WOMEN OCCUPATIONAL STATUS AND CONTRACEPTIVE USE IN IKORODU LOCAL GOVERNMENT AREA, NIGERIA.

OLADIMEJI BOLUWATIFE EXCELLENT

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CERTIFICATION

This is to certify that OLADIMEJI BOLUWATIFE EXCELLENT of the Department of Demography and Social Statistics, Faculty of Social Sciences, carried out a research on the topic WOMEN OCCUPATIONAL STATUS AND CONTRACETIVE USE IN IKORODU LOCAL GOVERNMENT AREA, NIGERIA in partial fulfillment of the requirements for the award of Bachelor of Science (B.Sc) in Federal University Oye-Ekiti, Nigeria under my Supervision

..... 26/3/2019

DR E.K ODUSINA **DATE**

PROJECT SUPERVISOR

..... 26/3/19.

DR S.B SHITTU **DATE**

CO-PROJECT SUPERVISOR

..... 3/4/19

DR. NTOIMO LORRETTA FAVOUR C. **DATE**

HEAD OF DEPARTMENT

....

EXTERNAL EXAMINER **DATE**

DEDICATION

The project is dedicated to God Almighty the one that is and yet to come, the same yesterday , today and forever, the unchangeable changer for keeping me and his love, grace and his tender mercy for keeping me throughout this project work. And also to my parent Mr. and Mrs. Oladimeji and to all my family and friends.

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ABSTRACT

The study examined women occupational status and contraceptive use in Ikorodu Local Government Area, Nigeria using data collected through structured questionnaire from 210 women between the ages 15-49. Analyses were carried out at univariate level (frequency distribution), bivariate level (chi square test) and multivariate level (logistic regression model). Findings revealed that 49.5% of the total respondents were employed, 14.8 were unemployed while 35.7 percent indicated they were self employed. In addition, 55.2 percent of the total respondent claimed they were using contraceptive method while 41.0 percent indicated otherwise. The results of multivariate analyses revealed no of significant relationship between occupational status and contraceptive use. However, income and educational levels were found to be significantly related to contraceptive use. The study concluded that income and educational levels were factors in contraceptive use of respondents in the study area.

CHAPTER ONE

1.0 INTRODUCTION

Women, as the bearers of children and the mostly unacknowledged economic providers of families, face continuing changes in their reproductive and productive roles. These changes in women productive and reproductive roles are generally attributed to changes in educational levels and occupational roles of women outside the home. In turn, these changes raise questions on whether these factors affect women fertility levels and family structure. While increased educational levels are associated with lower fertility in developing and developed countries. Empirical studies on the association of women labour-force participation (e.g., working for pay) with fertility show mixed results. Were asserts the association of the reproductive and productive aspects of women lives is conditional and varies by women life cycles. In developed countries, women work is associated with lower fertility, but in developing countries, where kinship networks provide unpaid child care for working women, or where child care and working for pay are not incompatible, working for pay and fertility levels are not associated. Cochrane cautions that increasing educational opportunities for women is not an efficient mode for decreasing fertility. Mason similarly cautions against promoting women labour-force participation as a means to reduce fertility, as the link between women employment and fertility is at best tenuous. On the other hand, educational and employment opportunities create certain viewpoints and values among women that may be favorable to having smaller families as a way of life.

While contraceptive use is expected to decrease fertility, the impact of contraceptive use on fertility remains a contentious issue in most developing countries. Some researchers have suggested that governmental institutions and donors need not implement family planning programs. Instead, governmental organizations must implement programs and policies that aim

at increased economic development. With increased economic development, lower fertility follows. Others, however, have contended that "slower population growth would be beneficial to the economic development of most developing countries. Along this line, fertility must decrease through contraceptive use so a country may achieve its planned economic development. The current study attempts to provide empirical evidence, if there is any, that contraceptive use is associated with a decrease in the number of children, using individual rather than aggregated data.

Such assessment of the association of contraceptive use and number of children is done while controlling for women's educational level, previous work experience and other control factors.

Measuring the potential impact of contraceptive use on fertility at the individual rather than country level brings into focus the need to base policies and programs on conditions and needs of individuals rather than the aggregated impact at country level.

Increased educational level and occupational opportunities are two aspects of the status of women that researchers consider may lead to fertility or mortality transition. To the extent possible, this study provides empirical data to explore whether the above two aspects of increased status of women is related at all with fertility. With the underlying assumption that increased educational level and work opportunities imbue women with values that are favourable to smaller family sizes, empirical data that link increased educational and occupational opportunities with lower fertility are needed to justify these programs for women. But more importantly, the program of action of the 1994 International Conference on Population and Development calls for increased educational and occupational opportunities for women, not simply as a means of controlling fertility, but for increasing the quality of life of women and

children. In addition, increased educational and occupational opportunities are important in building a country's human capital.

While it is ideal for women to make autonomous decisions themselves, practical realities and most empirical studies indicate that women make fertility and work decisions jointly with or probably in deference to their husbands' decisions. An understanding of the roles of husbands in fertility and women's work is needed to develop programs and policies that consider the context in which decisions about fertility and labour-force participation are made.

The report takes the position that while motherhood remains probably the most essential source of self-fulfilment and accomplishment for women, having obtained a certain level of education and having previously worked prior to childbearing are important personal resources and characteristics that enable women to fulfil their maternal and non-maternal roles. However, there remains a critical gap in governmental policies and programs that may assist women in performing their reproductive and productive roles. The current study attempts to provide empirical data that help justify promulgating and implementing policies and programs that may assist women perform their multiple roles.

The idea behind contraceptive is as old as time itself; but for just as long, finding an effective method that anyone can easily access has been the major hurdle to cross (Edgerton, 2011; Tone, 2002). Couples can choose from a range of contraceptives and the decision to use and to choose a particular method can be influenced by decisions made at various levels: at national and regional level, at community and clinic level and at individual level. At the national level, policies are set concerning the methods to be included and excluded from public and private family planning programs. At the community and clinic level, resources and administrative decisions influence the relative accessibility of particular contraceptive methods,

and at the individual level, people desiring to avoid or delay an additional birth make decisions about which method to adopt (Davidson, 1989). Use of contraceptive methods among women in stable marital relations may be influenced by a number of factors which include but not limited to socio-demographic variables such as age, education level and occupation. Age can be associated with the use of contraceptive methods, different age groups have different contraception knowledge and needs for example women in mid- twenties who are in stable relationship are likely not to use contraceptive methods because it a period to bear the children. However, women with advanced age above forty five are likely to use contraceptives. Furthermore, women with higher education level, are better informed than women with lower education; and therefore likely to use contraceptive methods. In addition, occupation is likely to influence the use of contraceptives, because sometimes job requirement may necessitate delay in conception. Further that, religious beliefs may discourage women and their spouses/partners from using contraceptive methods. Besides, mediating factors such as spousal communication, supply, and access to service are important in facilitating the above-described linkages between independent and dependent variables.

Access to family planning is both a human right and a socio–economic necessity. It is a human right issue because every woman has the fundamental right to determine how many children she wants and when she wants to have them. The socio-economic necessity flows out of the uncontrolled population growth will inevitably lead to overpopulation and its attendant consequences of high unemployment and youth dependency, rampant poverty, high child and maternal mortality, scarcity of resources like water that often leads to conflict, and general environmental degradation. As such, easing access to family planning is a practical imperative.

Presently, the world's population has exceeded 7 billion, and it is still growing at the rate of 1.13% per year

The 1994 International Conference on Population and Development (ICPD) and the Millennium Development Goal, both pledged to work to increase the growth in the prevalence of the use of contraceptives, since both have formed embankments of political commitment and funding for expanding the coverage of family planning globally. In sub-Saharan Africa, this hl translated to efforts such as information, education, communication (IE&C) inventions, decreasing cost of contraceptives and building better supply lines to assure access in the more remote places.

Nigeria has also undertaken several inventions to scale up the use of contraceptives such as the introduction to Ministry of Health -led reproductive health and family planning programs (to reduce material and infant death, increase the use of contraceptives among women of reproductive age, promote and improve access to reproductive health services at all levels of health care delivery), Also the factors and circumstances that help in expanding the use of contraceptives among who should use them women of reproductive age are not completely understand in some local socio-cultural contexts.

Source of information on contraceptive methods was significantly associated with contraceptive use acceptance. Finding revealed that a big portion of users in the study relied on the information from health facilities or reproductive health clinics. Further findings revealed the importance of getting information to potential users of contraceptive methods.

However, peasants are likely to be far from health facilities and far from accessing information on contraceptives. It was also revealed that a relatively big portion of non-users

would prefer service provision at home through community base distribution. This is consistent with other studies availability and accessibility of contraceptive methods influence the use of contraceptive methods. Findings of this study showed a significant association between availability and accessibility of contraceptive methods and use. This was also supported by observation from service provider and suggested that contraceptive methods should be available to all health facilities including private ones.

Africa has countries that have large population more women are engaging in work than ever before. By 2011, more than half (57%) of women 15-64 years old were in some form of employment. The increase in women working has been driven by women with the least amount of schooling finding work –these are the women who are more likely to be out of work than those who have had access to more schooling.

1.1 STATEMENT OF THE PROBLEM

In a situation where human reproduction is unchecked, it is most likely to lead to high rate of birth, which automatically brings about large family size with the negative impact on the health and well being of mothers and children in the household and population at large. This will have a negative impact on the family, the community and the nation at large as a result of economic overload and in covering the additional demand. In recent studies, there is proportionate and direct cause and effect of uncontrollable birth on the nation's development aspiration and can prevent the people from enjoying an improved standard of living (Derose 2002). The fertility rate in Nigeria has been consistently high whichis5.53 children per woman. Contraceptive prevalence rate stands at 26.8 %(any method and modern method) among all women of age 15- 49 with 42% of married women of age 15- 49 years with 31% using modern methods.

Studies have shown that women in Ikorodu Local Government Area, Nigeria experiences high fertility and they are not really educated, they involve in farming and trading activities. The main problem with the study is that they do not really use contraceptives because of their level of education and their women are not really empowered. The study aims at determining the women occupational status and contraceptive use in Ikorodu Local Government Area, Nigeria.

1.2 RESEARCH QUESTION

1. What proportion of women in Ikorodu Local Government Area, Nigeria knows at least one contraceptive method?

2. What is the prevalent rate of contraceptive use among women in Ikorodu Local Government Area, Nigeria?

3. What influence does women occupation occupational status have on contraceptive use in Ikorodu Local Government Area, Nigeria?

4. What other factor influence contraceptive use among women in Ikorodu Local Government Area, Nigeria?

1.3 OBJECTIVES OF THE STUDY

MAIN OBJECTIVE

The general objective of the study is to examine women occupational status and contraceptive use in Ikorodu Local Government Area, Nigeria.

SPECIFIC OBJECTIVE:

The specific objectives are to:

1. To ascertain the proportion of women in Ikorodu Local Government Area, Nigeria who know at least one contraceptive method.
2. To ascertain the prevalent rate of contraceptive use among women of Ikorodu Local Government Area, Nigeria.
3. Examine the influence of occupational status of women on contraceptive use in Ikorodu Local Government Area, Nigeria.
4. Determine other factors influencing contraceptive use among women in Ikorodu Local Government Area, Nigeria.

1.4 JUSTIFICATION OF THE STUDY

The findings of this study provided essential information regarding contraceptive use in Ikorodu Local Government Area, Nigeria. This study helped to identify socio - demographic and socio - cultural issues that are barriers to use of contraceptive methods by women working the study findings may help in developing new approaches for increasing use of contraceptive methods among women are economically active in the sample population (Ikorodu Local Government). The research will helped to generate ideas for reducing women's negative perceptions and attitudes towards use of contraceptives. The recommendations made by this study may play a role towards improving effective use of contraceptives and family planning services, and thereby contribute towards reducing fertility.

1.5 DEFINITION OF TERMS

Family planning: A program to regulate the number and spacing of children in a family through the practice of contraception or other method of birth control. Plan on when to have children and the use of birth control and other techniques to implement such plans.

Contraceptive prevalence rate: Is the proportion of women in reproductive age who are using (for whose partner is using) a contraceptive method at a given point in time.

Contraception: The deliberate use of artificial methods or other methods to prevent pregnancy.

Family planning method: Spacing or limiting child birth by using traditional or modern means.

Modern method: Technologically assisted method of birth control

Women in fertility age: Any female aged between 15-49 years.

Labour force participation: This is the number of people who are actively contributing to the economy of a nation.

HYPOTHESIS

H_0: Occupational status influence contraceptive use among women in Ikorodu Local Government Area, Nigeria.

H_1: Socio-demographic factors (e.g. age, education etc) influence contraceptive use among women in Ikorodu Local Government Area, Nigeria.

CHAPTER TWO

LITERATURE REVIEW

2.0 INTRODUCTION

Contraceptive use is the expression of individual desire to space or to limit birth. By practicing family planning, couples can improve the health of mothers and children through birth spacing and avoiding high risk pregnancies. In addition to this, family planning can help to slow down population growth thereby contributing to economic benefits such as poverty decrease. There are about 80 million unintended (mistimed or unwanted) pregnancies which occur each year worldwide which greatly contributes to high rates of induced abortion, maternal morbidity and mortality, and infant mortality. Family planning has been discovered to be an essential means by which the sustainable Development Goals (SDGs), can be achieved for improved child and maternal health outcomes.

Empowering women is central to promoting a quick and equitable economic growth and long term stability in any country. Gender equity gives rise to people's abilities to take advantage of opportunities and make reasonable choices. These abilities are essential for societal and national transformation. Expanding women's opportunity in public works, agriculture, finance and elsewhere accelerates economic growth. There is mounting evidence that women's ability to fully enjoy human rights - indeed, even to demand such rights - is integrally linked to their economic empowerment. Countries that invest in promoting the social and economic status of women tend to have lower poverty rates. Evidence has also shown that resources in women's hand result in household expenditure that benefit children (World Bank, 2014).

To date, there is considerable variation in the definition and conceptualization of women's empowerment. The World Bank defines empowerment as the "expansion of freedom of choice and action to shape one's life. This definition encompasses two features of women's empowerment: process of change (through which a woman gains power in making decisions) and agency. Kabeer defines women's empowerment as a "process by which those who have been denied the ability to make strategic life choices acquire such ability. This definition involves resources and achievements, in addition to process of change and agency, all of which are interrelated. A common underlying feature of these definitions is the recognition that household and interfamilial relations are central aspects of women's empowerment. Cutting-edge empirical research often incorporates analyses of empowerment that use data aggregated from individual and household levels or direct measures at the community and societal levels. Relationship between women's fertility level and employment is complex but there are certain aspects of the relationship that can be understood and subjected to programs and policies that may enable women to fulfil their multiple roles in less strained and more equitable environment. The complexity of the relationship stems from the fact that a woman's parity may determine whether she would seek employment or her parity more specifically, the presence of young children who demand significant child care may deter her from working. In the same manner, assessing the relationship of contraceptive use and parity may be complicated in that one factor affects another. That is, parity may determine contraceptive use or contraceptive use may determine parity. In addition to the potential bi-directional effects of parity and contraceptive use and parity and work status, the pattern of the association can be conditioned by the gender relations and other factors at the household and community levels. To understand the relationship between fertility and working for pay, the characteristics of the labour markets available to women must

be taken into account in addition to personal, household and partner factors. Despite the above difficulties, we found compelling results that may bolster continuing provision of contraceptives by governmental institutions, and promotion of educational and occupational opportunities for women and creation of awareness programs that focus on the contributions of women to economic development beyond fertility.

Empirical evidence suggested that contraceptive use could reduce the likelihood of birth in a short interval, as in Bolivia. Or if contraceptive use was used early during family formation, a negative effect on number of children could be documented, as in rural Zimbabwe. On the other hand, the absence of association between early contraceptive use and number of children in urban.

Zimbabwe suggests that a certain threshold on the effect of contraceptive use on number of children may have already been reached in urban Zimbabwe, while in rural Zimbabwe, the force of fertility transition mediated through early contraceptive use was continuing. In the Philippine qualitative data, empirical evidence of reactive contraceptive use was found, which may limit the negative effect of contraceptive use on number of children.

The effects of fertility measures on women's work status were mixed, which is not surprising given the different reproductive phases and reference periods in which the association of work status and fertility was examined. In the Bolivia sample, giving birth in the interval, e.g., having young children, rather than the number of children, had a negative effect on women working per se or working in the formal sector. Having a young child did not deter women from working in the informal sector in Bolivia or working as unpaid family worker in the Philippines.

Higher level of education among women was associated with an increased level of contraceptive use in all of the three countries and with fewer children among contraceptive users in Bolivia and

Zimbabwe. In a similar manner, the negative effect of previous work experience on parity was stronger among contraceptive users than non-users. Previous work and higher educational levels increased the likelihood that women were working for pay.

Considering that women who had additional births in the interval were women with lower parity, this result suggested that the negative effect of having young children on women's work status occurred when women were in their prime for childbearing. On the other hand, that older women were more likely to work than younger women suggests that at a certain point during the reproductive cycle, women became relatively free to work rather than bear and rear children.

The different work patterns of women across age groups as well as the effects of education and previous work experience can be understood within an economic model of work and fertility supplemented by an economic theory of human capital formation. An economic theory of women's fertility and work predicts that the competing demands for women's time to work outside the home or to bear and care for children reach equilibrium where the household obtains maximal gain. Based on this model, a woman with sufficient education, training and work skills who is well compensated in the paid labour market opts to limit her number of children as the relative cost of raising children for this woman is particularly high.

Thus, highly educated women or women with significant work experience may be more likely to marry later or to bear fewer children as they devote their time to labour-force participation. In extending the model through a woman's life cycle, one may also assert that women with appropriate occupational qualifications past the childbearing years should be able to participate in the labour force as time constraints imposed by childbearing are minimal. Whether women can work at any point in their reproductive cycle, however, will depend not on just

whether they have more time, but whether they have levels of training and skills needed for available jobs.

The mixed effects of living with a partner on women's work status (no effect in Bolivia, negative in Zimbabwe, and conditional in the Philippines) could be due to the differential mode in which sexually based division of labour , men as economic providers and women as homemakers, interact with the available jobs for men and women in each country. We conjecture that the available jobs in Bolivia are probably targeted to women. As suggested by Mitter, in economic settings where low-paying jobs are targeted to women, men are likely to reject available jobs because of their low pay and potential stigma of taking on "feminized" jobs while women are willing to accept them. In the Philippines, the qualitative data indicated that most men and women would prefer that men continue to be economic providers with women's work taken to be supplemental to men's income. Such statements from men and women point to possible continuing marginalization of women's economic contribution to the household, and as noted by economists to a country's developmental efforts. In Zimbabwe, the historic sexual division of labour promulgated at the time of its colonization with men working away from their own homes to meet the hut tax could still be prevailing.

2.1 USE OF CONTRACEPTIVE AMONG WOMEN

A survey on world fertility reported that it should be noted that in most of the countries in the world, on an average scale every woman wants to have four children. Even among countries with the largest average number desired. Kenya with seven and Jordan and Sierra Leone with six desired family size were smaller than the biological maximum a typical woman could have estimated to be about in the absence of breast feeding. This suggests that women in these countries should limit their family size to a reasonable level. In African countries, women who

wanted to have children later out-number those who wanted to end child bearing completely and compare to Asia and Latin America and the Caribbean that women prefer to end child bearing untimely. Spacing children in Africa is an important reason for using family planning (contraceptive method), (Deride, 2012)

Contraceptive use has increased worldwide over the last decade. Yet, Africa like many other regions of the developing world continues to have a high unmet need for family planning approximately 25% of women and couples in sub-Saharan Africa who want to space or limit their births are not using any form of contraception. More than half of the people in Africa are younger than 25 years old, so unmet need is only expected to increase as these individuals enter their reproductive years.

2.2 CONTRACEPTIVE PREVALENCE

The prevalence of contraceptive use has increased worldwide due to the development and introduction of modern contraceptives and the establishment of organized family planning programs. The contraceptive prevalence rate in many developing countries rose from 9% in the 1960 to 60% in 1997 and this has helped in reducing the total fertility rate of some developing countries (the lifetime average number of children per woman) from 6.0 in 1960 to 3.1 in 1997. The proportion of Nigerian women using modern contraceptive methods rose from 3% in 1990 to 8% in 2003.The low rate of contraceptive use in Nigeria results in high fertility rates, particularly in the rural areas and the northern part of the country. This high fertility rate accounts for Nigeria's high maternal, infant, and neonatal mortalities, and the use of modern contraceptive methods has been reported to be very limited in the northern part of Nigeria, with only 9% of Nigerian women reported to be using these in 2003. In addition, only 3% of women from the northeast and the northwest reported using a modern method, compared with 23% in the

southwest. These data correlate well with the high fertility rate in the northern part of the country. According to the 2003 Nigeria Demographic and Health Survey, the country's overall fertility rate was 7.0 children per woman in the northeast and 6.7 children per woman in the northwest, compared with only 4.1 in the southwest. This survey has shown that there is still a large unmet need for contraceptive use in Nigeria.

2.3 SOCIO-DEMOGRAPHIC VARIABLES AS PREDICTORS OF USE OF CONTRACEPTIVES

In most developing countries, use of contraceptive can be influenced by socio-demographic characteristics of women. Indian as a case study, studies have shown that in India women's education emerges as the strongest predictors of use of contraceptives. In one of Yemen study, parity, age, marital status, religion, husband's occupation, monthly family income and women's occupation were found to be associated with the use of contraceptives. The principal predisposing and enabling the use of contraceptives by women were socioeconomic status, knowledge, and education of the mother. This leads to the conclusion that the main limiting factors to the use of contraceptive methods in the state are poverty, ignorance, and illiteracy. Education was also associated with increase in the use of modern family planning methods. This might partly be explained by the fact that these women start their family life after their education, i.e. at a later age, and try to have the number of children they wish before their menopause begins. The likelihood of use of contraceptive methods is higher for those with higher parity, literate. The levels of knowledge and the use of contraceptive methods as well as communication between spouses regarding family planning issues were significantly associated with contraceptive use.

2.3.1 AGE

The age of a woman has been found to be significantly associated with the use of contraceptives, with older women are generally less likely to use contraceptives than younger women. Blanc et al., (2009) found that in 40 developing countries, adolescents (aged 15-19) were more likely to use contraceptives than adult women, even though continuation rates were lower among them (Blanc, Tsui, Croft, &Trevitt, 2009). In the United States, women who were aged above 35 years were found by Frost et al. (2007) to be more likely to use contraceptives with another study by Upson et al (2009) confirming this by finding that women aged 40-44 years were twice as likely not to use a contraceptive methods when compared with a younger group (Frost, Singh, & Finer, 2007; Upson, Reed, Prager, & Schiff, 2010). The specific odds ratios at the 95 percent confidence level for women 35-39 and 40-44 years old in the Foster et al. (2004) study were 1.686 and 2.497 respectively.

Whereas in the Frost, Singh and Finer (2007) study, women 34-40 were in excess of three times more likely not to know and use any contraceptive methods (odds ratio 3.25, $p<.001$).According to a study carried out by Okech et al. (2011) in Kenya, family planning was found to be highest among women aged between 20 - 39 years compared to those below 20 years and above 39 years. Whereas 49 percent of the women that were using contraceptives were aged 20- 29 years, 41 percent were aged between 30 - 39 years, 4 percent and 6 percent of the women who were using family planning services were less than 20 years and between 40 - 49 years of age, respectively. These results indicate the importance of age in contraception use.

2.3.2 EDUCATION

A woman's education governs her knowledge and contraceptive use, with higher education correlating with higher odds of use, independent of spousal characteristics. Other studies have further elaborated the association of a woman's education on contraceptive decision making and choice as well as having an influence on women reproductive desires and behaviours (Ali & Okud, 2013; Andalón, Williams, & Grossman, 2014; Asfaw & Gashe, 2014; Asiimwe et al., 2014; Meskele & Mekonnen, 2014). The impact of women's education level on contraception behaviour has been extensively studied. Higher education levels in women have consistently been shown to have a significant effect on fertility levels and a positive effect on contraceptive use (Martin, 1996: Stash, 2001). Education increases the cost of raising children and therefore reducing fertility levels through contraception makes sense (Mason, 1987). Lower fertility, in turn increases the likelihood that a woman with more education will need to use fertility control measures since she understands the benefits of a small family size. (Martin, 1995).Education is also believed to improve a woman's independence and has been suggested to increase a woman's ability to engage in innovative behaviour such as family planning. Specifically, education increases a woman's knowledge of contraception and makes it more likely that they will have financial means to acquire appropriate methods (Caldwell, 1986)

2.3.3 RESIDENCE

It is a well-known fact that urban dwellers generally fare better than their rural counterparts across different health and development indicators (Clifton, 2015). The use of contraceptives is not different, as the residence of a woman is a major predictor of her use of contraceptive, and can act as both a barrier and an enabler of use (Mutangadura et al., 2007). Although there are a few exceptions to the rule, such as Rwanda (where the gap is within the margin of error), this

rural-urban disparity often hold true across the developing world (Clifton, 2015) Rural-urban difference had different effect on the variables. In rural settlement, education level has a direct negative effects income has a positive effect, and women working had no effect on fertility. In urban settlement, education and income had no effect on contraception, while women working had positive effect on contraception (Organization for Economic Co-operation and Development, (2012).

2.3.4 RELIGION

Religious factors have the potential to influence the acceptance and use of contraception by couples from different religious backgrounds in very distinct ways. Within religions, different sects may interpret religious teachings on this subject in varying ways, and individual women and their partners may choose to ignore religious teachings (Srikanthan and Reid, 2006). Christian teachings vary depending upon the denomination. Roman Catholicism teaches that the primary purpose of sexual relations is procreation within marriage. Roman Catholics are therefore forbidden to use medical or physical contraceptive methods. Natural contraceptive methods such as abstinence and the rhythm method remain permissible. Although Eastern Orthodox Christianity holds a similar view of the purpose of sexual relations, most contraceptive methods are permitted (Srikanthan and Reid, 2006.

Concerning the role of religion in determining contraceptive use, a study in Cambodia, a deeply Buddhist country, shows that religious belief has had little or no effect on the use of contraceptives (Vathiny & Hourn, n.d.). A comparative study in Nigeria done on data 18 years apart also confirmed the negligible influence of religion on the use of contraceptives (Wusu, 2014). Tawiah (1997) study on factors affecting contraceptive use in Ghana came out with the finding that religion and culture did not affect use of contraceptives (Tawiah, 1997). The study

gave a possible reason that once a woman attains higher education, her ethnicity and religious affiliation do not have a significant effect on her current contraceptive use. This was confirmed by Adanu et al., (2009) whose findings revealed that religious affiliation did not affect contraceptive use in Accra. They however, attributed a possible reason to the fact that Accra is an urban area (Adanu et al., 2009). Women were able to make decisions regarding contraceptives use without the influence of religion and culture. However, two studies in Pakistan, a Muslim country and among Muslim minorities in India and Bangladesh was able to pinpoint religion as a substantial influence on the knowledge and use of contraceptives (Farid-ul-Hasnain, Johansson, Gulzar, & Krantz, 2013; Sahu & Hutter, 2012). Doctor et al. (2009) found that switching from traditional to the Christian.

2.3.5 OCCUPATION

The work status of women is often considered to be an important determinant of contraceptive use. Employment, especially where a woman has to work outside the home is viewed as an index of commitment to and involvement in non-familial roles. It has also been observed that female employment outside home often leads to a desire for small families and thereby increasing the acceptance rate of contraceptives. A study in Indonesia by Soeradji found that proportion of women who were working had a higher acceptance rate of contraceptive use. Another study done in Indonesia focused only on the woman's status and family planning and found that working women had a slightly higher level of contraceptive use than non-working women. However, the difference was not significant, although women did perceive benefits from practicing family planning. Dharmalingam and Morgan conducted another study in India which revealed that women's work give women autonomy that led to limit and space birth and contraceptive.

2.4 THEORETICAL FRAMEWORK

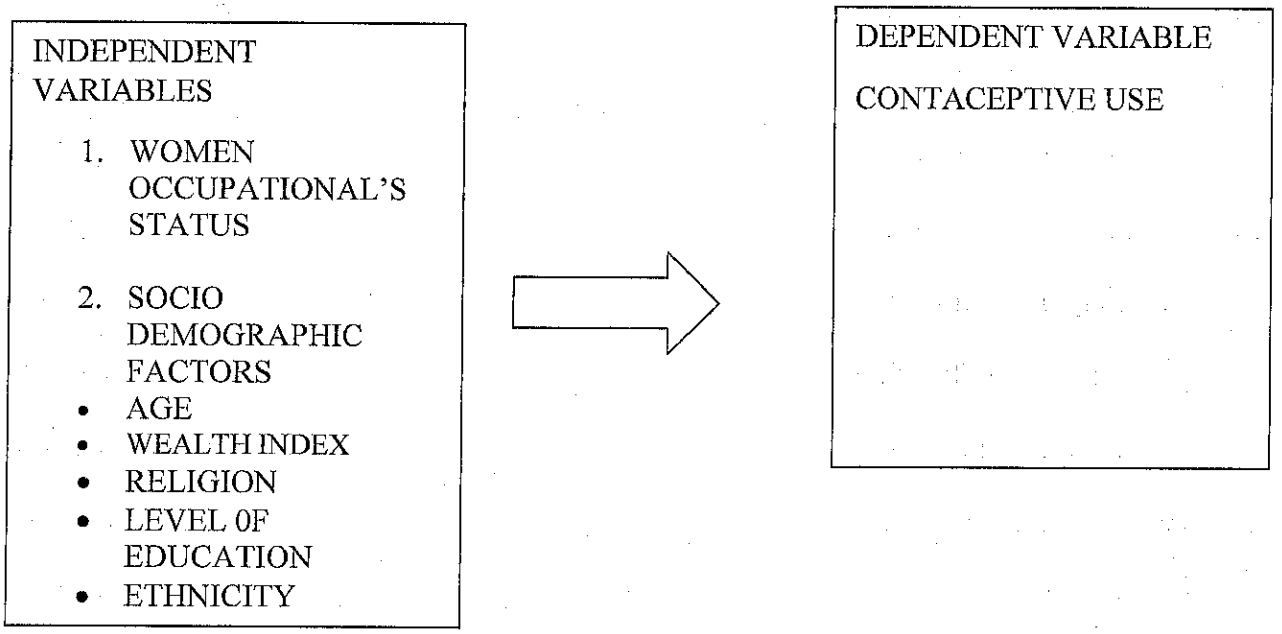
2.4.1 SOCIO-ECONOMIC PERSPECTIVE

In the socio-economic studies, fertility is arrayed against one or more independent variables both at macro and micro levels. The interpretation of the results from these analyses was improved upon by incorporating proximate determinant in the analysis. With the insertion of a new stage in the sequence, fertility is then seen as determined directly by a set of 'proximate determinants' with the background variables (social, economic, cultural, health and environmental factors) in turn operate only indirectly on fertility through these determinants. These determinants comprise factors such as the extent of exposure to intercourse (marriage patterns), fecundability (including frequency of intercourse), duration of postpartum in fecundability, Spontaneous intrauterine mortality, sterility and use of deliberate fertility control (contraception and induced abortion). The intermediate variables allow the identification of the pathway through which different socioeconomic variables affect fertility (Davis and Blake, 1955: Bongaarts 1978, Bongaarts and Potter 1983; Odometer, 1996).

Fertility differentials by ethnic group, place of residence, educational attainment, women's work and family wealth are largely due to compositional differences in age and age at marriage. Besides age at marriage, contraceptive use also plays an important role in explaining the fertility differentials. The wealth index emerges as the most important predictor of fertility in the multivariate context. Women from the poorest quintile have almost twice as many children as those from the richest quintile. Younger age at first marriage/birth and limited use of modern contraception are the main reasons for the higher fertility among the poor. The social and reproductive disadvantages associated with frequent and unplanned pregnancies are of public health concern.

The Bongaarts (1978) framework is one of the most tools which is widely used in fertility analysis and had a great influence on the collection of and reporting of fertility data. As a result, a large number of additional data on the proximate determinate is now available, which presents the opportunity to refine the proximate determinates indices (Stover, 1998). DHS datasets, found that contraceptives use in sub- Sahara Africa is fairly low and that fertility and its determinate have change over time. They also discovered that primary sterility of women in developing countries is much lower than the 3% estimates given by frank (1983). This study use bongaarts formulation to determine the contraceptive use and the proximate determinate variables on fertility.

2.5 CONCEPTUAL FRAMEWORK



CHAPTER THREE

METHODOLOGY

3.0 INTODUCTION

This chapter is going to explain the plan and approach for carry out the research work. It seeks to explain the study location, study population, research design, data collection, measurement of variables and method of data analysis

3.1 STUDY LOCATION

Lagos State is situated in south-western part of the Nigeria. The boundaries of this vast area are defined by 180 km long Atlantic Coastline in the south, the Republic of Benin in the west whiles the north and east boundaries are shared with Ogun State. It has a population of about (9.2million) which accommodates over 6.5 percent of the national population of 140 million (2006 population census figure). The study area is Ikorodu Local Government Area, Nigeria which is in Lagos State. It is a city in north-east Lagos State; Nigeria. It is located along the Lagos Lagoon and shares a boundary with Ogun State. At the 2006census the population of the Local Government was 535,619 and with an Area of 345 km^2 and Density of 2,107/km^2. The Area is bounded on the South by the Lagoon.

3.2 STUDY POPULATION

The study focus on women between the ages (15–49) are participating to the labour force and are willing to participate, available to give informed consent

3.3 SAMPLE DESIGN

The research would be carried out by using random sampling technique. It was used to select respondents from the general populace which are women in reproductive age between 15-49 years. From each of the enumeration areas, listing of major streets was being done. Two streets were randomly selected from the listings of the streets. National Population Commission house numbers were used to select ten houses randomly so that everyone was properly represented in the study

3.4 DATA COLLECTION

For the study I made use of questionnaires to obtain data form the respondent research was carried out among women within the age 15 - 49 years and were economically active in the labour force in Ikorodu LG (Local Government).

3.5 DATA ANALYSIS PROCESS

The administered questionnaire went through the editing process by me the researcher and data was entered into computer using SPSS. The research findings were statistically analyzed. The analysis would be performed using Statistical package for software solutions (SPSS) which enabled me to be able to carry out the necessary analysis on my findings to reach a conclusion.

3.6 MEASUREMENT OF VARIABLES

a. INDEPENDENT VARIABLES

AGE : The variable measure respondent's age of completed years and it is asked as age at last birthday. The research work focus on women between age 15-49, Ages would therefore be coded by using the age range of 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49

RELIGION: This variables measures the respondent religion, know and perception about method of contraception. It is categorize in following Christianity, Islam, and Traditionalist. The question is framed as what is your religion?

LEVEL OF EDUCATION: It refers to the level of education the respondent has attained and the different categories as follows Primary, Secondary, Tertiary and No formal education.

WEALTH INDEX: Respondents are being asked about their wealth status whether poor, middle or rich. Data are captured with the question Level of income. This could be Low, Medium and High.

ETHNICITY: This variable that measured the characteristics of people in accordance or similarities to their norms, believes, cultural background, language, ancestry and natural experience. It is categorized as Yoruba, Hausa, Igbo and others which would be specified.

b. DEPENDENT VARIABLE

CONTRACEPTIVE USE: This measured the knowledge of women about contraceptive and the usage of contraceptive among women data were be captured in two sections which are "knowledge and use of contraceptive" and "factors associated with the use and non-use"

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.0 INTRODUCTION

This fragment of the research focuses on the analysis and presentation of data collected from the field, women occupational status and contraceptives use in Ikorodu local government Area, Nigeria. This section will include three phases; the first is the description of socio-demographic variables. And then and then a bivariate analysis, testing for the significance in the differences in contraceptive use–The dependent variable- across the categories of the independent (occupational status, religion, highest level of education etc.)

4.1 SOCIO- DEMOGRAPHIC VARIABLES

Among the most noteworthy observations from the data collected as tabulated in the table 4.1.1 are the facts that the majority of the respondents are between the ages 40 to 49, accounting for more than 31% of the total sample size, while the least represented age group are between the ages 15-19. Who were less than 4% of the total sample size. Additionally, 72% of the respondents were Yoruba, claiming the majority of the sample size. 20% Igbo, 3% Hausa, while other tribes account for less 4% of the total sample.

Christianity was the most populous religion among the sampled population, accounting for over 83% of the total sample size, with Islam having less than 17% of the sample. More than half of the total sample size attained a secondary level of education, nearly 31% made it to a post-secondary level, while less than 2% had no formal education and more than 12% only attained a primary level education. It is also note-worthy that majority of the respondents were employed, nearly half of them either worked for the government or a private organization while

approximately 36% are self-employed, and less than 15% do not have a job. Majority of the respondents nearly 77% were married, more than 12% were single while 9% and 2% respectively were either divorced or widowed respectively. 49% low income earners, 42% medium and only 9% were high income earners.

Table 4.1.1. Respondents background characteristics.

Age group	***Frequency***	***Percent***
15-19	8	3.8
20-24	12	5.7
25-29	21	10.0
30-34	31	14.8
35-39	32	15.2
40-44	39	18.6
45-49	67	31.9
Total	210	100.0
Ethnicity		
Yoruba	153	72.9
Igbo	42	20.0
Hausa	6	2.9
Others	9	4.3
Total	210	100.0
What is your religion?		
Christianity	175	83.3
Islam	35	16.7
Total	210	100.0
What is your educational status?		
Primary	26	12.4

Secondary	115	54.8
Tertiary	64	30.5
no formal education	4	1.9
No response	1	.5
Total	210	100.0
Occupational Status?		
Employed	104	49.5
Unemployed	31	14.8
Self employed	75	35.7
Total	210	100.0
Marital Status?		
Single	26	12.4
Married	161	76.7
Divorced	19	9.0
Widow	4	1.9
Total	210	100.0
Level of income?		
Low	103	49.0
Medium	88	41.9
High	19	9.0
Total	210	100.0
No response	7	3.3
Total	210	100.0

Source: (Oladimeji 2018)

4.2. KNOWLEDGE AND USE OF CONTRACEPTVES

The total 210 sample size of nearly 70%, are aware of at least one type of contraceptive, and almost 30% said they do not know any method. Furthermore, 55% are using at least a method, while 41% of them are not using any method of contraceptive.

Table 4.2.1. Distribution of respondents by knowledge and use of contraceptive

Have ever heard of contraceptive of any type?		
Yes	146	69.5
No	62	29.5
No response	2	1.0
Total	210	100.0
Where did you get the information from?		
Media	85	40.5
from peer	35	16.7
seminar/training	14	6.7
from husband/partner	5	2.4
health facility	58	27.6
No response	13	6.2
Total	210	100.0
Total	210	100.0
Are you using any contraceptive method?		
Yes	116	55.2
No	86	41.0
No response	8	3.8
Total	210	100.0
What type of contraceptive method are you using?		
modern FP methods	97	46.2
Withdraw	26	12.4

Calendar	28	13.3
prolonged feeding	4	1.9
Abstinence	13	6.2
Nothing	18	8.6
Others	6	2.9
Total	192	91.4
No response	18	8.6
Total	210	100.0
No response	3	1.4
Total	210	100.0
Total	210	100.0
Have you used a family planning method before?		
Yes	106	50.5
No	92	43.8
Total	198	94.3
No response	12	5.7
Total	210	100.0
If Yes, Which family planning method have you ever used?		
no family planning	12	5.7
oral pill	35	16.7
emergency pill	9	4.3
Condom	30	14.3
IUD	11	5.2
Implant	19	9.0
Injectable	26	12.4
female sterilization	2	1.0
male sterilization	1	.5
rhythm/calendar method	5	2.4
Withdrawal	6	2.9

Others	2	1.0
don't know	20	9.5
Total	178	84.8
No response	32	15.2
Total	210	100.0
Is your husband/partner in support of you using any contraceptive methods?		
Yes	68	32.4
No	54	25.7
I don't know	78	37.1
Total	200	95.2
No response	10	4.8
Total	210	100.0
Do you discuss contraceptive methods with your husband?		
Yes	78	37.1
No	122	58.1
Total	200	95.2
No response	10	4.8
Total	210	100.0
Whom do you prefer as service provider?		
female service providers for women	70	33.3
male service providers for men	44	21.0
community based distributors CBDs	20	9.5
no sex preference	65	31.0
Total	199	94.8
No response	11	5.2
Total	210	100.0

Source: (Oladimeji 2018)

4.3. Chi-square analysis of the use of contraceptive against occupation and other socio-demographic factors.

From Table 4.3.1roughly 61% of the respondent who were Christian are using contraceptive method while less than 40% of them do not use any method. 43% of the Muslims make use of a contraceptive method while 57% do not make use of any method. Furthermore, over 46% of those employed into civil service or private organisation use a method of contraceptive, 54% of them do not use any method. 72% of those who are self-employed and 56% of the unemployed are using while 28% and nearly 44% of them respectively are not using any method. Surprisingly, none of the respondents with no formal education use any method of contraceptive while 44%, 53% and nearly 76% of those who attained primary, secondary and tertiary level of education respectively make use of at least one method of contraceptive.

More so, 46% women who confide in their spouse make use of any method of contraceptive. 75% who had spousal support on the use of contraceptive make use of at least a while 62% of those whose husbands or partner do not support contraception do not use any method of contraceptive

Conclusively, from the chi-square analysis, testing the use of contraceptive methods across various categories of independent variable, all the P-values were less than 0.05 (p-value<0.005), except for the test on religion which produces a probability value of 0.055 which is greater than 0.05. In essence, it means there are significant different in the use of contraceptive across the categories of all the independent variable including occupation. Except for religion affiliation, meaning there is no significant difference in contraceptive use across religion.

We therefore reject the null hypothesis, and accept the alternative hypothesis that there is a significant difference between the use of contraceptive and occupation of women.

Table 4.3.1 Bivairate **analysis of the use of contraceptive against occupation and other socio-demographic factors.**

		Are you using any contraceptive method?		Total	Test
		yes	No		
Religion					
Christianity	Count	101	66	167	X^2=.3.675
	Percentage	60.5%	39.5%	100.0%	p-value= 0.055
Islam	Count	15	20	35	
	Percentage	42.9%	57.1%	100.0%	
Total	Count	116	86	202	
	Percentage	57.4%	42.6%	100.0%	
Occupational Status					
Employed	Count	44	51	95	
	Percentage	46.3%	53.7%	100.0%	X^2=11.330
Unemployed	Count	18	14	32	p-value=
	Percentage	56.2%	43.8%	100.0%	0.003
self employed	Count	54	21	75	
	Percentage	72.0%	28.0%	100.0%	
Total	Count	116	86	202	
	Percentage	57.4%	42.6%	100.0%	
Educational status					
Primary	Count	11	14	25	
	percentage	44.0%	56.0%	100.0%	
Secondary	Count	56	51	107	

	percentage	52.3%	47.7%	100.0%	
Post-secondary	Count	49	16	65	X^2=16.970
	percentage	75.4%	24.6%	100.0%	p-value= 0.001
no formal education	Count	0	4	4	
	percentage	0.0%	100.0%	100.0%	
Total	Count	116	85	201	
	percentage	57.7%	42.3%	100.0%	
Whom do you comfortably talk to when you need to ask about contraceptive methods?					
husband/partner	Count	18	21	39	
	percentage	46.2%	53.8%	100.0%	
Relatives	Count	16	9	25	
	percentage	64.0%	36.0%	100.0%	X^2=22.200
friends of opposite sex	Count	3	2	5	p-value=0.000
	percentage	60.0%	40.0%	100.0%	
friends of the same sex	Count	7	2	9	
	percentage	77.8%	22.2%	100.0%	
health care providers	Count	72	34	106	
	percentage	67.9%	32.1%	100.0%	
Others	Count	0	10	10	
	percentage	0.0%	100.0%	100.0%	
Total	Count	116	78	194	
	percentage	59.8%	40.2%	100.0%	
Is your husband/partner in support of you using any contraceptive methods?					
Yes	Count	48	19	67	
	percentage	71.6%	28.4%	100.0%	
No	Count	20	32	52	
	percentage	38.5%	61.5%	100.0%	X^2=13.689
i don't know	Count	45	28	73	p-value=0.001
	percentage	61.6%	38.4%	100.0%	
Total	Count	113	79	192	
	percentage	58.9%	41.1%	100.0%	

Source (Oladimeji 2018)

4.4. Odds Ratio Based on Binary Logistic Regression Analysis of Occupation with Socio-Demographic Characteristics and Contraceptive Use.

Table 4.4.1 below showed the result of binary logistic regression of occupation with socio-demographic characteristics on contraceptive use. Result from Model 1, below revealed no significant effect of occupation on contraceptive use. Result from Model 2, adjusted occupation with other socio-demographic characteristics showed that women with post-secondary education

were 4.33 times more likely to use contraceptive than those with primary education (RC). Women with medium income were 0.19 times less likely to use contraceptive to women with low income (RC). Women with higher income were 0.07 less likely to use contraceptive to women with low income (RC).

Table 4.4.1: Odds Ratio Based on Binary Logistic Regression Analysis of Occupation with Socio-Demographic Characteristics and Contraceptive Use.

Background Characteristics	Model 1		Model 2	
	Odds Ratio	Lower-Upper Confidence Interval	Odds Ratio	Lower-Upper Confidence Interval
Occupational Status				
Employed **(RC)**	**1.00**		**1.00**	
Unemployed	1.02	(0.46-2.29)	0.55	(0.17-1.72)
Self-employed	0.72	(0.39-1.33)	1.28	(0.60-2.73)
Age			1.03	(0.98-1.08)
Ethnicity				
Yoruba			**1.00**	
Igbo			0.76	(0.33-1.74)
Hausa/Fulani			1.00	(0.00-0.00)
Others			1.04	(0.15-7.01)
Religion				
Christianity			**1.00**	
Islam			2.76	(0.95-8.01)
Level of Education				
Primary			**1.00**	
Secondary			1.60	(0.54-4.78)
Post-secondary			4.33*	(1.08-17.47)
No formal education			1.30	(0.09-19.48)
Marital Status				

Single			**1.00**	
Married			0.48	(0.11-2.18)
Divorced			0.44	(0.07-2.79)
Widower			1.00	(0.00-0.00)
Income				
Low			**1.00**	
Medium			0.19***	(0.08-0.45)
High			0.07***	(0.02-0.29)

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

Source: (Oladimeji 2018)

CHAPTERFIVE

DISCUSSION, CONCLUSION AND RECOMMENDATION

5.1 DISCUSSION OF FINDINGS

Contrary to the trend and the common outcome, data collected from Ikorodu Local Government Area, Nigeria exhibited totally different characteristics in terms of contraceptive use. Contrary to data collected in Nigeria is a whole (through the NDHS) Religion has no significant effect on contraceptive use among the women of the study location. In fact, usage across occupational status was not as expected, the class with the most frequent usage are those whoare self-employed followed by those who are not employed at all while nearly 60% of those who are employed do not use a contraceptive method.

From statistical observation, unemployed people in this area have 2% tendency of using a contraceptive method than the employed folks (from Model 1, Table 4.3) while those who are self-employed 28% odds of using a contraceptive than those who are employed (Model 2, Table 4.3).

However, education proved to be influential and beneficial to contraceptive useas none of those who had no formal education make use of any method of contraceptive 44% of those who had at primary education to over 52% usage among secondary school graduates and almost 76% among those with a post-secondary education.

5.2. CONCLUSION

Conclusively, occupation does not determine the usage of contraceptives among the women of reproductive age (15-49) in Ikorodu Local Government Area, Nigeria. But other socio-demographic factors such as education also affects.

5.3 RECOMENDATION

The findings reviews that there should be more attention given to education and the rate at which contraceptives is used. The government should encourage the women to have formal education and make it affordable for everyone to be able to obtain. (Because education is a form of indirect family planning).There should be provision for forums, seminars to encourage women to be empowered (to enable them to participate to the labour force and to develop economic growth) and also there should be more awareness made on contraceptives (i.e. how to use, when to use, where to get contraceptives) to make it easy to obtain so that the fertility rate will reduce. It should not be only restricted to women the men should also be encouraged to make use of contraceptives and to also influences their spouse to make use of contraceptives.

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FEDERAL UNIVERSITY, OYE EKITI

Research Topic: Women Occupational status and use of contraceptive in Ikorodu local government

This research is a student research project that is channelled to studying women occupation and use of contraceptive in Ikorodu local government, Nigeria.

This research excessive is purely for academics purpose and has nothing to do with you as a person. Any information given will be treated confidentially.

Serial No:
Interview Date:
Area of Interview:
Interview Completed [ ] Not Completed [ ] Refused [ ]

SOCIO-DEMOGRAPHIC CHARACTERISTICS			
1	Age at last birthday?		
2	Your ethnicity?	Yoruba Igbo Hausa Others	
3	What is your religion?	Christianity Islam Traditionalist	
4	What is your educational status?	Primary Secondary Tertiary No formal education	
5	Occupational status?	Employed Unemployed Self employed	
6	Marital status?	Single Married Divorced Widow Cohabiting	
7	Level of income	Low Medium High	

SECTION B:	KNOWLEDGE AND USE OF CONTRACEPTIVES		
8	Numbers of live children ever born?	1.	
9	At which age did you get your 1st child?	2.	
10	Have ever heard of contraceptive any type?	3. Yes 4. No	
11	If no, why?		
12	Where did you get the information from?	1. Media 2. From peer 3. Seminar/ Training 4. From Husband/ Partner 5. Health facility	
13	Do you know about contraceptive methods?	1. Yes 2. No	
14	If your response to Q 04. Above is "yes" Which types of contraceptive method do you know?	1. Pills 2. Intrauterine device (IUCD) 3. Injectable 4. Condom (female) 5. Condom (male) 6. Vasectomy/Male sterilization 7. Tubal ligation/female sterilization 8. Periodic abstinence 9. Prolonged breast feeding 10. Natural method 11. Others (specify)_____	
15	Are you using any contraceptive method?	1. Yes 2. No If Yes,	
16	What type of contraceptives methods are you using?	1. Modern FP methods 2. Withdraw 3. Calendar 4. Prolonged feeding 5. Abstinence 6. Nothing 7. Others (Specify)	
17	How often do you use contraceptives?	Sometimes Always Never	
18	Who informed you about the method (s)?	Friend Relative (specify) Neighbor Health worker Mass media (TV, Radio) Internet Others	

19	Which method do you think is most suitable?	Pill Injectable Condom Emergency Pill Withdrawal Periodic Abstinence Other	
20	Have you used a family planning method before?	Yes No	
21	If Yes, Which family planning method have you ever used?	Oral pill Emergency pill Condom IUD Implant Injectable Sterilization/permanent Female Sterilization Male Sterilization Rhythm/Calendar Method Withdrawal Emergency Contraception Others (specify) Don't know	
22	When was the last time you used it?	Less than 24 hours Less than1 week Less than 1 month Less than 1 year More than 1 year	
23	What do want to achieve in using your preferred method?	Birth spacing Limiting birth prevent unwanted pregnancy Others (Specify)	

SECTION C: WOMEN OCCUPATION

1. Name of occupation:_____
2. Specific kinds of duties of occupation: _____
3. Education requirements for the occupation? _____
4. Does your occupation specify the number of children you can have? Yes or No
5. If yes how many? _____
6. Does your occupation give you a certain birth space between your children? Yes or No
7. If yes, what is the years difference_____
8. Does your occupation allows you spend quality time with your family? Yes or No

9. Are you the breadwinner of the family? Yes or No
10. Do you work every day of the week? _____
11. If yes, how many hours per day are required in your place of work?
12. Does your place of work give maternity leave? Yes or no
13. If yes, how many months? _____
14. How many years have you been serving in your place of work?

_____

15. How many children have you given birth to since you started working?

_____

16. What time do you close from your place of work on a daily basis? _____
17. Does you occupation have any effect on your personal health? Yes or No
18. Does your occupation give special treatment to women? Yes or No