Komakech H. Perceptions, attitude and use of family planning services in post conflict Gulu district, northern Uganda. BioMed central. Conflict and Health. 2015; 9:24 DOI 10.1186/s13031-015-0050-9
40. El-Zanaty F, Way A. Egypt Demographic and Health Survey 2008. Cairo, Egypt: Ministry of Health, El-Zanaty and Associates, and Macro International 2009.
41. Storey JD, Boulay M. Improving family planning use and quality of services in Nepal through the entertainment-education strategy. Baltimore, Maryland, Johns Hopkins School of Public Health, Population Communication Services, 2000 (Field Report No. 12).
42. Lanre O. Factors influencing the choice of family planning among couples in Southwest Nigeria. International Journal of medicine and medical science. 2011;3(1):227-232.
43. Gupta N, Leite LC. Adolescent Fertility Behavior: Trends and Determinants in Northeastern Brazil. International Family Planning Perspectives. 1999;25(3):125-130
44. Bureau of Statistics and Macro International Uganda Demographic and Health Survey 2000 Report. 2000 Available at: <http://www.ubos.org/onlinefiles/uploads/ubos/pdf> Accessed 24/2/2017
45. Creanga AA, Gillespie D, Karklins S, Tsui AO. Low use of contraception among poor women in Africa: an equity issue. Bulletin of the World Health Organization. 2011;89:258-266. doi: 10.2471/BLT.10.083329.
46. Family Health Initiative Expanding Contraceptive Use in Urban Uttar Pradesh: Family Planning: Effect of Data Driven Strategies. Policy Brief. 2010 Available at [www.uhi-india.org](http://www.uhi-india.org) Accessed 24/2/2017
47. United Nations Population Fund. Reproductive Health. Ensuring that every

pregnancy is wanted. 2012 Available at <http://www.unfpa.org/rh/planning.htm> Accessed 24/2/2017

48. Palamuleni ME. Demographic and Socio-economic Factors affecting Contraceptive Use in Malawi. *J Hum Ecol.* 2014;46(3): 331-341
49. Olaitan OL. Factors influencing the choice of family planning among couples in Southwest Nigeria. *International Journal of Medicine and Medical Sciences.* 2011;3(7):227-232.