

ATTITUDE OF MARRIED WOMEN TOWARDS FAMILY PLANNING IN NIGERIA

BY

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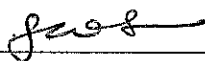
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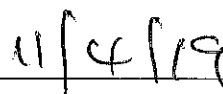
CERTIFICATION

This is to certify that this project work was done by Falodun Oluwatosin Emmanuel, an undergraduate of Demography and Social Statistics with registration number DSS/14/1820 who has satisfactorily completed the requirement for the award of B.Sc degree in Demography and Social Statistics of Federal University Oye-Ekiti, Ekiti State.

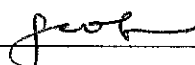


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DEDICATION

This project is dedicated to the glory of almighty God, without whom I am nothing. Also this is dedicated to my parent for their loving care.

ACKNOWLEDGMENT

The completion of this study was enabled through the numerous contributions of different persons. I express my gratitude to God Almighty whose tender mercies have led me through this career. It is however, pertinent to mention but few, wish to appreciate the untiring effort of my supervisor, Mrs Ntoimo Lorreta who in spite of his very tight schedule found time thoroughly supervise this work and also gave me very resourceful information that contributed immensely to the success. My greetings goes to my HOD, Dr (Mrs) Ntoimo Lorreta Favour and other lecturers in the department including Dr Adeyemi Oluwagbemiga, Dr Odushina E. kolawole, Dr Shittu Sarafa B, Miss Alex-Ojei Christianah, Mr. Babalola Blessing, for impacting good knowledge unto me. I want to appreciate my parent Mr and Mrs Falodun and my siblings Ifeoluwa, Olaoluwa, Ibukunoluwa , Boluwatife, and Mrs ogunniyi for their prayers, financial support and encouragement.

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ABSTRACT

Nigeria is among the countries with the highest unmet needs for family planning, with a population of about 198 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 women in Nigeria. Without a thorough understanding of, and due attention to the local context, utilization of family planning may continue to be low. This study also seeks to odds Ratio Based on Logistic Regression Analysis of Socio-Demographic Characteristics and Attitude towards contraceptives Use.

TABLE OF CONTENT

TITLE.....	I
CERTIFICATION.....	II
DEDICATION.....	III
ACKNOWLEDGMENT.....	IV
ABSTRACT.....	V

CHAPTER ONE: INTRODUCTION

1.0 Background to the Study.....	1-7
1.1 Statement of the Problem.....	5-7
1.2 Research Questions.....	7
1.3 Research Objectives.....	8
1.4 General Objectives.....	8
1.5 Specific Objectives.....	8
1.6 Justification of Study.....	8-9
1.7 Operational definition of Terms.....	9

CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction.....	10
2.1 Global overview of Family Planning.....	10-11
2.2 Contraceptive use in Africa.....	11-13
2.3 Contraceptive use in Nigeria.....	13-14
2.4 Prevalence of Contraceptive Use.....	15-16
2.5 Types of Contraceptives.....	16-18
2.6 Attitude of women towards Family Planning.....	18-19
2.7 Socio-Demographic Factors.....	20-22

2.8 Theoretical Frame Work.....	22-23
2.9 Conceptual Frame Work.....	23
2.10 Statement of Hypothesis.....	24
CHAPTER THREE: RESEARCH METHODOLOGY	
3.0 Introduction.....	25
3.1 Description of the Study Area.....	25-26
3.2 Target Population.....	26
3.3 Quantitative Data Source.....	26
3.4 Sample Design for the 2013 NDHS.....	26-27
3.5 Sample Size.....	27
3.6 Data Management and Variable Measurement	28-31
3.7 Data Processing and Analysis.....	31
3.8 Measurement of Variables.....	31-32
CHAPTER FOUR: DATA PRESENTATION, ANALYSIS AND INTERPRETATION	
4.0 Introduction.....	33
4.1 Distribution of Married Women by Socio-Demographic Characteristics by Weight percentage.....	33-36
4.2 Distribution of Married Women by Socio-Demographic Characteristics and Pattern and Intention of Contraceptives Use.....	36-39
4.3 Odds Ratio Based on Logistic Regression Analysis of Socio-Demographic Characteristics and Attitude towards contraceptives Use.....	40-43
CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATION	
5.0 Introduction.....	44
5.1 Summary of Findings.....	44
5.2 Conclusion.....	44
5.3 Recommendations.....	44-45
REFERENCES.....	46-48

CHAPTER ONE

1.0 BACKGROUND OF THE STUDY

One of the global problems of today is the increasing population without commensurate rise in the world resources to care for the numerous needs of the people. The population of Nigeria was estimated to be around 198 million in 2018, with a projected estimate of 398 million by the end of 2050. By 2100, if current figure continue, the population of Nigeria will be over 746 million (United Nation 2018). This makes Nigeria the seventh most densely inhabited country and the third most populous in the world by 2050. Nigeria's reproductive statistics are also very challenging, in 2016, fertility rate for Nigeria was 5.5 births per woman. Fertility rate of Nigeria fell gradually from 6.4 births per woman in 1967 to 5.5 births per woman in 2016. "Also by 2050, global population is projected to rise to 9.3 billion. Between now and mid-century, these diverging growth patterns will boost the population share living in today's less developed countries from 82 percent to 86 percent." According to World Health Organization (WHO), maternal mortality is unacceptably high. About 830 women die from pregnancy or childbirth related complications around the world every day. It was estimated that in 2015, roughly 303,000 women died during and following pregnancy and childbirth. Almost all of these deaths occurred in low-resource settings in the world, and most could have been avoided. (World Health Organization 2018).

The Maternal Mortality Ratio in developing countries is 15 times higher than that of the developed countries (United Nations, 2013); United Nations also reports that the unmet need for family planning is slowly being met for more women. However, the demand is increasing at very

rapid rate. It is shown that out of 210 million pregnancies occurring in the world annually about 89 million are estimated to be unintended and more than 50% end up in abortion (Bonqarts and West off, 2000).

The World Health Organization estimates that at least 33% of all women seeking care from hospital for complication related to abortion are less than 20 years of age, this may be elaborated due to the fact that adolescent fertility is high, this affect not only the young women but also their children's health because birth of women aged 15-19 years have the highest risk of infant and child mortality as well as high risk of maternal mortality (Mpangile et al., 1992).

By protecting women from the risk of pregnancy and its associated complications, family planning can play a vital role in reduction of infant, child and maternal morbidity and mortality. Despite extensive global effort and investments to reduce maternal mortality this remains high in many developing countries. There are approximately 25million unsafe abortions annually. Of these one third or approximately 8 million were performed under the least safe conditions by untrained persons using dangerous and invasive methods (Singh, Maddow-zimwet 2012).

In developed regions, it is estimated that 30 women die for every 100 000 unsafe abortions. That number rises to 220 deaths per 100,000 unsafe abortions in developing regions and 520 deaths per 100,000 unsafe abortions in sub-saharan Africa (Singh, 2012). Mortality from unsafe abortion disproportionately affects women in Africa. While the continent account for 29% of all unsafe abortions, it sees 62% of unsafe abortion-related to deaths (Ganatra, Gerdts, Alkema, and John 2017).

The persistence of high fertility in sub-Saharan Africa has been the subject of considerable investigation in the past decade. Social forces and pro-natalist factors sustaining

high fertility and impeding family programs are also well known. Added to this, is the fact that in sub-Saharan Africa, husbands tend to want larger families than their wives. (World health organization, 2013). In sub-Saharan Africa, extreme poverty, lack of access to birth control, and restrictive abortion laws cause about 3% of women to have unsafe abortions (Rasch, 2011).

In sub-saharan Africa, 23 percent of married women are using family planning, 18 percent with a modern method and 5 percent with a traditional method (Population Reference Bureau and Africa Population and Health Research Center, Africa Population Data Sheet 2008).

Socioeconomic class constitutes an inequity in relation to mortality and morbidity. The disparity between the rich and poor in the use of contraception has remained the same despite overall improvements in socioeconomic status and expansion of family planning services. (Creanga, Andreea, Gillespie, Kaklins 2011).

There has been a lot of campaign on the use of family planning and reduction of population from country to country especially in Nigeria. Even at that, a study by NPC (2009) indicates that “contraceptive use is still low in many developing countries”. This could be related to lack of adequate information and ignorance as postulated by (Adinma & Nwosu 2005).

(Reshma 2015) adds that, other factors such as “culture, low education, poverty and poor access to information on contraceptive are among numerous reasons that have been identified by scholars to militate against the use of family planning methods”. The presence of young children and pregnancy of the mother may negatively influence women’s possibilities to engage in paid employment through a higher care need and because pregnant women in poor countries are prone to different types of morbidities (UNFPA 2005, Liu 2004). Among families with children, wealth may also vary according to family phase and type, with couples with children aged 15 to 24 showing the highest wealth levels and lone parents with young children the lowest (Baekgaard,

1998; Northwood et al, 2002). Traditional values also play a big role in family planning acceptance and decision, as many cultures and traditions support giving birth to as many children as possible.

“Traditional values feature prominently because the cultural valuation of children is evident in studies which indicate that, among Nigerians, having fewer than five surviving children negatively affected the use of family planning methods” (Lawoyin et al, 2002). In developing nations like Nigeria, children are valued as they not only demonstrate the masculinity of the men but equally provide the extra useful hands in communities where agriculture is the major source of income. Besides, aged parents and extended family relations depend on their children for maintenance at old age. Hence, they are reluctant to limit birth.

Despite all endeavors to reduce the number of birth through family planning in Nigeria, there are a lot of problems still emanating. Nigeria's population is one of the fastest growing population in the world and the most populated country in Africa. Nigeria is currently the seventh most populated country in the world. The current population of Nigeria is 186 million (United Nation, 2016). The annual rate of Natural increase is estimated to be 2.53% (United Nation, 2017). This has come to pass. Also, Nigerian's report on the implementation of the Beijing platform for action and common wealth plan of action by the (Federal Ministry of Women Affairs 2004), estimates that Nigeria's population was about 120 million and an annual growth rate of 2.8% spread over 350 ethnic groups and two major religions, Islam and Christianity. It is, however, projected that there may be as many as 189 million people to its current population between 2018 and 2050 (UN DESA 2018). And the repercussion of such a growth rate in the nation's economic development and social services call for great concern.

(Oyeleke, 1991) states that African from time of their ancestors is known to bear many children. It was believed that having many children was a pride and a way of boosting one's ego. Providing enough labor and increasing the productivity on the farms. (Fajobi, 1987) discovers that another major problem hindering modern family planning in Nigeria is illiteracy; he describes illiterates as the worst offenders of unplanned families. Majority of the married people in the rural areas of the six geo political zones are illiterates and they are ignorant of the importance and necessity of the modern family planning programme and alternatively, they rather prefer to ask their children to stay or live with other family members who are financially capable than themselves. Delano (1988); US Department of Agriculture Centre for Nutrition Policy and Promotion (2007) have pointed out various ways of controlling birth before the modern family planning came into existence and natural traditional method of family planning have been in use before the introduction of contraceptives. Family planning is a vital issue to investigate considering the rapid increase of Nigeria's population. Against this backdrop, the study seeks to assess the perception and Attitude of family planning among married women in Nigeria.

1.1 STATEMENT OF THE PROBLEM

The acceptance and use of family planning among married women in Nigeria has become a contentious problem. Most of them know little or incorrect information about modern family planning methods. Even when they know some names of contraceptives, they don't know where to get them or how to use it. Some women have negative attitude about family planning, while some have heard false and misleading information. The poor correspondence between knowledge, attitude and acceptance of modern family planning methods has drawn attention to

women's perception about the positive and negative aspect of modern contraception, (Gaur, Kumar, Meenu 2008) noted that the reluctance to use modern methods stemmed from a fear that uses might cause infertility, that the contraceptive might produce damaging side effects and forgetting to take the contraceptive pills was a serious risk. This is a problem, serious problem in that in view of the global economic challenge and that of security, where children that are not catered for by parents turn out to be security threats or wayward (World Health Organization 1971).

While, some couples believe that the use of condoms are unnatural and unhygienic thereby reduce the pleasure or sensation (Umoh ,Abah , Ekanem 2012) and that their use is complete lack of respect to their partner. Others believe that if their wives use any of the modern methods, she has engaged in extra-marital affairs. Nevertheless, some believe that the IUD (Intra Uterine Device) use to dry their blood. Some said they have heavy menstrual flow (Oyedokun Ao 2007) while those that use implant said that it causes numbness to their body.

However, the age at which the woman engages in sexual activities varies considerably depending on the various socializing influences and the opportunities available for practicing sexual behaviors. For instance, the economic situation of individuals, lifestyle or family history which posit that some families prefer not to stay in their husbands house or don't want to give birth to only one man; or a polygamous family where there is competition to give birth as many times as possible. The state of Nigeria population today is a matter of great concern to the general public. This concern arises from the population figure of 198 million people, growing at a rate of approximately 5.5 per cent per year (United Nation, 2018) making her one of the countries with the fastest growing population in the world. NPC/FMOH (2004) reported that Nigeria adds about 3.5 million people to its population annually. If this growth rate is not

checked, the population will double in about 24 years and this will have enormous implications on the economy and the overall development of the country.

Today, family planning has been advocated as a control mechanism to regulate and control this rapid population growth. Some women feel that when they attempt to procure contraceptives they subject themselves to gossip and to negative attitudes from health personnel (Gorgen, Biraga and Diesfeld 1993). 'Women of reproductive age (15-49 years) maybe married or not married. Most of them know little or incorrect information about modern family planning methods. Even when they know some names of contraceptives, they don't know where to get them or how to use it. These women have negative attitude about family planning, while some have heard false and misleading information. Others believe that condoms are unnatural that they reduce pleasure or sensation (Agyei and Epema 1992). The poor correspondence between knowledge, attitude and acceptance of modern family planning methods has drawn attention to women's perception about the positive and negative aspect of Modern contraception noted that the reluctance to use modern methods stemmed from fear that uses might cause infertility, producing damaging side effects and forgetting to take the contraceptive pills was a serious risk.

1.2 RESEARCH QUESTIONS

The following research questions are formulated to guide this study;

1. What is the attitude of married women in Nigeria towards family planning?
2. What factors influence married women's choice of family planning methods in Nigeria?

1.3 OBJECTIVES OF THE STUDY

This study aims to;

1. Investigate the attitude of women towards family planning
2. Examine the factors that influence married women's choice of family planning method in Nigeria

1.4 GENERAL OBJECTIVE

The general objective of this study is to examine the attitude of married women towards contraceptive use in Nigeria.

1.5 SPECIFIC OBJECTIVES

The study will focus on the attitude of married women towards family planning methods in Nigeria. All married women who were either permanent residents of the households in the 2013 NDHS sample or visitors present in the households on the night before the survey will be eligible to be interviewed.

1.6 JUSTIFICATION OF THE STUDY

Concern about the attitude of married women towards family planning and the consequences of high fertility in recent times makes this study very vital and important. The study is important because it would provide an explanatory analysis of the attitude of women towards family planning in Nigeria. The knowledge acquired from the study will be used to create the study awareness on the modern family planning methods. To individual, families and

communities, a study of this nature will help on the importance of child spacing to the public as it will also help in the economic development of the nation.

Besides, the findings of the research would also aid and help the population planning which enable the government and its agencies to make decisions concerning policies that affect the welfare and standard of living of the people. Also, the study would be a valuable piece of information to family planning agencies in giving advices to people concerning available methods and their family size.

1.7 OPERATIONAL DEFINITION OF TERMS

1. **Women:** The women used in this study refer to women of reproductive age (i.e. 15-49 years). Who are in a mutual union.
2. **Family planning:** The conscious efforts of couples or people in union to regulate the number and spacing of births through artificial and natural methods of contraception. Family planning connotes contraception control to avoid pregnancy and abortion.
3. **Contraceptive:** The devices that attempt to prevent pregnancy by physically preventing sperm from entering the uterus. They include male condoms, female condoms, cervical caps, diaphragms, and contraceptive sponges with spermicide.
4. **Fertility:** The natural capability to produce offspring.
5. **Maternal Mortality Ratio (MMR):** The number of women who die as a result of pregnancy and childbirth complication per 100,000 live births in a given year.

CHAPTER 2

Literature Review

2.0 INTRODUCTION

This chapter reviews the existing knowledge or literature on the attitude of married women in Nigeria towards family planning and the gaps left by past research and publications. This chapter also presents the conceptual framework to be used in the analysis of data.

2.1 GLOBAL OVERVIEW OF FAMILY PLANNING

Globally, Population growth has been a problematic issue all over the world consequently; many developed countries have approved and resorted to birth control or family planning. Family can play a vital role in the reduction of infant, child and maternal morbidity and mortality. By preventing unwanted or mistimed pregnancies, family planning can also reduce abortions by unskilled providers or under unhygienic conditions. However, the benefits of family planning go beyond improvements in maternal health for women. For example, family planning can result in higher educational attainment, better employment opportunities, higher socioeconomic status and empowerment (Canning , Schultz, 2012).

Despite extensive global efforts and investments to reduce maternal mortality, this remains high in many developing countries (World Health Organization, 2012). The 22 million “unsafe” abortions that occur each year cause an estimated 47,000 maternal deaths mostly in developing countries and lead to short-term or lifelong disabilities in many women (Ahman, Shah IH, 2011) . It has been estimated that up to one third of maternal deaths could be averted through the use of effective contraception by women wishing to postpone or cease further childbearing (Ahmed, Liu, Tsui, 2012). About 222 million women in developing countries are thought to have an unmet need for a modern method of family planning (Singh, Darroch, 2012).

This unmet need is particularly prevalent in certain populations, especially individuals with low socioeconomic status, those living in rural communities and those coping with conflicts and disasters (World Health Organization, 2012).

In some developing countries, increased contraceptive use has already cut the annual number of maternal deaths by 40% over the past 20 years and reduced the maternal mortality ratio the number of maternal deaths per 100,000 live births by about 26% in little more than a decade (Cleland, Conde-Agudelo, 2012). It has been estimated that a further 30% of the maternal deaths still occurring in these countries could be avoided if the unmet need for contraception could be fulfilled (Peterson, Ross, Tsui, 2012).

2.2 CONTRACEPTIVE USE IN AFRICA

Sub-Saharan Africa has the highest average fertility rate in the world. In 2009 the total fertility rate (TFR), or the average number of births per woman, was 5.1 more than twice that in South Asia (2.8 or Latin America and the Caribbean 2.2 (World Bank 2009). In 2009 it was estimated that 35 million women in Africa had an unmet need for family planning. Emerging research shows that fertility transition has already begun in Sub-Saharan Africa and that some countries are undergoing dynamic and unprecedented changes in fertility patterns.

Acceptance of family planning in the region has traditionally been low and cultural resistance to family planning high (Caldwell and Caldwell 1987). Nevertheless, over the past two decades, contraceptive use increased in several countries. Its impact, along with that of changes in other determinants of fertility, is leading the onset of fertility decline in the region.

Family planning programs that have been successful in Africa have promoted birth spacing. Marriage patterns in Africa differ from those in Asia, possibly accounting for a cultural

preference for spacing methods. Various studies in the region document African cultural preferences for spacing rather than limiting births (Cohen 1998). In contrast to Asian family planning programs, which have emphasized permanent contraceptive methods, such as sterilization and abortion, programs in Africa rely on temporary methods, such as pills, injectables, and implants (Caldwell and Caldwell 1988). It has been suggested that successful program strategies in Africa must promote methods that are temporary, can be used covertly by women, and do not have to be stored at home (Caldwell and Caldwell 2002).

In the past few decades investments in family planning programs have raised the level of contraceptive use from 19% to 62% in the developing world and contributed to an estimated 75% decline in fertility (Greanga et al. 2011).

However, despite the increase in supply of and demand for family planning services, gross inequities exist both between and within countries in the use of contraceptives, posing challenges to health policy and programming. Use of modern contraceptives in developing countries remains comparatively low, with West Africa having the lowest rates. In many countries the demand for contraceptives is still not being fulfilled. Worldwide, in 2010 12% of women currently married or in union who do not want any more children or want to postpone their next pregnancies for at least two years are not using any form of contraception that is, they have an unmet need for family planning (Alkema et al. 2013).

In developing countries an estimated 222 million women have an unmet need for modern contraception (Singh and Darroch 2012). The proportion of married women with unmet need for modern contraception is 18% in the developing world as a whole, but is much higher than average (30–37%) in Western Africa, Middle Africa, Eastern Africa and Western Asia, and is

somewhat higher than average (22–24%) in South Asia and the Caribbean (Singh and Darroch 2012).

2.3 CONTRACEPTIVE USE IN NIGERIA

Nigeria is currently the seventh most populated country in the world. The current population of Nigeria is 186 million (United Nation, 2016). The annual rate of Natural increase is estimated to be 2.53% (United Nation, 2017). However, Nigeria has a growth potential to become the third largest population which would make Nigeria surpass United States.

In Nigeria today, the birth rates are higher than the world averages. (Nwachukwu and Obasi, 2008). Contraceptive Prevalence Rate (CPR) is still embarrassingly low in Nigeria, according to the report published by the International women's health coalition; the CPR among married women aged 15-49 years was 8% for modern methods and 12% for all methods. Also, other studies have reported a similarly low adoption rate of Modern Birth Control Methods (MBCM). (Haub and Yangishila, 1992), (Makinwa-Adebusuyi, 2001).

In Nigeria, reasons for nonuse of contraceptives have included fear of side effects, partner objection, and religious conflicts, with the fear of side effects largely fueled by misinformation (Abiodun OM, Balogun 2009). Nigeria in particular remains a focus for increasing contraceptive use, as it is one of the most populous countries in Sub-Saharan Africa. Nigeria has a high total fertility rate (TFR), estimated to be between 5.5 and 5.7 for women of reproductive age (15–49). Low rates of contraceptive use are also pervasive in Nigeria (NPC, NDHS 2013).

According to the most recent Demographic and Health Survey, rates of contraception in Nigeria have stagnated, remaining approximately 9% between 2008 and 2013. Like many other

developing nations, majority of Nigeria's population (about 70%) live in the rural communities (Ekong, 2003). These rural communities have very high rate of fertility and the CPR is also considerably lower in rural areas with CPR of 8% as compared with 18% in the urban areas in Nigeria. (Ekong, 2003;) Many rural women are reportedly reluctant to accept any artificial method of contraception. (Gaur, Goel M.K, Goel M, 2008) Several studies also revealed that rural women who were unwilling to accept family planning methods were concerned about child survival and viewed children as a source of support in old age. (Kartikeyan and Chaturvedi, 1995). Studies carried out in Nigeria have shown that lack of adequate information and ignorance are key factors militating against family planning practice in Nigeria. (Adinma and Nwosu, 1995; Moronkola, Ojediran and Amosun, 2006).

The socio-economic characteristics of women, notably educational levels have been argued to explain differences in reproductive behavior and contraceptive choices. (Anju, Vanneman and Kishor, 1995). The perceptions and the behavior related to reproduction have also been said to be strongly determined by prevailing cultural and religious values. (Srikanthan and Reid, 2008). With high unmet need for family planning in several developing countries including Nigeria, there may be likelihood of unintended pregnancies among women of advanced reproductive age (Akinyemi, Adedini, Hounton, Akinlo 2015). With only 9% of women aged 15–49 years being menopausal in Nigeria, the susceptibility to pregnancy remain high among women in advanced reproductive age (NDHS 2013, NPC and ICF International; 2014). Many of these women do not accept female sterilization as a fertility regulation method, and in the event of unintended pregnancies, may result to induced abortion which remains largely illegal in Nigeria (Bankole, Oye-Adeniran, Singh, Adewole, Wulf, Sedgh G, et. 2016).

2.4 PREVALENCE OF CONTRACEPTIVE USE

The fertility inhibiting effect of contraception has been demonstrated by several studies (Westoff and Bankole, 2001). Although somewhat small at present due to low prevalence and high use of less effective methods, in line with the experience of other countries (Westoff, 1990, Ross and Frankenberg, 1993, Cohen, 1998), the fertility inhibiting effect of contraception can be expected to increase as levels of contraceptive use increase, especially if there is a shift to more effective methods.

A United Nations analysis of contraceptive prevalence estimates for the world by region, given low, medium, and high assumptions, confirms a global trend toward rising contraceptive use and declining fertility. Given medium assumptions, the percentage of married women of reproductive age who were using a contraceptive method in late 1983 was 51% for the entire world, 45% in developing regions (33% when China was excluded), and 70% in developed regions. This rate was 14% for Africa, 74% for East Asia, 34% for South Asia, and 56% for Latin America. On a global level, the most widely used forms of fertility control are sexual sterilization (36%), the IUD (19%), oral contraception (15%), condoms (10%), withdrawal (8%), and periodic abstinence (7%). Contraceptive use is also shown to improve child survival through optimal child spacing, lengthening birth intervals, and reducing sibling competition for scarce family and maternal resources (Potts 1990; Rutstein 2005; DaVanzo, Hale et al. 2007; DaVanzo, Hale et al. 2008; Yeakey, Muntifering et al. 2009).

According to a new study led by researchers at the Johns Hopkins Bloomberg School of Public Health, contraceptive use would likely prevent more than 272,000 maternal deaths from childbirth each year. Researchers further estimate that satisfying the global unmet need for contraception could reduce maternal deaths an additional 30 percent. According to the United

Nations, 63 percent of partnered, reproductive-age women worldwide, representing about 740 million couples practice some form of contraception. Almost 90 percent of them employ modern methods, which include oral contraception (“the pill”), condoms, injections, intrauterine devices (IUDs), and sterilization. Contraceptive prevalence was increasing until 2000, but growth has stalled since then.

Nigeria which has a population of 186 million and an annual growth rate of 2.53% (United Nation, 2017) is the most populous country in Africa. Nigeria, according to (Khurfeld 2006), is already facing a population explosion with the resultant effect that food production cannot match the growing population. In Nigeria today, the birth rates are higher than the world averages (Nwachukwu & Obasi, 2008).

Contraceptive Prevalence Rate (CPR) is still embarrassingly low in Nigeria, according to the report released by the International women’s health coalition; the CPR among married women aged 15-49 years was 8% for modern methods and 12% for all methods. Also, other studies have reported a similarly low adoption rate of Modern Birth Control Methods (MBCM). (Haub & Yangishila, 1992, Makinwa-Adebusuyi, 2001)(Population Reference Bureau, 2002).

2.5 TYPES OF CONTRACEPTIVES

The effectiveness of a contraceptive method mainly depends on quality of practice. Previous research reveals that modern methods are more effective than traditional methods in preventing pregnancy (Trussel and Kost 1987). We have the modern and the traditional contraceptive. Modern contraceptive are mainly those that can be scientifically proved e.g. Pill, IUD, Male condom, Injectable, Implants, Female sterilization, Male sterilization etc. traditional contraceptive, they are not scientific nothing to

prove how effective they are (they can also be called natural method) e.g. Periodic abstains, Coitus interruptus, Withdrawal method, Rhythm.

The world over , health has improved over the past four decades, but everywhere the health status of the rural poor has been left behind as compared to their affluent counterparts. (Creanga,Gillespie,Karklins,Tsu, 2011)

Parallel disparities in fertility and in contraceptive use are found between poor and wealthy countries. Even in the same country, the disparities between the affluent and the poor in terms of contraceptive use cannot be refuted. Creanga et al , 2011 contends that in developed countries modern contraceptives methods are used only by 43% of women of reproductive age overall and a gulf exists between the highest and the lowest wealth quintiles(52% for the rich class and 35% for the poor class.)

Contraceptive use has become more common in developing countries and the increase is largely centered on modern contraceptives (Gille, 1985) Modern Contraceptives include voluntary sterilization, oral contraceptive, intrauterine devices (IUD), Condoms, infectables and vaginal methods. (Robey1992) contends that the use of modern methods has grown more than the use of traditional methods, such as periodic abstinence (rhythm), withdrawal and folk methods. This has been necessitated by the obvious relative effectiveness of modern contraceptives as compared to traditional methods. However, (Palmore and Bulateo1989) contend that in some countries users have shifted toward greater use of traditional methods.

According to a study by, (Donaldson and Tsui1990), the use of traditional methods is found among about 10 percent of married couples in developing countries. In some countries (Bertrad 1993) noted that there is a positive association between traditional methods use and women's level of education. The expectation has been that modern contraceptives will override

traditional contraceptives as society develops economically and socially. In some quarters, traditional contraception has been classified as “no contraception” (Alan Guttmacher Institute, 1994).

2.6 ATTITUDE OF WOMEN TOWARDS FAMILY PLANNING

This section comprises the attitudes of people especially women towards family planning both outside and within the country. The fertility intention of women is associated with contraceptive use (Ibisomi & Fotso, 2010). The use of family planning allows women to meet their fertility intentions in terms of the timing of births and number of births (Moerland & Talbird, 2006).

Furthermore, a study by (Ettarh's 2011) shows that contraceptive use is low among women who desire to have children within two years and use contraceptive increases as the number of children a women has increases. Women who do not want to continue childbearing are more likely to use contraceptives compared to women who wish to have more children (Rahayu et al., 2009). Furthermore, women with 3 or 4 children were more likely to use contraceptives given that they have reached the desired number of children compared to those with 1-2 children (Rahayu et al, 2009). However, in Uganda the number of non-contraceptive users increases as the number of children increases (Ojaka, 2008).

According to (Fumilayo 1986), attitude to family planning varies from place to place and is influenced by cultural beliefs and practices, religious, socio-economic status, political organization, level of education, the information available to individual, place of residence (that is whether urban or rural) and the manner in which the concept is presented to the individuals. Considering the place of residence, Caldwell and Wane (1977) claim that urban women are likely

to adopt the use of contraceptives than their rural counterparts. This they claim is associated with the level of education.

(Chaimie 1977) maintains that sexual inequalities and birth control methods are likely to be disruptive of the decision making of a woman who is poorly educated and has low participation in the urban life. This he claims is because women whose husbands are not cooperative and get no information from their husbands or from the environment have few alternative sources of information.

According to (Ghanasah 1972), many Africans see family planning as unnecessary. They say that family planning should be practiced only in Asia and not in Africa which has large tracts of land lying idle. Africa is not over populated rather they emphasize the negative effect of family planning on future population,

(Blair 1967) in her study of the negro and white attitude toward family planning in Chicago said: "that the reasons for acceptance of family life and adequate child care and that the reasons for disapproval of family planning are against God's will, immoral, taking a life, harmful to health and large families and desirable for economic and social reason".

In Nigeria, (Akingba 1968) noted that most unwanted pregnancy of most women are due to most husbands' disagreement with their wives, suggestion for family spacing or family limitation.

2.7 SOCIO-DEMOGRAPHIC FACTORS

LEVEL OF EDUCATION

Education remains the most important factor that affects contraceptive use (Rahayu et al., 2009). In Nigeria, it was found that highly educated women were more likely to use

contraceptive thereby decreasing their fertility (Olalekan&Olufunmilayo, 2012). In addition, women are more likely to use contraceptives when they have any level of education compared to no education (Rahayu et al., 2009). Highly educated women have a tendency to replace child numbers with quality (Backer & Lewis 1973). Dommaraju and Agadjanian (2009) explained that changes fertility regime in Bangladesh is most cases are not due to changes in women's status, but due to changes in the reproductive behavior of illiterate women.

Additionally, Hoque and Murdock (1997) observed statistically significant and substantial differences in use of contraceptive between women with different levels of education, even after controlling other related variable. Women with degree from colleges/universities had three times more likelihood of using contraception than those without any education. Emphasis on education in the role of contraceptive use has been made by many scholars.

In the writings of (Caldwell, 1982) education is a vehicle by which individuals easily learn more Western views about the family which affects ones decision to demand for fewer children, thereby creating the need for use of contraceptive to prevent or space childbirth. According to (Tawiah 1997), educating a woman at least to higher level influences her decision for contraceptive use. Research shows that women with secondary education have lower level of unmet needs (GDHS Report, 2008).

In another study in Malawi, women who are poor do not have high level of education compared to the wealthy and less likely to use contraceptive (Adebowale et al., 2013). The most plausible explanations for these shifting relationships are that better-educated women marry later and less often, use contraception more effectively, have more knowledge about and access to contraception, have greater autonomy in reproductive decision making, and are more motivated

to implement demand because of the higher opportunity costs of unintended childbearing. (Cochrane ,1978) notes, in a study of fertility in Nigeria, that only 10 percent of the women with education above the primary stage believed fertility to be determined by God', whereas 50 percent of the totally uneducated women held that belief.

INFLUENCE OF RELIGION ON CONTRACEPTIVE USE

Studies on the relationship among religious institutions, religiosity and reproductive behavior in Nigeria are few. (Caldwell, 1987) confirmed this assertion that the religiosity of Africans conflicts with reproductive regulation with marriage. In addition, those with more intense religiosity were less likely to use contraception (Goldscheider & Mosher 1991).

(Idowu et al, 2012) found that despite the low acceptance of birth control by Roman Catholics, there was no significant difference in their choice of contraceptive methods when compared with Pentecostal faithful and other non-Catholics orthodox members.

Muslim scholars have allowed birth control methods under these conditions; birth control methods should be used with both parties consent, the method should not cause permanent sterility and should not otherwise harm the body (Yusuf Al-Qaradawi & Muhammed, 2004). The variety of positions towards contraception among Christian denominations and Islam has seriously hampered the work of World Health Organization (WHO) in some fields because of failure by members to agree as to the desirability of certain methods of family limitation (Campbell, 1960). For instance, many generally point to women's perceived lack of need, fear of side effects, and opposition to contraception on personal or religious grounds and spousal negative attitude to contraceptive use. Extending these past researches, this study examined the relationship between married women and their use of any method of contraception.

Some religions, such as Catholicism, have restrictions on contraception based on the belief that it is God's will to bring children into the world. According to (Dixon-Muller, 1999) religious believers or observers might choose to avoid certain methods of family planning, such as birth control pill, in an effort to live their lives according to the teachings of their religion.

PLACE OF RESIDENCE

Research shows that there exist rural-urban differentials in contraceptive use despite knowledge of contraceptive methods in many countries, such as Nigeria, Zambia and Indonesia (Olalekan&Olufunmilayo, 2012; White & Speizer, 2007; Rahayu et. 2009). These studies found that rural areas have lower levels of contraceptive use as opposed to urban areas in which women are more likely to be using contraceptives (Olalekan&Olufunmilayo, 2012; White & Speizer, 2007; Rahayu et, 2009). In addition, Bogale et al (2011) found that married women in urban areas are more likely to use contraceptives compared to their married rural counterparts.

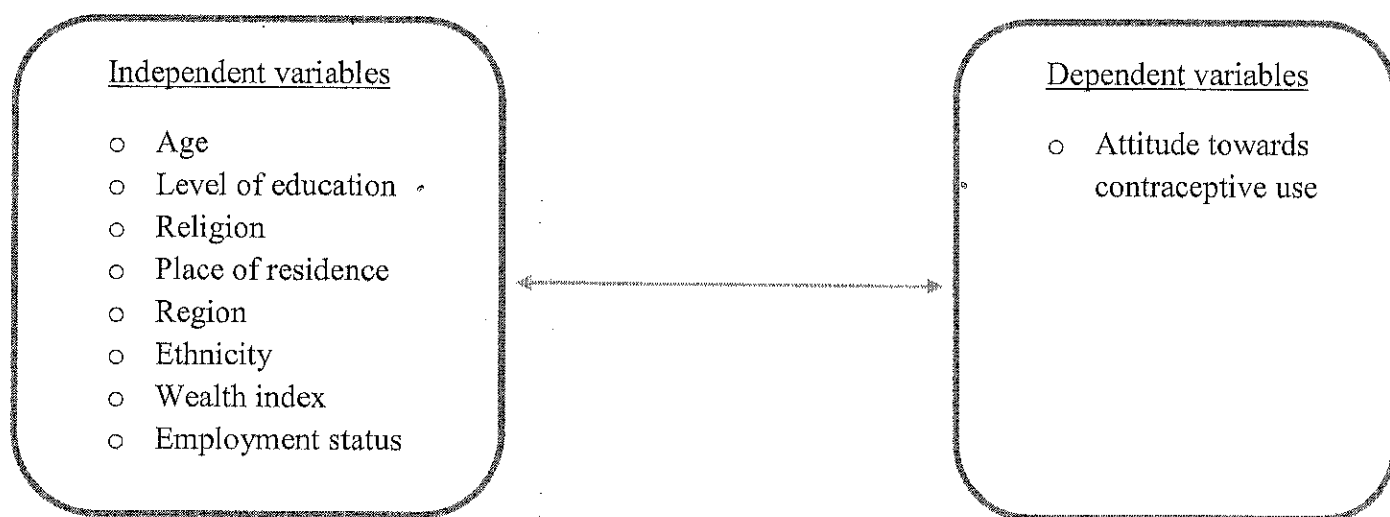
2.8 THEORETICAL FRAME WORK

Andersen's Behavioral Model of Health Services Use

One important step in addressing the unmet need for family planning in Nigeria is exploring factors influencing women's decisions to use or not use contraception. Early research in this area focused mainly on individual-level determinants of contraceptive uptake, including individual characteristics, such socioeconomic and demographic factors (Stephenson et al., 2007), and psychosocial factors encompassed by theories of behavior change (Warriner et al., 2012). More recently, researchers have emphasized the importance of considering multilevel determinants of health behavior, including not only factors at the individual and interpersonal

level, but also contextual factors, such as community norms and environmental/structural barriers and facilitators to family planning access and utilization (Stephenson et al., 2007), especially in resource-limited settings (Campbell, 2003; Marks, 2008; Murray and Campbell, 2003). Such factors are encompassed in Andersen's Behavioral Model of Health Services Use (ABM, Andersen, 1968), a multilevel model developed to explain and predict health service use. The ABM was originally developed in the 1960s to explain health service use among families and has since undergone multiple revisions, changing the unit of analysis from families to individuals, and expanding the model to include both individual-level and broader contextual factors in the external environment and health care system (Andersen, 1995; Andersen & Davis, 2001; Andersen & Newman, 1973). The model suggests an explanatory process or temporal ordering between the components to predict use, though each component of the model may make an independent contribution to predicting use (Andersen, 1995).

2.9 CONCEPTUAL FRAME WORK



Source: Author's construct, 2018

2.10 STATEMENT OF HYPOTHENSIS

Ho: There is no significant relationship between socio-demographic characteristics and attitude of married women towards family planning

H1: There is significant relationship between socio-demographic characteristics and attitude of married women towards family planning.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 INTRODUCTION

This chapter seeks to explain the plan and approach for executing the research work. It covers the description of the study area, target population, source of data, sampling design and sample size, method of data collection, measurement of variables and method of data analysis.

3.1 DESCRIPTION OF THE STUDY AREA

Nigeria lies on the west coast of Africa between latitudes 4°16' and 13°53' north and longitudes 2°40' and 14°41' east. It occupies approximately 923,768 square kilometres of land stretching from the Gulf of Guinea on the Atlantic coast in the south to the fringes of the Sahara Desert in the north. The territorial boundaries are defined by the republics of Niger and Chad in the north, the Republic of Cameroon on the east, and the Republic of Benin on the west. Nigeria is the most populous country in Africa and the 14th largest in land mass.

The 2006 Population and Housing Census reported Nigeria's population to be 140,431,790, with a national growth rate estimated at 3.2 percent per annum. With this population, Nigeria is the most populous nation in Africa, as noted, and the seventh most populous in the world (Population Reference Bureau, 2013). Nigeria's population is unevenly distributed across the country. Large areas in the Chad Basin, the middle Niger Valley, and the grassland plains, among others, are sparsely populated. The average population density for the country in 2006 was estimated at 150 people per square kilometre. The most densely populated states are Lagos (2,607 people per square kilometre), Anambra (868 people per square

kilometre), and Imo (758 people per square kilometre). Most of the densely populated states are found in the southern part of the country. Kano, with an average density of 442 people per square kilometre, is the most densely populated state in the north (National Population Commission [NPC], 2010).

3.2 TARGET POPULATION

The target population for this study was currently married women aged 15-49 years, who are not using contraceptives currently.

3.3 QUANTITATIVE DATA SOURCE

This study analyses secondary data from women recode of Nigeria Demographic and Health Survey (NDHS) 2013 dataset.

3.4 SAMPLE DESIGN FOR THE 2013 NDHS

The sample for the 2013 NDHS was nationally representative and covered the entire population residing in non-institutional dwelling units in the country. The survey used as a sampling frame the list of enumeration areas (EAs) prepared for the 2006 Population Census of the Federal Republic of Nigeria, provided by the National Population Commission. The sample was designed to provide population and health indicator estimates at the national, zonal, and state levels. The sample design allowed for specific indicators to be calculated for each of the six

zones, 36 states, and the Federal Capital Territory, Abuja. The 2013 NDHS sample was selected using a stratified three-stage cluster design consisting of 904 clusters, 372 in urban areas and 532 in rural areas. A representative sample of 30,327 households was selected for the survey, with a minimum target of 943 completed interviews per state. A fixed sample take of 45 households were selected per cluster.

All women who were either permanent residents of the households in the 2013 NDHS sample or visitors present in the households on the night before the survey were eligible to be interviewed. In a subsample of half of the households, all women age 15-49 who has a child that is within the age range of 0-59 months that were either permanent residents of the households in the sample or visitors present in the households on the night before the survey were eligible to be interviewed (National Population Commission [NPC], & ICF International, 2014).

3.5 SAMPLE SIZE

All women age 15-49 who were either permanent residents of the households in the 2013 NDHS sample or visitors present in the households on the night before the survey were eligible to be interviewed. The sample size of married women age 15-49 years that were used are 26,403.

3.6 DATA MANAGEMENT AND VARIABLE MEASUREMENT

The table below shows the various level of data measurement of selected variables for the purpose of analysis.

NAME OF VARIABLE	VARIABLE MEASUREMENT AND CODES	DATA RECORDED
DEPENDENT VARIABLE: Attitude towards contraceptive use		
<ul style="list-style-type: none"> • Intention to use 	V362 (categorical) Use later Unsure about use Does not intend	The same categories
INDEPENDENT VARIABLES: <ul style="list-style-type: none"> • Age 	V013 (Categorical) 15-19 years, 20-24 years, 25-29 years, 30-34 years, 35-39 years, 40-44 years, 45-49 years.	The same categories

<ul style="list-style-type: none"> • Level of education 	v106(Categorical) No education, primary, secondary, Higher.	The same categories
<ul style="list-style-type: none"> • Household Wealth index 	v190(categorical) Poorest, Poorer, Middle, richer, richest.	Poor Middle Rich
<ul style="list-style-type: none"> • Place of residence 	v025(Categorical) Urban Rural	The same categories
<ul style="list-style-type: none"> • Employment status 	v705 (categorical) not working, sales, professional/technical/managerial, agricultural, household and domestic service, manual, clerical (working)	Not working Working

<ul style="list-style-type: none"> • Religion 	v130 (Categorical) Catholic, Other Christian, Islam, Tradition, Others	Three main religion group: Christianity, Islam and Traditional
<ul style="list-style-type: none"> • Ethnicity 	v131 (categorical) Fulani, Hausa, Ibibio,Igala, Igbo, Ijaw/izon, Kanuri/beriberi, tiv, Yoruba, Others.	The main ethnic groups: Yoruba, Hausa, Igbo
<ul style="list-style-type: none"> • Marital status 	V501 (Categorical) Never in union, married, living with partner, widowed, divorced, separated.	Single, married, widowed and separated
<ul style="list-style-type: none"> • Number of living children 	V218 (Continuous)	No children, 1-4 children and 5 children above
<ul style="list-style-type: none"> • Husband's Age 	V730 (Continuous)	15-19 years, 20-24 years, 25-29 years, 30-34 years, 35-39 years, 40-44 years, 45-49 years and 50 years above.

<ul style="list-style-type: none"> Husband's level of education 	V701 (Categorical) No education, primary, secondary, Higher and Don't know.	No formal education, Primary, Secondary and Higher
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3.7 DATA PROCESSING AND ANALYSIS

The NDHS datasets from 2013 women recode will be processed and analyzed using Stata application package (STATA 13.0). The data processing will be necessary before the proper analysis in order to measure the variables in this study accurately as well as to make the analysis well presentable and easily interpretable. The tools for data manipulation were employed on the STATA application package to achieve this task. To ensure reliable data, sample weights and STATA survey command (SVY) were applied to adjust for stratified sample design and the effect of over-sampling or under-sampling of some regions or areas.

3.8 MEASUREMENT OF VARIABLES

The general binary logistic regression model used for the multivariate analysis is:

$$\log\left(\frac{p}{1-p}\right) = \beta_0 + \beta_1x_1 + \beta_2x_2 + \dots + \beta_nx_n$$

Where p = probability of exposure to current contraceptive use

x1-xn = predictor variables

$\beta_0, \beta_1 - \beta_n$ = regression coefficients

Univariate analysis will be carried out using tables of frequency distribution to describe the background characteristics of the respondents and the bivariate analysis will be done using the Pearson Chi-square (χ^2) test to show the association between current contraceptive use and attitude of women with women socio-demographic characteristics that are categorical variables in the datasets. Furthermore, logistic regression is used in the multivariate analysis to identify the strength of association and examine the influence of attitude of women towards contraceptive use with women socio-demographic characteristics on current contraceptive use among women in Nigeria.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

INTRODUCTION

This chapter deals with presentation, analysis and interpretation of the data collected from secondary sources Nigeria Demographic and Health Survey (NDHS, 2013) to show the socio-demographic characteristics effect on attitude of married women towards family planning in Nigeria. However, in supportive of descriptive statistics, inferential analysis, Pearson Chi-square test was used to ascertain relationship while binary logistic regression analysis was used in testing the study hypothesis.

4.1. Distribution of Married Women by Socio-Demographic Characteristics by Weighted Percentage.

Results in Table 4.1 below showed socio-economic and demographic characteristics of non-using contraceptive among married women. It was reported that married Women of age group 25-29 years was the highest by 21.3%, followed by age group 30-34 years and age 20-24 years by 16.8% and 16.1% respectively, the least age group was age 40-44 years and age 45-49 years by 11% and 10.8% respectively, lastly was age group age 15-19 years by 9.3%. Husband age showed that age group 50 years and above was 26.2%, followed by age 35-39 years and age 40-44 years by 16.6% and 15.7% respectively, the least age group was age 25-29 years and age 20-24 years by 9.7% and 3.1% respectively, lastly age 15-19 years by 0.2%. Women in rural area by 68% was higher than those living in urban area by 32%. Women with no formal education was higher by 55.2%, followed by women with secondary education and primary education by

24.9% and 17.7% respectively, lastly was women with higher education by 5.7%. Husband with no formal education was higher by 45.9%, followed by secondary education by 24.9% and primary education by 17.7%, the least was husband with higher education by 11.6%. Hausa women was highly reported by 47.7%, Yoruba women by 9.5% and igbo women by 9, other ethnicity accounted for 33.8%. Women from north-west was higher by 40.7%, followed by north-east by 19.2% and north-central by 14%, women from south-west was least reported by 11.7%, south-south by 7.4% and south-east by 7%. Muslim women were more reported by 67.3%, followed by Christian women by 31.6% and traditional by 1.1%. Poor women was higher by 50.6%, followed by those reported to be reach by 31.2% and middle wealth status by 18.2%. Employed women was more reported by 68.9% than not employed by 31.1%. Women reported to have 1-4 children was 59.2%, 5 children and above by 30.1% and no children by 10.7%. Women reported mostly not intended to use contraceptive by 76.6% and those intended to use contraceptive by 23.4%.

Table 4.1: Distribution of Married Women by Socio-Demographic Characteristics by Weighted Percentage.

Background Characteristics	Frequency	Percent
Age		
15-19 years	2,102	9.3
20-24 years	3,660	16.1
25-29 years	4,835	21.3
30-34 years	3,802	16.8
35-39 years	3,345	14.8
40-44 years	2,487	11.0
45-49 years	2,454	10.8
Total	22,684	100.0
Husband's Age		
15-19 years	38	0.2
20-24 years	691	3.1
25-29 years	2,189	9.7
30-34 years	3,331	14.7

35-39 years	3,762	16.6
40-44 years	3,552	15.7
45-49 years	3,182	14.0
50 years and above	5,939	26.2
Total	22,684	100.0
Place of resident		
Urban	7,250	32.0
Rural	15,434	68.0
Total	22,684	100.0
Level of education		
No formal education	12,520	55.2
Primary	4,170	18.4
Secondary	4,699	20.7
Higher	1,294	5.7
Total	22,684	100.0
Husband's level of education		
No education	10,399	45.9
Primary	4,015	17.7
Secondary	5,650	24.9
Higher	2,620	11.6
Total	22,684	100.0
Ethnicity		
Yoruba	2,165	9.5
Hausa	10,812	47.7
Igbo	2,030	9.0
Others	7,677	33.8
Total	22,684	100.0
Region		
North-Central	3,180	14.0
North-East	4,363	19.2
North-West	9,234	40.7
South-East	1,585	7.0
South-South	1,675	7.4
South-West	2,646	11.7
Total	22,684	100.0
Religion		
Christianity	7,119	31.6
Islam	15,181	67.3
Traditional	258	1.1
Total	22,684	100.0
Wealth Index		
Poor	11,479	50.6
Middle	4,122	18.2
Rich	7,082	31.2
Total	22,684	100.0
Occupational status		

Not employed	7,019	31.1
Employed	15,568	68.9
Total	22,586	100.0
Number of living children		
No children	2,386	10.7
1-4 children	13,192	59.2
5 children above	6,697	30.1
Total	22,275	100.0
Intention to use Contraceptive		
No	17,024	76.6
Yes	5,191	23.4
Total	22,215	100.0

Source: Author's work, 2018 (Data 2013)

4.2.: Distribution of Married Women by Socio-Demographic Characteristics and Pattern and Intention of Contraceptives Use.

Result from table 4.2 below revealed that there is significant association socio-demographic characteristics and attitude of contraceptive use among married women ($P < 0.05$).

The statistically significant relationship between women's age and intention to use contraceptives ($X^2 = 700.72$, $Pr = 0.0000$), women of age 25-29 years intended to use contraceptive by 26.4%, age 30-34 years by 22% and age 20-24 years by 18%, the least to intend was age 40-44 years by 7.8%, age 15-19 years by 6% and lastly was age 45-49 years by 3.4%. There is significant relationship between Husband age and women intended to use contraceptives ($X^2 = 602.20$, $Pr = 0.0000$) Women intended to use contraceptives whose husband age was age 35-39 years by 21.4%, age 30-34 years by 19.3%, age 40-44 years by 18.1%, the least to use was age 25-29 years by 11.5%, age 20-24 years and 15-19 years by 24% and 0.0% respectively. The statistically significant relationship between place of resident and intention to use contraceptives ($X^2 = 743.83$, $Pr = 0.0000$), women from rural area intended to use contraceptives by 53.2% than

women from urban area by 46.8%. The statistical significant relationship between women's level of education and intention to use contraceptives ($X^2= 2685.52$, $Pr= 0.0000$), women with secondary education highly intended to use contraceptive by 38%, followed by women with no formal education by 26.4%, primary and higher education by 23.8% and 11.8% respectively. There is significant relationship between husband level of education and women intention to use contraceptive ($X^2= 2121.43$, $Pr= 0.0000$), women that husband's had secondary education intended to use contraceptive more by 40%, followed by those with primary education by 21%, those with no formal education and higher education by 19.6% and 19.4% respectively. There is significant relationship between ethnicity and women intention to use contraceptive ($X^2= 2017.92$, $Pr=0.0000$), hausa women intended more to use contraceptive by 24.3%, followed by Yoruba women and igbo women by 18.8% and 15.8% respectively. There is significant relationship between region and women intention to use contraceptives ($X^2=1844.05$, $Pr=0.0000$), women from north-west intend more to use contraceptive by 25%, followed by those from south-west by 20.6% and north-central by 18.9%, the least was women from south-south and south-east by 12.3% and 12.2% respectively, lastly was women from north east by 11%. There is significant relationship between women's religion and intention to use contraceptives ($X^2=2134.02$, $Pr=0.0000$), Christian women intend more to use contraceptives by 57.1%, followed by muslim women and traditional by 42.1% and 0.8% respectively. There is significant relationship between women's wealth index and intention to use contraceptive ($X^2=1530.78$, $Pr=0.0000$), rich women intend more to use contraceptive by 50.4%, followed by poor and middle wealth status by 29.5% and 20.1% respectively. There is significant relationship between women employment status and intention to use contraceptive ($X^2=210.09$, $Pr= 0.0000$), employed women intends to use contraceptive more by 76.8% than not employed women by

23.2%. There is significant relationship between number of living children and intention to use contraceptive ($X^2=87.93$, $Pr=0.0000$), women with 1-4 children and 5 children and above intends more to use contraceptives by 65.1% and 24.4% respectively than women with no children by 10.5%.

Table 4.2.: Distribution of Married Women by Socio-Demographic Characteristics and Attitude of Contraceptives Use.

Background Characteristics	Intention to use contraceptive		Statistics
	No	Yes	
Age			
15-19 years	10.5	6.0	$X^2=700.72$ $Pr=0.0000$
20-24 years	15.8	18.0	
25-29 years	19.9	26.4	
30-34 years	15.0	22.0	
35-39 years	14.0	16.4	
40-44 years	11.8	7.8	
45-49 years	13.1	3.4	
Husband's Age			
15-19 years	0.2	0.0	$X^2=602.20$ $Pr=0.0000$
20-24 years	3.3	2.4	
25-29 years	9.2	11.5	
30-34 years	13.3	19.3	
35-39 years	15.1	21.4	
40-44 years	14.9	18.1	
45-49 years	14.4	12.5	
50 years and above	29.8	14.6	
Place or resident			
Urban	26.6	46.8	$X^2=743.83$ $Pr=0.0000$
Rural	73.5	53.2	
Level of education			
No formal education	65.3	26.4	$X^2=2685.52$ $Pr=0.0000$
Primary	16.4	23.8	
Secondary	14.7	38.0	
Higher	3.6	11.8	
Husband's level of education			
No education	54.9	19.6	$X^2=2121.43$
Primary	16.6	21.0	

Secondary	19.7	40.0	Pr= 0.0000
Higher	8.8	19.4	
Ethnicity			X ² = 2017.92 Pr=0.0000
Yoruba	5.8	18.8	
Hausa	55.9	24.3	
Igbo	6.7	15.8	
Others	31.5	41.1	
Region			X ² =1844.05 Pr=0.0000
North-Central	12.4	18.9	
North-East	22.1	11.0	
North-West	46.3	25.0	
South-East	5.4	12.2	
South-South	5.7	12.3	
South-West	8.1	20.6	
Religion			X ² =2134.02 Pr=0.0000
Christianity	22.9	57.1	
Islam	75.9	42.1	
Traditional	1.3	0.8	
Wealth Index			X ² =1530.78 Pr=0.0000
Poor	58.2	29.5	
Middle	17.7	20.1	
Rich	24.1	50.4	
Occupational status			X ² =210.09 Pr= 0.0000
Not employed	34.0	23.2	
Employed	66.0	76.8	
Number of living children			X ² =87.93 Pr=0.0000
No children	11.9	10.5	
1-4 children	57.8	65.1	
5 children above	30.3	24.4	

4.3: Odds Ratio Based on Logistic Regression Analysis of Socio-Demographic Characteristics and Attitude towards contraceptives Use.

Table 4.3 below showed the result of binary logistic regression of the effect of socio-demographic characteristics on attitude towards contraceptive use among married women. Result Model 1 Women from age group 35-39 years were 0.76 less likely to intend using contraceptive to women age 15-19years (RC). Women ages 40-44 years were 0.43 less likely to intend using contraceptive to women age 15-19years (RC). Women ages 45-49 years were 0.17 less likely to intend using contraceptive to women age 15-19years (RC). Rural women were 0.80 less likely to intend using contraceptive to urban women (RC). Women with primary education were 1.62 more likely to intend using contraceptive than women with no formal education (RC). Women with secondary education were 2.03 more likely to intend using contraceptive than women with no formal education (RC). Women with higher education were 2.52 more likely to intend using contraceptive than women with no formal education (RC). Women that husband's had primary education were 1.46 more likely to intend using contraceptives than women that husband's had no formal education (RC). Women that husband's had secondary education were 1.47 more likely to intend using contraceptives than women that husband's had no formal education (RC). Women that husband's had higher education were 1.59 more likely to intend using contraceptives than women that husband's had no formal education (RC).

More so, Hausa women were 0.30 less likely to intend using contraceptive to Yoruba women (RC). Igbo women were 0.47 less likely to intend using contraceptive to Yoruba women (RC). Other ethnic groups were 0.48 less likely to intend using contraceptive to Yoruba women (RC). Women from the north-east region were 0.71 less likely to intend using contraceptive to women from the north central (RC). Women from the south-south region were 0.81 less likely to

intend using contraceptive to women from the north central (RC). Women from the south-west region were 0.76 less likely to intend using contraceptive to women from the north central (RC). Muslim women were 0.45 less likely to intend using contraceptive to Christian women (RC). Women from traditional religion were 0.46 less likely to intend using contraceptive to Christian women (RC). Women with 1-4 children were 1.34 more likely to intend using contraceptive than women with no children (RC). Women with 5 children and above were 2.34 more likely to intend using contraceptive than women with no children (RC).

Table 4.3: Odds Ratio Based on Logistic Regression Analysis of Socio-Demographic Characteristics and Attitude towards Contraceptives Use.

Background Characteristics	Odd Ratio	Lower Confident Interval	Upper Confident Interval
Age			
15-19 years (RC)	1.00		
20-24 years	1.09	0.91	1.32
25-29 years	0.99	0.82	1.21
30-34 years	0.98	0.79	1.21
35-39 years	0.76*	0.61	0.96
40-44 years	0.43***	0.33	0.57
45-49 years	0.17***	0.12	0.24
Husband's Age			
15-19 years (RC)	1.00		
20-24 years	1.16	0.36	3.72
25-29 years	1.70	0.57	5.09
30-34 years	1.60	0.54	4.69
35-39 years	1.60	0.54	4.73
40-44 years	1.36	0.45	4.05
45-49 years	1.19	0.40	3.59
50 years and above	1.05	0.34	3.21
Place or resident			
Urban(RC)	1.00		
Rural	0.80**	0.69	0.93

Level of education			
No formal education(RC)	1.00		
Primary	1.62***	1.40	1.88
Secondary	2.03***	1.74	2.38
Higher	2.52***	2.01	3.15
Husband's level of education			
No formal education(RC)	1.00		
Primary	1.46***	1.24	1.72
Secondary	1.47***	1.24	1.74
Higher	1.59***	1.31	1.93
Ethnicity			
Yoruba(RC)	1.00		
Hausa	0.30***	0.21	0.42
Igbo	0.47***	0.35	0.64
Others	0.48***	0.37	0.63
Region			
North-Central(RC)	1.00		
North-East	0.71**	0.57	0.89
North-West	1.16	0.88	1.53
South-East	0.90	0.65	1.24
South-South	0.81*	0.67	0.98
South-West	0.76*	0.59	0.99
Religion			
Christianity (RC)	1.00		
Islam	0.45***	0.37	0.55
Traditional	0.46***	0.32	0.67
Wealth Index			
Poor(RC)	1.00		
Middle	1.13	0.98	1.31
Rich	1.15	0.96	1.37
Occupational status			
Not employed(RC)	1.00		
Employed	1.12	0.99	1.27
Number of living children			
No children(RC)	1.00		
1-4 children	1.34***	1.16	1.54
5 children above	2.34***	1.96	2.80

RC means the reference categories *P<0.05 **p<0.01 ***p<0.001

HYPOTHESIS TESTING

H_0 : There is no significant relationship between socio demographic characteristics and attitude of married women towards family planning.

H_1 : There is significant relationship between socio demographic characteristics and attitude of married women towards family planning.

Decision

From the binary logistic regression, the relationship between socio demographic characteristics and attitude towards family planning utilization is statistically significant in ($P < 0.05$), from this, we can conclude that there is a significant relationship between socio-demographic characteristics among married women (Age of women, Place of residence, Level of education, husband level of education, Ethnicity, Region, Religion, Number of living children) and intention of family planning utilization. Therefore we fail to accept the null hypothesis.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This study provides how to establish and understand the attitude of married women in Nigeria towards family planning. This chapter provides the summary of the findings, discussion of the findings, and conclusion of the findings from the research and references.

5.1 Summary of the findings

The first objective of was to ascertain the percentage of women of age 15-49 who are married and their attitude towards the use of family planning. The second objective of this study was to examine the factors that determine the attitude of contraceptive use in Nigeria.

From the binary logistic regression, the relationship between socio demographic characteristics and attitude towards family planning utilization is statistically significant.

Furthermore, the multivariate result revealed that there is a significant relationship between socio-demographic characteristics among married women (Age of women, Place of residence, Level of education, husband level of education, Ethnicity, Region, Religion, Number of living children) and intention of family planning utilization.

5.2 Conclusion

The main purpose of this study was to know the behavior or attitude of women in Nigeria towards family planning. The research therefore conclude that there is a significant relationship between socio-demographic characteristics among married women (Age of women, Place of residence, Level of education, husband level of education, Ethnicity, Region, Religion, Number

of living children) and intention of family planning utilization. Overall, there is low knowledge on contraceptive use and most of them don't intend to use any method. This can be done by focusing on information and education about birth preparedness to the newly wed couples and pregnant mothers during antenatal check-ups. In this way infant and maternal mortality and morbidity as well as the need for abortion are decreased and the overall well-being of the family is maintained. In some parts in Nigeria, there is still practice of early marriage whereas in some communities even child marriage is practiced, Delay in age at marriage shifts the time for sexual activities. Unintended pregnancy is clearly a public health issue, a gender issue, and a population issue; effectively addressing such a problem will result in multidimensional improvements in Nigeria.

5.3 Recommendations

In the light of the conclusions drawn and discussed in this study, the following recommendations are offered.

1. There should be adequate information and material sources available throughout the country. The illiterate ones in rural areas especially should be enlightened through campaigns about their health and economic importance of birth control.
2. Secondary and higher institution should contain family planning methods in their curriculum and also that family planning was not for the purpose of destroying unborn child, especially the non-literate ones. This might have affected the result of the study especially on attitude of married women towards family planning.

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