

# Factors Influencing Acceptability of Family Planning among Women in Rural Communities in Ife Central Local Government Area, Osun State, Nigeria

Akokuwebe, Monica Ewomazino and Ojo, Oluwawole Abraham

Department of Demography and Social Statistics, Joseph Ayo Babalola University, Osun State, Nigeria

Family planning has been proven to save and enhance the lives of women and children. However, sub-Saharan Africans living in rural areas tend to use fewer contraceptives and have more children than their urban counterparts. Moreover, there is gap between awareness and use of modern contraceptive. This study, therefore, investigated the factors that may influence acceptability and consequent use of family planning among rural women in two communities in Ife Central Local Government Area, Osun State, Nigeria. A survey of 400 consenting women was done using a pretested self-administered questionnaire, which included questions on awareness on family planning and factors which are likely to predict its use. Data were analyzed using descriptive statistics, Chi-square test of association and logistic regression. The age of the respondents was  $21.1 \pm 9.0$  years and there were more Christians (94.2%) than Muslims and other religious groups. A large majority (79.0%) were currently married, with most respondents possessing junior secondary certificate. Almost all (96.4%) respondents had heard about family planning. However, only 20.0% were aware of the place where the services are available in their communities. Most of them (61.5%) noted that they were influenced to use family planning through organisations, which did social marketing of the products. Twenty-one percent respondents opined that their spouses would not approve of the use of family planning. Forty-three percent desired to have at least four children. Factors predictive of uptake of family planning were number of children ( $HR=1.74$ , 95% CI 1.15–2.53) and level of education ( $HR=2.12$ , 95% CI 1.43–3.22). A total of 35% of the respondents agreed to accept the method but practice and acceptance of family was very low. Interventions such as reproductive/family planning health education, social marketing, awareness and campaign targeting this population must be intensified in order to derive the maximum benefits of family planning to individuals and the nation, ultimately.

**Keywords:** Acceptability, family planning, rural communities, women of reproductive age

## Introduction

Studies have shown that family planning save and enhance the lives of women, children and families (Conde-Agudelo and Belizan, 2000; Rutstein, 2005; White and Speizer, 2007; Agbo, Chikaike and Okeahialam, 2013). It has been identified by the World Health Organisation (WHO) as one of the six essential health interventions needed to achieve safe motherhood and by the United Nations Children Fund (UNICEF) as one of seven strategies for child survival (Hyeladi, Gyang and Chuwang, 2014). Reports show that contraceptive use in sub-

Saharan Africa is low in spite of evidence of the pivotal role of family planning. Sub-Saharan Africa, which is home to only 10% of the world's women, contributes annually 12 million unwanted or unplanned pregnancies and 40% of all pregnancy-related death worldwide (WHO, 2004; Utoo and Araoye, 2012). In addition to disparities in the uptake of family planning across sub-regions of Africa, wide variation also exists within the countries. In particular, sub-Saharan Africans living in rural areas tend to use fewer contraceptives and have more children

than their urban counterparts (Agbo, Ogbonna and Okeahialam, 2013).

Conversely, the overall contraceptive prevalence among women in Nigeria is 16% and the use of any family planning method increases with age from 6% among women age 15-19 to 21% among women age 35-39, after which it declines to 12% among women age 45-49 (NPC and ICF International, 2014). Overall, 15% of currently married women in Nigeria are using a contraceptive method, indicating only a 2% increase from the 2003 NDHS (Nigeria Demographic Health Survey, 2003). The majority of the contraceptive users rely on a modern method (10% of currently married women) and 5% use traditional methods. Moreover, report indicated that rural areas have a much higher total fertility rate than urban areas (6.2% versus 4.7%) and currently married women in urban areas are considerably likely to use any method of contraception (27%) than women in rural areas (9%) (NPC, 2013; NPC and ICF International, 2014).

Studies have also recorded high level of knowledge and awareness on contraception but with low usage (Moronkola, Ojediran and Amosun, 2006; Barrett and Buckley, 2007; Olugbenga-Bello, Abodunrin and Adeomi, 2011; Odusina, Ugal and Olaposi, 2012; Eko, Osonwa, Osuchukwu and Offiong, 2013). Differences in the knowledge and usage of family planning methods may be due to socio-economic factors, such as those inherent in the individual's environment. These contribute to the socio-cultural determinants of health, which include factors like marital status, culture, religion, education, tribe and occupation (Kelly, Morgan, Bonnefoy, Butt and Bergman, 2007; Adeyemo, Oladipupo and Omisore, 2012). Some of these factors impact synergistically on health and several of these factors are found in living and working conditions (such as the distribution of income, wealth, influence, power and cultural factors including beliefs, customs and norms), rather than individual factors (WHO, 2010). Most women's contraceptive knowledge and practices are influenced by several factors which make it extremely difficult or impossible for these women to take decisions concerning their own health in the absence of their spouses (Beekle and McCabe, 2006; Agbo *et al.*, 2013).

Therefore, this study was designed to investigate factors influencing acceptability of family planning among women in rural communities in the study area.

### ***Methodology***

#### ***Research Design***

This was a descriptive study aimed at investigating the acceptability of family planning in two rural communities named Ajebandele and Fasina, located within Ife Central Local Government Area (LGA), Osun State, Nigeria.

#### ***Study Setting***

Ife Central Local Government Area was the study setting. It is located within the ancient city of Ile-Ife, which is about 95 kilometres from Ibadan, the capital of Oyo State. Ile-Ife is regarded as the ancestral home of the Yoruba as it is believed to be the origin of Oduduwa, the father of the Yoruba. Ile-Ife is known worldwide for its ancient and naturalistic bronze, stone and terracotta sculptures, which reached their peak with artistic expression between 1200 and 1400 A.D. It has a population of 501,952. The Ife people are of the Yoruba ethnic group, one of the largest ethno-linguistic groups in Africa and its diaspora. Ile-Ife is home to a number of educational institutions, such as the Obafemi Awolowo University, and many health care facilities at the primary, secondary and tertiary levels.

#### ***Sample Size and Sampling Procedure***

A four-stage sampling technique, which comprised stratified, proportionate and simple random sampling techniques, was adopted in the selection of the 400 consenting rural women from households in the local government area. In the first stage, five wards were selected out of twelve wards in Ife Central Local Government Areas. In stage two, five streets were then randomly selected in each of the five wards chosen for the study in Ife Central LGA making twenty-five streets. Then, the researchers proceed to select houses along these streets and choose households directly from the streets. In stage three, 600 households were randomly selected within the selected streets for study, while stage four involved the selection of 400



respondents from households within the selected streets for the study.

#### ***Instrument for Data Collection***

A pre-tested self-administered semi-structured questionnaire, which was translated in the protocol of language of the respondents, was self-administered, which contained question items on socio-demographic indices, awareness and attitude towards and the practice of family planning, was used for data collection.

#### ***Data Collection Process***

Each interview started with an introduction and overview of the research, including the objectives of the study. The respondents were told not to write any name on the self-administered questionnaire. They were encouraged to ask questions on what they did not understand in the questionnaire. Explanations were given to respondents as required to aid their understanding of unfamiliar terms. Interviewers assisted respondents who could neither read nor write, by giving them the translated questionnaire in their own protocol language in order for them to complete the questionnaire with ease. Copies of the questionnaire were retrieved back from each respondent immediately after completion and they were reviewed for completeness.

#### ***Data Management, Analysis and Presentation***

Administered copies of the questionnaire were edited and coded with the aid of a data dictionary. Coded data were word-processed into a computer for analysis using the IBM/Statistical Package for Social Sciences (SPSS) version 17.0. Summary statistics, such as mean, median and standard deviations were used to summarise quantitative variables. Association between categorical variables was tested using

the Chi-square test. Level of significance was at 5%.

#### ***Ethical considerations***

This study followed the ethical principles and was guided by the social science research ethics; confidentiality, voluntariness, translation of protocol to local language, beneficence, and non-maleficance. Prior to entering the research sites, permission to carry out the study was obtained from relevant community gatekeepers (heads of the communities). Adequate information on the objectives of the study was given to respondents and they were also informed that participation in the study was voluntary and that they are free to withdraw from the study at any point. Verbal informed consent was also obtained from the respondents before the commencement of the study.

#### ***Results***

##### ***Socio-demographic characteristics of the respondents***

The distribution of respondents' socio-demographic characteristics revealed that about a quarter of proportion of women were between 35 to 39 years and 40 to 44 years respectively; 6.3% were less than 20 years, with a mean age of  $21.1 \pm 9.0$  years.

The majority of the respondents were Christians (94.2%), 5.8% of the respondents were Muslims, and others chose to remain silent about their religion. A large majority of the respondents were currently married with children (79%) followed by the single who are cohabiting with their partners (13.8%), divorced (5%) and widowed (2.2%). Most of the respondents had junior secondary school education (41.2%). This was followed by senior school (29%), primary school (21.8%), diplomas (3%), bachelor degree (2.8%), and Masters degree (0.5%).

**Table 1: Socio-demographic Characteristics of the Respondents**

Socio-demographics characteristics	N <sub>o</sub>	%
<b>Age</b>		
15-19	25	6.3
20-24	40	10.0
25-29	33	8.3
30-34	59	14.8
35-39	93	23.3
40-44	90	22.5
45-49	60	15.0
<b>Religion</b>		
Christianity	308	77.0
Islam	19	4.8
Others*	73	18.3
<b>Marital status</b>		
Single (but cohabiting)	55	13.8
Married with children	316	79.0
Widowed	9	2.2
Divorced	20	5.0
<b>Highest education level</b>		
No formal education	7	1.7
Primary school certificate	87	21.8
Junior school certificate	165	41.2
Senior school certificate	116	29.0
Bachelor's degree	11	2.8
Master's degree	2	0.5
Others**	12	3.0
<b>Employment status</b>		
Unemployed	158	39.5
Self-employed	193	48.3
Employed	49	12.2
<b>Family structure</b>		
Monogamy	308	77.0
Polygamy	17	4.2
Preferred to be silent about it	75	18.8

Source: Fieldwork, 2013

\*"Others" includes those who want to remain silent about their religion

\*\*"Others" includes those with various diplomas, Mean age = 21.1 ± 9.0 years

They were predominantly self-employed (48.3%), 39.5% were unemployed, while 12.2% were employed. There were more respondents from monogamy family (77.0%) than polygamy family (4.2%), while 18.8% preferred to be silent about their family structure [Table 1].

#### **Awareness about Family Planning**

Almost all (96.4%) of the respondents had ever heard about family planning. However, only 20% were aware that family planning services were available in their immediate community.

**Table 2: Respondents' awareness on family planning**

Variables	No	%
<b>Ever heard of family planning</b>		
Yes	370	92.5
No	30	7.5
<b>Know any method of family planning</b>		
Yes	363	90.8
No	37	9.2
<b>If Yes, methods aware of (n=363) *</b>		
Pills	250	37.7
Male condom	349	52.6
Intra-uterine devices (IUD)	18	2.7
Injectables	46	6.9
<b>Family planning services available in the community</b>		
Yes	80	20.0
No	320	80.0
<b>Family planning promotion in the last one year</b>		
Yes	377	94.2
No	23	5.8
<b>If Yes, specific family planning type promoted (n=377) *</b>		
Child spacing	111	27.8
Benefits of birth control	101	25.3
Advantages of the use of family planning methods	97	24.3
Breastfeeding	35	8.8
Use of contraceptive	30	7.5
<b>Awareness of places where family planning services are available in their community</b>		
Places where services are available	26	6.5

Source: Fieldwork, 2013

\* Multiple responses

An overwhelming majority (94.2%) of the respondents were aware of family planning campaign in the last one year. However, the respondents were aware of some features of the specific family planning type that was promoted in the last one year and such family planning promotion programmes were tagged as 'child spacing', 'benefits of birth control', 'advantages of the use of family planning methods', 'breastfeeding' and 'use of contraceptive'. On the other hand, the top on the list of specific family planning methods that were promoted in family planning campaigns that the respondents are aware of, were child spacing (27.8%), benefits of birth control (25.3%) and the advantages of the use of family planning methods (24.3%) [Table 2]. Notedly, child spacing is part of family planning but it is mentioned as the different specific programs that are tagged to promote family planning.

### **Respondents' attitude towards Family Planning**

On the influence that organisations promoting family planning had on the audience, 61.5% of the respondents were of the view that these organisations had great influence on them in the uptake of family planning. On the number of children considered ideal for newly married couples, 43% considered four children to be ideal while 26.2%, 24.0% and 6.8% respondents posited that three, five, three and more than five respectively were ideal numbers of children for newly married couples. More than half had ever discussed the number of children they would like to have with their husbands prior to the study. A majority (60.3%) considered more than five children too many for a family. However, only 1.5% were of the view that three children were many and they were comfortable with a fewer number of children.

**Table 3: Respondents' attitude towards family planning**

Variables	No	%
<b>Organisations promoting family planning influenced my attitude towards family size</b>		
Yes	246	61.5
No	154	38.5
<b>If just married, number of children considered ideal for newly married couples</b>		
Three	96	24.0
Four	172	43.0
Five	27	6.8
>Five	105	26.2
<b>Ever discussed the number of children with husband</b>		
Yes	214	53.5
No	186	46.5
<b>Number of children considered too many for a couple</b>		
Three	6	1.5
Four	37	9.2
Five	116	29.0
>Five	241	60.3
<b>Education</b>		
No formal education		
Primary school certificate		
Junior school certificate		
Senior school certificate		
Bachelor's degree		
Master's degree		
Others**	$\chi^2$	p<.000
<b>Age</b>		
15-19		
20-24		
25-29		
30-34		
35-39		
40-44		
45-49	$\chi^2$	p<.000

Source: Fieldwork, 2013

others\*\* include those with various diplomas

A total of 32.0% suggested that husbands would approve of the use of family planning in controlling the number of children. About 21% indicated that their husbands would not approve of family planning. More than half of them were not sure whether their husbands would or would not approve the use of family planning in controlling the number of children they desired to give birth to.

However, the Chi-square test of socio-demographic variables such as education ( $\chi^2 = 8.689$ ,  $p < 0.000$ ) and age ( $\chi^2 = 8.245$ ,  $p < 0.000$ ) revealed a significant association between them. Education and age were found to be significantly

associated to attitude ( $p < 0.05$ ) using chi-square test of association.

#### **Respondents' acceptability of Family Planning**

Overall, 35% of the respondents indicated the acceptability of family planning methods, while 65% declined the acceptability of family planning methods. Most of the respondents gave reasons for not accepting family planning, such as excessive bleeding (34.2%), husband's disapproval (16.2%), high cost of family planning methods (12.3%) and fear (36.9%). However, spousal approval and acceptance of the use of family planning method played a vital

role in the acceptability of family planning method by the women in the rural community. If their spouses agree that they can go ahead with the use of family planning method, they will tend to accept the practice of family planning method.

Moreover, 32% of the respondents also indicated that their spouses would approve of the use of any method of preventing pregnancy, while 10.8% pointed out that their husbands would not. However, more than half of the respondents (57.2%) were not sure whether their spouses would approve of the use of any pregnancy-prevention method. Of those who

indicated that their husbands would approve of the use of any method of preventing pregnancy, 31.3% indicated that the most preferred family planning method was male condom. This was followed by traditional medicine (26.8%), injectables (16.8%) and withdrawal (15.5%) methods.

When asked about the number of children desired, a majority of the respondents (43.0%) reported that they desired four children, 24.0% indicated their preference for three children, while 22.2% preferred to be silent about the desired number of children.

**Table 4: Respondents' acceptability of family planning**

Variables	No	%
<b>Acceptability of family planning method by respondents</b>		
Yes (Acceptable)	140	35.0
No (Unacceptable)	260	65.0
<b>Reasons for unacceptability of family planning (n = 260)*</b>		
Excessive bleeding	89	34.2
Husband disapproves	43	16.2
Cost too much	32	12.3
Fear	96	36.9
<b>Husband would approve of the use of any method for preventing pregnancy now</b>		
Yes	128	32.0
No	43	10.8
Not sure	229	57.2
<b>If Yes, method preferred (n=128) *</b>		
Pills	11	2.8
Withdrawal	62	15.5
Male condom	125	31.3
Traditional medicine	107	26.8
Rhythm abstinence	25	6.3
Intra-uterine devices (IUD)	3	0.8
Injectables	67	16.8
<b>Number of children desired</b>		
Three	96	24.0
Four	172	43.0
Five	27	6.8
Six	16	4.0
Decided to be silent about this	89	22.2
<b>Reasons for choice of less than three children</b>		
Economic reason	121	30.3
Family decision	62	15.5
No response	217	54.2
<b>Reasons for choice of more than three children</b>		
Agreement with spouse	30	7.5
God's work	19	4.8
No response	351	87.7
<b>Preferred sex</b>		
	<b>Boy</b>	<b>Girl</b>
One	No (%)	No (%)
Two	32 (8.0)	44 (11.0)
Three	71 (17.8)	61 (15.3)
Four	19 (4.7)	8 (2.0)
Decided to be silent about this	2 (0.5)	1 (0.3)
	276 (69.0)	286 (71.5)

Source: Fieldwork, 2013

\* Multiple responses

### Discussion

Nigerian women are known to have high fertility rates and a low utilization of family planning methods but understanding the factors for its non-use among women especially at the grassroots level remains crucial to demographers. The current total fertility rate is estimated to be 5.7 per woman (NPC and ICF International, 2009; 2014). Low use or non-use of family planning methods is one of the key determinants of high fertility in Nigeria (WHO, 2004; WHO, 2005; Bogale, Mekite, Tizta and Eshetu, 2011). The use of family planning method is an important component of maternal, new born and child health services (WHO, 2005). It plays a significant role in fertility reduction by facilitating both the spacing and limiting of pregnancies in women of reproductive age, which is vital to the reduction of the risk of maternal and pre-natal complications from early childbearing, thereby resulting to decrease in infant, child and maternal mortality (WHO, 2004; Bogale, Mekite, Tizta and Eshetu, 2011).

A lot of studies have revealed that there is a high level of awareness and knowledge of family planning methods in Nigeria but ample evidence from literature indicated that low contraceptive prevalence and non-use of contraceptive is associated with high maternal mortality ratio (Okonofua, 2003; Oye-Adeniran, Adewole, Odeyemi, Ekanem and Umoh, 2005). Similarly, findings from this study illustrated that majority of the women (96.4%) have heard about family planning and only few (35.0%) accepted the use of family planning methods that were available on their immediate community as this corroborates the work of Igbodekwe, Oladimeji, Oladimeji *et al.* (2014). This implied that high prevalence of awareness among women of reproductive age is indicative, but the use of it is still low. Family planning services can be made to reach a large number of people if it is well-marketed, and this can break barriers such as cultural obstacles.

Similarly, more than half of the respondents (61.5%) have positive attitude towards family planning from the influence of the promotion of family planning from organisations that comes to promote family planning services in the community. Though, very few (1.5%) women view that couples having three children were many and they reported that they were comfortable with

a fewer number of children. A quarter number of the respondents (21.0%) mentioned that their husbands would not approve of the use of family planning in controlling the number of children they desired to have. This findings support the works of Malhotra, Reeve and Sunita (1995) and Nwachukwu and Obasi (2008). Majority (65.0%) declined the acceptability of the use of family planning methods with reasons such as excessive bleeding (34.2%), husband's disapproval (16.2%), high cost of family planning methods (12.3%) and fear (36.9%). These reasons has been similarly reported by previous studies (Barrett and Buckley, 2007; Nwachukwu and Obasi, 2008; Olugbenga-Bello, Abodurin and Adeomi, 2011; Igbodekwe Olademiji, Olademiji *et al.*, 2014). Notably, spouse approval and acceptance of the use of family planning method is a major hurdle hindering the use of family planning methods by rural women in Nigerian communities. If their spouses approve their acceptance of family planning methods, the women will tend to accept and practice family planning methods. This was also corroborated by Ekani-Bessala and Carre (1998), Malhotra, Vanneman and Sunita (1995) and Makinwa-Adebusuyi (2001) in their studies carried out in India and sub-Saharan Africa. This pattern should be expected in the light of fertility dimensions and non-use of family planning methods as a result of spousal refusal to use family planning methods. This is an ongoing issue on family planning in Nigeria, especially at grassroots level.

However, the low number of people who are aware of the availability of family planning services in the locality is not unexpected considering the fact that the areas where the study took place were rural. Except when there is need to access the health services, many of the community members might not have any course to know where family planning services are being rendered. It is known that the study areas are particularly poor socio-economic areas (Peer and Morojele, 2013). Globally, low socio-economic status (SES) is associated with poor and inconsistent contraceptive use (Idehen, 2001; Jacobs and Makaudze, 2009). Lower SES women, and particularly those in rural areas, have limited access to health services, which may limit their



Of those who desired less than three children, the major reasons reported by the respondents for this choice are economic reason (30.3%), family decision (15.5%) and 54.2% were silent about their reason for choice of less than three children. And for those who desired more than three children, their reasons for this choice were agreement with spouse (7.5%), God's work (4.8%) and 87.7% were silent about their reason for choice of more than three children [Table 4]. The implications of this findings revealed that spouse agreement on choice of more children is very important in desiring for more children. For instance, if a woman desire for more children and the man does not want more children, such decision can tear the family apart especially where patriarchy system of male domination and socio-cultural factors are often practiced in African countries such as Nigeria. This is documented in the works of Amalah (2016) that when both couples disagree over their desire for more children, it always lead to path of unhappy and unhealthy relationships between them (Amalah, 2016). However, one partner becomes resentful and pulls the silent treatment by refusing to budge, and get angry whenever the spouse attempt to bring the subject up again.

Similarly, findings also revealed that unplanned pregnancies (Sedgh, Bankole *et al.*, 2006) are often linked with God's work, and religion supports desire for couples to have more children, owing to the fact that the work of God is testified as couple announces pregnancy or arrival of a new born baby. The religious group

sees the desire for more children as an irresponsible choice as it is in line with God's work or plans (Gibson, 2016). In addition, African men and women are more likely to desire children more than their European counterparts, which illustrate how important reproduction is among African populations (Heard, Sitta France and the VESPA Study Group, 2007). However, the findings from table 4 above showed that 87.7% of the respondents were not willing to disclose the choice of the number of children they desired to have. Though, the disclosure of the number of children desired by couples remain a challenge and centred on socio-cultural factors (Makinwa-Adebusuyi, 2001; Heard, Sitta France and the VESPA Study Group, 2007; Beyeza-Kashesya, 2010), which inhibit couple to disclose their desire for choice of more children by both partners.

Of those who indicated the desired number of children (that is, 3 to 6 children), 17.8% preferred two boys out of them; while 4.7% preferred three boys. But 69.0% of them preferred to be silent on this. Of the same respondents who indicated the desired number of children, 15.3% preferred two girls and 11.0% preferred one girl. However, 71.5% preferred to be silent on the number of girls they desired to have [Table 4].

Conversely, table 5 below depicts the information on the effect of factors predictive of uptake of family planning.

**Table 5: Effect of factors predictive of uptake of family planning**

Variables	OR	95% CI	P
<b>Number of Children</b> Three	1.74	1.15 – 2.53	0.00
<b>Level of Education</b> Junior School Certificate	2.12	1.43-3.22	0.00

**Source:** Fieldwork, 2013. **OR – odds ratio; CI = Confidence interval**

Factors predictive of uptake of family planning were number of children (OR = 1.74; 95% CI = 1.15-2.53) and level of education (OR = 2.12; 95% CI = 1.43-3.22), which showed a significant relationship between the socio-demographic variables [Table 5]. Increasing reproductive health education and acceptability of family planning

among rural women especially those who are disadvantaged, those with no education and the desire for more children among the poor would significantly improve acceptability and use of family planning to delay conception, which can lead to optimal maternal and child health outcomes.



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contraceptive access (Biddleton and Fapohunda, 1998; DHRSA, 2005).

In this study, only about a quarter respondents asserted that their spouse would approve of the use of any form of family planning. This is very important because spouse approval of family planning is the most important predictor of future use of contraception. This is to be expected because respondents and spouses who approve of family planning are more likely to ensure that their favourable attitude is translated into high use of contraception. However, discussion of family planning with spouse was not positively associated with current use of contraception. This finding is not in line with other studies (Oni and McCarthy, 1991; Salway, 1994; Tawiah, 1997; Beekle *et al.*, 2006; Wood and Jewkes, 2006; Agbo *et al.*, 2013). This has implications for health education and social marketing strategies adopted in promoting family planning services. Considering the importance of family planning in population regulation, promotional messages on family should target various segment of the population. More importantly, adequate information of various modern methods of family planning should meet the needs of the community members. The importance of child spacing as well as the policy of government on the number of children a couple should have need to be stressed. Moreover, the number of children respondents had was a predictor of uptake of family planning and level of education. This is similar to the study of Agbo, Ogbonna and Okeahialam (Agbo *et al.*, 2013).

The respondents in this study reported using various contraceptive methods. Condom was the most used method among respondents and this was followed by traditional methods. Residents in these communities are more likely to have hindered access to adequate information on contraception, such as the ability of condoms to give dual protection (prevention of unwanted pregnancies and sexually transmitted infections). Findings from this study showed that 20% of the respondents were aware of the family planning services available in their communities and 6.9% new places within the communities where family planning services were available. This is similarly reported by other studies (Moronkola, Ojediran and Amos, 2006; Chipeta, Chimwaza and Kailani-Phiri, 2010; Olugbenga-Bello, Abodurin and Adeomi, 2011; Igbodekwe, Oladimeji,

Oladimeji *et al.*, 2014). In rural areas, there is poor accessibility to healthcare facilities and healthcare services, hence low patronage of the injectables, which are relatively long acting.

### Conclusion

This study found high level of awareness about family planning methods with accompanied low practice in these rural communities. There was an association between level of education and the number of children and intention to use any form of family planning in the future. Improvement and sustenance of health and economic benefits of family planning or contraception are well documented. The main reasons for non-use of family planning methods were excessive bleeding, husband's approval, high cost of family planning methods and fear, which have significant association with the use of family planning methods. Findings from this study are useful in advocating more comprehensive fertility control interventions in rural areas through improved promotion and accessibility to contraceptive counselling and services. It is therefore necessary for women who have side effects with the use of family planning methods to be targeted and carried along with family planning providers and health workers to address such problems, so as to enable rural women access and use family planning methods with ease. The issue of patriarchy system and socio-cultural factors in the area of spouse refusal for the non-use of family planning methods can be addressed by creating awareness on the benefits of the use of family planning methods by couples.

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