FACTORS INFLUENCING USE OF CONTRACEPTIVES AMONG THE NON-TEACHING STAFF OF COLLEGE OF MEDICINE, UNIVERSITY OF IBADAN

BY

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A DISSERTATION

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Dedication

This research work is dedicated to the Almighty God. for His abundant grace, mercy, love and for granting me life and good health to undertake MPH programme successfully.

It is dedicated to the loving memory of my late husband. Dr. Ekundayo Ayoola AYODELE, my father Chief T. A. Bada and my sweet mother late Mrs. Elizabeth A. Bada. May the Lord grant their souls eternal rest. (Amen).

I also dedicate it to my darling children Ayobami, Ayomide and Ayokunmi for their tolerance, perseverance and support through out the program. May the Lord bless and be with you.

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ABSTRACT

The Nigerian population continues to increase despite the introduction of family planning services as a means of curbing population growth rate in the country. Although several studies have identified barriers to effective use of contraceptives, major emphasis has been placed on the role of women. However, there are few of these studies that focused on public servants working in tertiary institutions. Therefore this study identified factors influencing use of contraceptives among non-teaching staff of the College of Medicine, University of Ibadan.

The study was descriptive and involves the use of both quantitative and qualitative methods of data collection to obtain information on knowledge and pattern of use of contraceptives. A semi-structured self-administered questionnaire was used to obtain data. Eight Focus Groups Discussions (FGDs) were conducted among male and female respondents. The FGD themes provided detailed information on factors influencing choice of contraceptives. Of all the 500 members of staff invited to participate in the study, 80 members participated in 8 focus group discussions while only 371 (88.3%) consented to administer questionnaire and returned. Quantitative data analysis was done using Inferential Statistics while qualitative data were analyzed thematically.

Respondents included senior (56.9%) and junior (43.1%) staff that had worked in the College for between one and thirty-five years. Respondents mean age was 42.4 years (±9.21). Most were males (62.6%) of Yoruba origin (89.8%). More than three-quarter were married (84.1%) and belonged to a monogamous marriage (78.2%). A large majority (91.1%) correctly defined family planning. Of the 98.1% that were aware of family planning only 67.1% had ever used any method. Previous use of contraceptives is significantly higher among those aged 40-49 (76.9%) ($P<0.05$) and senior staff (75.8%) ($P>0.05$). Condom (65.8%) ranked the highest of the well-known contraceptives. Sources of information on contraceptives include electronic media (43.2%), health institutions (23.5%), friends/family (14.6%), print media (11.8%), and religious organization. Slightly, more male (62.2%) than female (60%) reported use of contraceptives.

However, more females (60.4%) than males (46.1%) had visited a clinic for the purpose of receiving the service. The chemist shops (85.4%) was the most patronized outlet for obtaining contraceptives. The couple (93.4%) was identified as responsible for making decision on use of contraceptives. Factors influencing choice of facilities reported by respondents include cost (37.0%), privacy (17.5%), availability of different methods (10.5%), attitude of health workers (4.6%), and accessibility at all times (2.4%). Current contraceptive use is common among males (74.6%), those aged 30-39, (60.2%) and senior staff (70.6%). The preferred methods include condom (28.6%), withdrawal (8.1%), safe period (7.0%) and IUCD (6.7%). In addition, FGD discussants identified cost, side effects and perceived effectiveness as factors influencing choice of contraceptives use. Similarly, reasons stated for not using any contraceptive include not being married; need to have more children, religion and attainment of menopausal age.

There was low contraceptives use among women of childbearing age and junior members of staff. This informs the need to intensify effort to improve coverage of contraceptives through effective health education strategies and government intervention such as subsidies on contraceptives and creation of more users' friendly outlets.

Key Words: Family planning Methods, Contraceptives, Non-teaching staff, Condom, Clinics.

Word count: 484

Certification

I hereby certify that this study was carried out by AYODELE Olukemi Ajoke in the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Nigeria.

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Abbreviations used in the text

AIDS	Acquired Immune Deficiency Syndrome
FGD	Focus Group Discussion
FP	Family Planning
HIV	Human Immunodeficiency Virus
HBM	Health belief model
IPPF	International Planned Parenthood Federation
IEC	Information Education and Communication
IUDs	Intra Uterine Devices
KAP	Knowledge Attitude and Practice
LAM	Lactation Amenorrhea Method
MCH	Maternal and Child Health
NDHS	Nigeria Demographic Health Survey
NDS	Nigeria Demographic Survey
NPC	National Population Commission
OND	Ordinary National Diploma
PPFN	Planned Parenthood Federation of Nigeria
STIs	Sexually Transmitted Infections
TFR	Total Fertility Rate
UCH	University College Hospital
WHO	World Health Organization
ESD	Extending Service Delivery
LAPM	Long Acting and Permanent Methods
IPPF	International Planned Parenthood Federation
FGD	Focus Group Discussion

Operational Definition

Family planning.....use of birth control, contraceptives, for planning the number of children, intervals between birth and to protect oneself against infectious diseases.

Sexually Transmitted Infections.....diseases acquired through sexual intercourse (coitus)

Coitus.....sexual intercourse to the point of orgasm between two human beings; the insertion of the penis into the vagina

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

The relatively high birth rate in Nigeria which has been accompanied by steady declines in death rates has resulted in high rates of population growth (Ebigbola and Ogunjuyigbe, 1998; Oyedokun, 2007). Nigeria's annual rate of population growth of about 2.87 percent has been a major cause of concern for population experts and policy makers for some time. With an estimated doubling period of less than 25 years at the current rate of population growth, the current level of consumption can only be maintained if production of goods and services will also double in less than 25 years (Ebigbola and Ogunjuyigbe, 1998; Oyedokun, 2007).

Unfortunately, this is almost impossible to achieve as all available evidence indicates that the rate of growth of the economy has been lower than the rate of growth of the population. Standards of living tend to worsen when the rate of population growth exceeds the rate of economic growth (Feyisetan and Bamiwuye 1998; Oyedokun, 2007). Within the last four decades, there has been increased pressure towards limiting family size in Nigeria. These are the results of the rapid growth of the large towns, the very great extension of educational facilities, and among the elite, the far greater difficulty of securing top jobs that have come with independence (Ebigbola and Ogunjuyigbe, 1998; Oyedokun, 2007).

In response to the situation highlighted above, the national policy on population for development, unity, progress and self-reliance was formulated in 1988 and revised in 2004. A major goal of the policy is a reduction in fertility through increased adoption of contraception (Federal Government of Nigeria 2004; Oyedokun, 2007). Understanding the factors that influence contraceptive use is critical to the efforts of programmes to

increase prevalence- Much unmet need for family planning persists, even in settings where knowledge of contraceptive methods is high. Studies suggest that many potential users choose not to use more reliable methods due to misperceptions and concern about health-related risks. For example, a study in Maldives found that knowledge of family planning was universal, but only 30% of couples were using contraceptive methods (Oyedokun 2004 and 2007) Several studies, including one from Malaysia, found that non-use of contraceptives was linked to fears about side effects (Population Reports, 1999).

All individuals and couples have a basic human right to decide freely and responsibly the number, spacing, and timing of their children. Fulfilling this right is an important intervention for improving maternal and child health, preventing HIV infections, and improving the overall well-being of entire families. Yet, only a small proportion of women in Africa (20%) who want to space or limit their pregnancies are using some form of contraceptives. Among those that are using contraception, most are using short-acting methods, such as oral contraceptives and injectables (FHI, 2007).

Women and couples who want safe and effective protection against pregnancy would benefit from access to more contraceptive choices, including long-acting and permanent methods (LAPMs). LAPMs are convenient for users and effectively prevent pregnancy. They are also cost effective for programmes over time which can result in substantial cost savings for governments, and contribute directly to reaching national and international health goals. Despite these advantages, LAPMs remain a relatively small, and sometimes missing, component of many national reproductive health and family planning programmes (FHI, 2007).

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 e.g. contraceptive materials and refusal of people to adopt family planning. Approximately 25 percent of women and couples in sub-Saharan Africa who want to space or limit their births are not using any form of contraception (Sonfield, 2006). 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 (USAID, 2006).

Timing and spacing of pregnancies are necessary for improving the outcomes of pregnancy and childbirth for both mothers and their children. Harmful outcomes can be avoided if a woman waits at least two years between the birth of a child before becoming pregnant again (Extending Service Delivery (ESD) Project, 2007). Although women in sub-Saharan Africa claim that they prefer to space their births by more than two years, most births in the region are still spaced closer than that (Ross and Winfrey, 2001). Better availability of family planning services, including long-acting, reversible methods (i.e., intrauterine devices and implants), would fulfill the need for healthier timing and spacing of pregnancies.

Permanent methods of family planning, as well as long-acting methods, would meet the need of individuals and couples who want no more children. A woman in Africa gives birth on average to five or six children in her lifetime (CDC, 2000). As health conditions improve and rates of child mortality decline in Africa, it is expected that more couples will choose to have smaller families (Singh, Darroch and Vlassoff, 2003).

One method of combating the problem of unwanted pregnancy and unsafe induced abortion, which is a major contributor to maternal morbidity and mortality in Nigeria is through effective contraception (Adewole, Oye Adeniran, Iwere, Oladokun, Gbadegesin and Babarinsa, 2002) Also contraception has been promoted as an effective means of family planning. Over the years family planning services have been provided in many communities in Nigeria as part of the Maternal and Child Health (MCH) programme and the drugs greatly subsidized by governments and other donor agencies in the country (Olukoya, 1987). It has also been promoted as part of population control strategies of government especially in the late 80s and 90s.

Yet Nigeria's population has continued to rise significantly and abortion has remained widespread in the country. For example, up to 610,000 abortions are reportedly

performed yearly in Nigeria (Henshaw, Singh, Oye Adeniran, Adewole, Iwere and Cuca, 1998). Mortality from unsafe abortion has also been reported to contribute as high as 40% of all maternal deaths (Okonofua, Odimegwu, and Ajabor, 1999; Oye-Adeniran, Umoh and Nnatu, 2002). This is so despite the restrictive legal nature of the provisions of the Criminal and Penal Codes on Abortion in Nigeria. The prevalence of use of modern contraceptive in Nigeria still stands at 6% among married women (15-49 years). Data from the most recent Demographic Health Survey of 2003 show that 9% of Nigerian women used modern contraceptives compared with the African and World average of 20% and 53% respectively (DHS, 2003).

In the West African sub-region Cape Verde has as at 2003 achieved a 46% prevalence rate of modern methods among married women, aged 15-49 years (Population Reference Bureau 2003). Some previous reports have however, reported high levels of awareness for modern contraception in Nigeria (Adewole *et al* 2002; Olukoya *et al* 1998; Onuzurike and Uzochukwu, 2001).

Nigeria the most populous country in Africa with more than 140 million people also has a high annual rate of population growth (2.8%) and total fertility rate of 5.7 life time births per woman (NDHS 2000; NPC, 2003). Additionally, the country has relatively high level of infant mortality (123 infant deaths per 100,000 live births) and maternal mortality (800 maternal deaths per 100,000 live births) (UNICEF, 2005). In response to these and other serious demographic and health issues, the Nigeria government called for a reduction in the birth rate through voluntary fertility regulation methods compatible with the nation's economic and social goals (NPC, 2003; NDHS, 2003; NPC, 2004).

Contraceptive knowledge in Nigeria is said to be generally low. However, in the last decade, there is sufficient evidence to show that there has been an increase in knowledge among women (NDHS, 1990 and NPC 2003). In most instances, men also are aware of modern contraceptives but have little access to such family planning services either because they are not available or they are not affordable (Lofferdo and Ashford, 1995). In addition, there has been improvement in contraceptive use since the 1990 Nigeria

Demographic and Health Survey (NDHS, 2000) when only 6 percent of women were reportedly using any method. In the 1999 NDHS survey, 15.3 percent were currently using any method, while 9 percent were using any modern method (NPC, 2000).

Traditional methods continue to play a major role in fertility regulation and fertility appears to have dropped significantly in Nigeria in the last decade (NPC, 2000). Total fertility rate (TFR) according to the National Population Commission report for 1990 was 5.2 (4.5 for urban and 5.4 for rural Nigeria). In the 1990 NDHS Survey, TFR was reported as 6.2, suggesting a recent decline of about one child per woman. Understanding the utilization of contraceptives and the preferences of users will help to strengthen existing networks and planning strategies to address areas of deficiency in a bid to encourage their use. This study therefore assessed the factors that influenced use of contraceptives among the Non-teaching staff of College of Medicine, University of Ibadan, Nigeria.

1.2 Statement of the Problem

It has been observed that several studies on family planning have been conducted in Nigeria among different populations including men, women of child bearing age and adolescents (Ozumba and Amacchi, 1992; Odujirin, 1991). Such studies including role of men in family planning, knowledge, attitude and practice of family planning, factors influencing utilization of family planning, identified the barriers to effective use of contraceptives (Odujirin, 1991).

This study was initiated out of my personal experience when I was working at the personnel unit of the College of Medicine, University of Ibadan. It was mandatory that any staff who wants to use the staff clinic should come to the personnel for letter of introduction. It was noticed that most of the non-teaching staff collected two or more letters for different women and having many children. It was also noticed that some of the officers impregnated two or more women at a time. More interestingly, a porter that married a new wife purposely because his first wife was old and he did not need any child from her again also refused to have sexual intercourse with the woman.

From records available at Personnel Division at College of Medicine, it was observed that junior non-teaching staff in the College of Medicine tends to have larger family size compared to the senior non-teaching and academic members of staff. This situation can consequently endanger the health of the mother, father and children (Emuveyan, 1989) as a result of poor nutrition and lack of adequate care for the children.

The contributory factors that have been found to influence the ability of an individual to adopt family planning services include: level of academic qualification, exposure and contact with relevant information and perception of contraceptives use (Olupona, 1993). In spite of the fact that a family planning clinic exists within the University College Hospital and in one of the Departments in College of Medicine, (Department of Obstetrics and Gynaecology), many of the non teaching staff have not availed themselves of this opportunity thus engaging in unprotected sexual activities and multiple sexual partners, most especially among drivers with consequences of sexual transmitted diseases, unplanned pregnancies and illegal abortion.

In view of the above problems and concern, this study is aimed at assessing the level of family planning awareness, its utilization and identification of possible barriers to utilization among the non teaching staff in College of Medicine. It will also suggest ways of overcoming the identified barriers.

1.3 Justification of the study

Marriage and family life are important universally acceptable practices within which procreation and up bring of children take place. Family planning as a way of life helps in paving way for a better quality of life for the family. The government policy is aimed at blending family planning services with the existing health care system at the grass root levels, create public awareness of population issues, change attitude of large family size and encourage greater acceptance of family planning contraceptives.

Despite several studies focusing on women since 1965 (Lolfredo and Ashford, 1995), fertility still remains high in Nigeria because of poor adoption of contraceptives methods

Several studies have also shown men play an important role in decision about family size and the adoption of family planning methods (Mbizuo and Adamchak, 1991; Oni and McCarty 1991; Khalifa, 1988; Adamchak and Adebayo 1987; Ukaigbu, 1977). This study will assess factors influencing use of contraceptives among these public servants of College of Medicine, University of Ibadan and the findings will therefore constitute important baseline information for the design and implementation of educational intervention for the utilization of contraceptives among the respondents.

1.4 Research Questions

The following research questions will be answered by the study.

1. What are the respondent's level of awareness and knowledge of contraceptives?
2. What are the pattern of contraceptives use and accessibility among the respondents?
3. What factors influence choice of contraceptive services?
4. What are the respondent's sources of information about contraceptives?
5. What are the problems and benefits associated with the use of contraceptives?

1.5 Broad Objective

The broad objective of this study was to determine prevalence of contraceptives use among the non-teaching staff of College of Medicine, University of Ibadan with the view of making appropriate intervention.

1.5.1 Specific Objectives

The specific objectives were to:

1. Determine the level of awareness and knowledge of contraceptives among the respondents.
2. Assess pattern of contraceptives use and accessibility among the respondents.
3. Identify motivating and constraining factors which affect choice of contraceptive use among the respondents.
4. Determine sources of information about contraceptives.
5. Identify problems and benefits of contraceptives among the respondents.

1.6 Hypotheses

The following hypotheses were tested during that data analysis

1. There is no association between respondents' level of education and practice of contraceptive.
2. There is no association between respondents' socio-economic status and use of contraceptives.
3. There is no association between sex of respondents and their level of contraceptive use.
4. There is no association between respondents' knowledge of contraceptive and the use of the same.

CHAPTER TWO

LITERATURE REVIEW

2.1 Historical Background

From ancient times, various methods were attempted to prevent unwanted pregnancy and unwanted births. In the Holy Bible, Onan used coitus interruptus (Genesis 38:8-9) which earned him the expression "Onanism". A review of Greek practices included 12 pages listing abortifaccients plus instrument, injections and medicated pessaries or tamposns (Moissides, 1922). At that time, use of abortion and infanticide exceeded the use of contraceptives (Mimes, 1970). Hippocrates, in order to discourage the practice of abortion and infanticide, encouraged couples to practice periodic abstinence (Shapens, 1991) while the Rev. Thomas Malthus advised" approach in his call for greater caution on procreation at about the middle of industrial revolution, 1798 (Riches, 1988).

Modern contraceptives came into limelight around the 1960s with the introduction of the steroidal oral contraceptive pills. From then on, a great deal of improvements and discoveries has taken place and today, quite a number of choices are available. The choice of contraceptive however depend on several variables such as parity, side effects, age, attitude of heath workers, cost; medical history of diabetes mellitus, hypertension etc.

The World Health Organization (WHO) in 1971 defined Family Planning "as a way of thinking and living that is adopted voluntarily, upon the basis of knowledge, attitudes and responsible decisions by individuals and couples, in order to promote the health and welfare of the family group and thus contribute effectively to the social development of a county". Despite this definition, the term "Family Planning" still has different meanings to different people (Fajobi, 1985). It may mean birth spacing; fertility regulation; birth limitation, tailoring; family welfare or contraception.

Family Planning should mean all the above although different countries often emphasize one or a combination of the possible means earlier stated. In Nigeria one of the objectives of the National Population Policy is to make family planning means and services to all couples and individuals easily accessible at affordable cost, at the earliest possible time to enable them regulate their fertility.

Fertility regulation can be achieved through contraception which is defined as all the methods through which unplanned pregnancies may be avoided (Donnay, 1991). Based on the foregoing; several people use the terms 'family planning" and "contraception interchangeable.

In the last century, family planning was quite rudimentary. Population control achieved largely through coitus interruptus (withdrawal). People resorted to the termination of pregnancy (abortion) if coitos interruptus failed (Diller and Hambree, 1977). During this period family planning movements had no modern contraceptive methods to offer, lacked government support and often faced legal and religious opposition (Robey et al, 1994). Now fertility in developing countries is falling nearly twice as fast as in Europe during its fertility transition a century ago. This is largely due to the advent of modern contraceptive methods targeted at women (LoFredo and Ashford, 1995).

In developing countries couples using contraceptives has increased from 10% in the 1960s to 54% in 1997. Similarly, fertility has also declined from 6 children on the average per woman to about 3.4 (WHO, 1997). This has not been particularly true for Nigeria which has a contraceptive prevalence rate of 6% and total fertility rate of 6.2 (WHO, 1997). The success or failure of family planning programmes is traceable to men. Men influence not only whether a woman will use contraceptive but also how well she will use her chosen method (Green, 1990).

Growth of population picked up after Nigeria achieved independence on October 1, 1960. Although concern about the number of illegal, induced abortions led to the establishment

of the first family planning clinic in Lagos in 1958, for the first three decades following independence the federal government kept a low profile on population questions. Prior to the late 1980s, family planning services were mainly provided by the Planned Parenthood Federation of Nigeria (PPFN), which was started in 1964 by the National Council of Women's Societies with assistance from the Pathfinders Fund, the International Planned Parenthood Federation (IPPF), and the Unitarian Universities Service Committee. PPFN's efforts were assisted by teaching hospitals at the universities of Ibadan and Lagos which took the lead in educating the public on the importance of birth control and also provided family planning services.

2.2 Family Planning Practice in Nigeria

Planned Parenthood Federation of Nigeria (PPFN), an affiliate of the International Planned Parenthood Federation (IPPF) (which is a world body, grouping together more hundred countries interested in family planning) came into existence in Nigeria in 1964. From then, family planning or Planned Parenthood Federation of Nigeria (PPFN) was accorded the right and was seen as an essential component of the nation (Family Planned news 1985).

The organization was founded in November 1964 in line with the recommendations of an ad hoc committee set up by the national council of women societies and marriage Guidance Council of the Social Welfare Department in Lagos. The body is charged with the responsibility of finding solutions to the prevailing high incidence of maternal death through induced abortion by various means. In order to resolve this problem, the same year, by a group of volunteers in conjunction with the national council of Social Welfare Department in Lagos. It was then known as the Family Planning Clinic of Nigeria which current has been metamorphosed into the Planned Parenthood Federation of Nigeria.

The PPFN has established its offices in thirty (30) states of the federation including Abuja and now has more than 158 family planning clinics scattered in various parts of the country. The Nigerian government recognized the PPFN activities since 1966, but council in Nigeria in 1975, that the Federal government started giving annual subvention

to the PPFN (Planned News, 1985). The PPFN has been involved in training field workers and various aspect of family planning and major efforts have been directed towards motivating people to accept family planning through community outreach, lectures and seminar/ workshops. Family planning clinic/facilities are now readily available in almost all the state hospitals and primary health clinics in the country.

2.3 Groups of Contraceptives

Short-Acting Methods

Short-acting contraceptives such as pills, injections, and condoms can be highly effective for couples who want to delay or space pregnancies, have reasonable access to sources of supply, and use them consistently and correctly. These methods enable women to become pregnant again when they stop using them. Oral contraceptive pills (also known as the pill) are the most popular temporary method of family planning in most of the world. The pills contain hormones and are taken daily in monthly cycles.

In sub-Saharan Africa, however, hormonal injections that are given every two or three months have overtaken the pill in popularity. Injections have the advantage of ease of use: Women do not need to take something every day and can be more discreet about using a contraceptive. Male latex condoms can protect against both pregnancy and sexually transmitted infections, including HIV/AIDS. Though only about 4 percent of married couples reported using condoms in developing countries, condoms have gained in popularity since the early 1990s with the spread of the HIV/AIDS epidemic. Some couples use both condoms and another method to prevent pregnancy.

Long-Acting Methods

Long-acting, reversible methods include IUDs, which are inserted in the uterus, and hormonal implants, which are inserted in the arm under the skin. These methods have several advantages: Women have little to do once the method is in place; they can use it for three to 12 years, depending on the method; and they can become pregnant again after the device is removed (The INFO Project, 2008) Women can use these methods to space

pregnancies or to stop childbearing, as long as they return to a provider for removal or replacement.

Unlike IUDs, implants are not widely available or used around the world. They account for 1 percent or fewer users in most countries (MEASURE DHS, 2006). Implants have higher manufacturing costs than other methods, making it harder for governments and programs to afford them. Also, providers must be trained to insert and remove them properly.

However, implants offer an alternative hormonal method for women who cannot or do not want to return to clinics or pharmacies often for supplies. New implants coming to the market promise to be both cheaper and easier for providers to use (Deepa and Ushma, 2007).

Permanent Methods

Female sterilization, also known as tubectomy, is a surgical procedure in which a woman's fallopian tubes are blocked or cut to prevent pregnancy. One-fourth to one-third of married women rely on sterilization in Asia and Latin America and the Caribbean, but only a small percentage choose sterilization in northern and sub-Saharan Africa. Sub-Saharan African countries have relatively few trained providers, especially in rural areas where much of the population lives, and women are less likely to hear about sterilization from their peers.

Male sterilization, also known as vasectomy, is one of the least known and used methods, although it is simpler, safer, and less expensive than female sterilization. Less than 1 percent of couples use it in the vast majority of developing countries. China is an exception, with 7 percent of couples reporting using the method. Male sterilization is more common in developed countries, and exceeds female sterilization in some, including the United Kingdom and the Netherlands. Several reasons may account for the low use of vasectomy in most of the world. Governments have not widely promoted it; relatively few providers are trained in the procedure; and many men mistakenly believe

that it will affect their sex drive (FHI, 2003). Counseling is an important component of programs offering permanent methods for women or men.

Women, who were sterilized at a young age, such as in their 20s, are more likely to regret having had the procedure than women who were sterilized at older ages. Reversing the procedure is nearly impossible in low-income countries. Counseling can help ensure that individuals and couples understand that temporary contraceptive methods are also available; that the procedure is voluntary and probably cannot be reversed; and that they can decide against having the procedure at any point before it takes place (Info Project, 2008).

2.4 Review of types of Contraceptive Choices Available

A contraceptive is a device, drug or method used to prevent conception (Churchill's Medicnl Dictionary, 1989). The introduction of birth control pills and improved intra uterine Devices (IUDs) produced a virtual revolution in contraceptive technology. For the first time in the history of human reproduction, contraceptive methods which were comparatively easy and convenient to use as well as reversible, highly effective and relatively safe became available giving women almost total control over the timing of pregnancy (Population Reports, 1982)

Advances in medical technology over the last 35 years have made it possible for all women and men to plan their childbearing Family planning methods include oral contraceptives (the "pill"), hormonal injectibles; subdermal implants; intrauterine devices (IUDs); male and female sterilization; and barrier methods such as male and female condoms, diaphragms, and spermicides. Other methods include the Lactational Amenorrhea Method (LAM), fertility awareness methods such as methods that involve keeping track of when the fertile time of the menstrual cycle starts and ends (the Standard Days Method); and symptoms-based methods, which depend on observing signs of fertility (cervical secretions, basal body temperature)(INFO Project 2007)

Emergency contraception can keep a woman from getting pregnant after she has had unprotected sex. Emergency contraceptive pills contain the same hormones used in oral

contraceptives: they can be obtained by using higher doses of regular packets of pills or by buying pills designed for that purpose (INFO Project, 2007). They are not intended to be used as a regular family planning method, but can help a woman avoid a pregnancy if used up to five days after having unprotected sex.

While there is no "ideal method" of family planning, there is a safe and effective method for every woman. Family planning methods vary according to their convenience, cost, effectiveness, side effects, risks, and benefits for the individual. Family planning users are best able to evaluate the relative importance of these factors based on their preferences; their desired family size; stage of life, goals of delaying, spacing, or limiting future pregnancies; health status; relationship status, and living conditions (Family Planning Saves Lives 2009).

A brief review of some of the methods is as presented below, especially the modern methods that may be considered for young people, married women and men. Everyone who makes informed choice about a contraceptive method is weighing the potential health benefits and risks against the consequences of an unwanted pregnancy.

For each method, the risk- benefit calculation varies from individual to individual and from place to place. For example in Western Countries, advances in obstetrical care have overcome most health risk associated with child bearing and safe legal abortion has almost eliminated abortion related mortality (Population Report, 1985). Thus for individual women in western countries, the health risks of the pill or IUD although in most cases minor, may weigh more heavily in the choice of a contraceptive method.

In Africa, Asia and Latin America, the complications constitute a leading cause of death among women of reproductive age (Population Report, 1985). In these setting the health benefits of contraception regardless of the method, almost always out weigh the risks.

Barrier Methods

These methods act by preventing penetration of sperm into the uterus thereby preventing fertilization of the ovum (female egg). Latex condoms are available for use by men at every act of coitus. If properly used, they are effective for protection against unwanted pregnancy and sexually transmitted infections (Bullough and Bullough, 1991). Other contraceptives in this group for females include vaginal diaphragm, cervical cap and the female condom. Their major draw back is the inconvenience in wearing it before each coitus.

Spermicides are powerful chemical substances which kill the sperm and ideally should be used with condoms and other barrier methods. It provides extra protection if a condom bursts or slip during intercourse. Although not as effective as the condom when used alone, it provides some protection against unwanted pregnancy and it is under the women control.

Hormonal Methods

Hormonal methods consist of the synthetic female hormones, oestrogen and progesterone. They act mainly by suppressing ovulation thereby preventing fertilization. The combined oral contraceptives (the pill) contain two hormones similar to the natural hormones in a women's body e.g. a synthetic oesthrogen and a synthetic progesterone (Robert, 2003).

The pills are required to be taken daily in order to make the most effective use of it. WHO does not recommend restriction on the pill on the basis of age (WHO, 1995). Like the condoms, the pill and other hormonal methods do not have effect on future fertility (Liskin and Rutledge, 1984). Most people may have problem with remembering to take the pill on daily basis and this will cause serious drawback.

Emergency contraception also called postcoital or morning after is now possible using the combined oral contraceptives (Robert, Hatcher, 2003 and Yuzpe, 1985). However, postcoital oral contraception is not a substitute for other contraceptive methods but it can

be very useful for preventing pregnancy when a woman has been coerced or raped, had an emergency sex when no other contraceptive was available or had a condom burst.

Injectable hormonal contraceptives contain only synthetic progesterone injections similar to natural hormone that a woman's body makes and are required only every three months for Depo-provera and every two months for Noristerat. They are convenient and provide privacy but require trained personnel to give the injection (Population Reports. 1995). Robert Hatcher (2003) reported that it is very effective with 0.3 pregnancies per 100 women in a year of use (1 in every 333) when injection are regularly spaced, three months apart.

Norplant implants consist of small hormone releasing capsules usually six in number which when inserted under skin can prevent pregnancy for a period of five years (Population Report. 1992 and Robert Hatcher. 2003) the major set back with norplant is that it requires highly trained staff for its insertion and removal. All hormonal contraceptives causes changes in menstrual cycle and do not offer any protection against sexually transmitted infections

Intra Uterine Device

These are devices inserted into the uterine cavity and they prevent pregnancy by impeding sperm transport to the site of fertilization thus preventing fertilization. They also cause inflammatory reactions in the uterus thereby preventing implantation of the fertilized ovum (Population Report, 1995).

The earliest forms were Lippes Loop and Marguilles Spiral which appeared in the 1960s. The most widely used IUD today is the copper containing IUDs especially T Cu-380A. IUD is long- acting contraceptives but they are not recommended for women who are at higher risks of STIs. More so, IUDs may cause increased menstrual bleeding and spotting and menstrual cramps leading to higher expulsion rates in women (Robert, 2003).

Table 2.1
Types of Contraceptives and their effectiveness

DMPA INJECTABLE CONTRACEPTIVE	• Very effective and save • One injection every 3 month • Bleeding changes are normal- spotting, light bleeding between periods, and, after one year, often no periods. Some weight gain or mild headaches can occur. • Private. Others cannot tell that a woman is using it. • Can be used by women of any age, whether or not they have children • Women who stop using DMPA take an average of four months longer than usual to get pregnant. • Safe during breastfeeding, beginning at six weeks after childbirth • Helps prevent uterine tumors and pregnancy outside the womb.
NORPLANT IMPLANTS	• 6 small capsules placed under the skin of the upper arm. • Very effective for up to 5 years (and perhaps longer) • Can be used by women of any age, whether or not they have children. • A woman can have the capsules taken out at any time. • A woman can get pregnant once the capsules are taken out. • Changes in the vaginal bleeding are normal—light bleeding between periods, spotting, or no periods. Mild headaches can occur. • Safe during breastfeeding, beginning at 6 weeks after childbirth. • Help prevent anemia and pregnancy outside the womb.
COMBINED ORAL CONTRACEPTIVES	• Effective and reversible. • Take every day for the best protection. • Especially in the first few months, some users have side effects such as stomach upset, bleeding between periods or spotting, weight gain, mild headache, or moodiness. Not dangerous. • Safe for almost all women. Serious side effects are rare. • Can be used by women of any age, whether or not they have children. • Help prevent certain cancers, anemia (low iron), menstrual cramps and irregular bleeding, and other medical conditions. • Can be used as emergency method after unprotected sex.

Source: The essential Contraceptives Technology: A hand book for Clinic Staff, Health Care Providers. Robert A. Hatcher, (2003)

Table 2.1 Contd.
Types of Contraceptives and their effectiveness

PROGESTIN-ONLY ORAL CONTRACEPTIVES	• Good choice for nursing mothers who want pills, beginning at 6 weeks after childbirth. • Very effective during breastfeeding. • If used when not breastfeeding, bleeding changes are normal—especially spotting and bleeding between periods. • Can be used as emergency method after unprotected sex.
CONDOMS	• Can prevent sexually transmitted diseases (STIs) including AIDS *and* prevent pregnancy. • When condoms are needed to prevent STIs/ AIDS, many couples use them along with other family planning methods. • Easy to use with a little practice. • Effective if used correctly every time. However, usually only somewhat effective because some men do not use condoms all the time. • Some men object that condoms interrupt sex, reduce sensation, or embarrass them.
IUD (Intrauterine Device)	• Small device that a specially trained family planning provider places inside the womb. • Very effective, reversible, long-term method. • Teu-380A IUD lasts at least 10 years. • Menstrual periods may be heavier and longer, especially at first. Brief discomfort after IUD is put in. • No effect on breastfeeding. A specially trained provider can be put in an IUD after childbirth. • Pelvic infection more likely if the user gets a sexually transmitted infection (STI). Serious complications are rare. • Can come out, especially in the first month, so checking for the strings is important.
VAGINAL METHOD	• Spermicide, diaphragm, and cap — methods a woman controls and can use when needed. • Must be placed in the vagina each time before sex. Can do ahead of time instead of interrupting sex. • Can be effective when correctly used every time. However, often not very effective because many women do not use them correctly every time. • May help prevent some sexually transmitted infections (STIs) somewhat. • Bladder infection is more likely.

Source: The essential Contraceptives Technology: A hand book for Clinic Staff: Health Care Providers. Robert A. Hatcher, (2003)

Table 2.1 Contd.
Types of Contraceptives and their effectiveness

FEMALE STERILIZATION	• Permanent method for women who are sure that they will not want more children. Think carefully before deciding. • Safe, simple surgery. Usually done without putting the woman to sleep. Local anesthetic blocks pain. • Very effective. • No known long-term side effects. Brief discomfort after procedure. Serious complications of the procedure are rare. • No effect on sexual ability
VASECTOMY	• Permanent method for men who are sure that they will want no more children. Think carefully before deciding. • Safe, simple, convenient surgery. Done in a few minutes in a clinic or office. Local anesthetic blocks pain. • Very effective after at least 20 ejaculations or 3 months. Need another method until then. • No known long-term side effects. Brief discomfort after procedure. • No effect on sexual ability or feelings.
FERTILITY AWARENESS-BASED METHODS	• A woman learns to tell the fertile time of her monthly cycle. • Knowing this, a couple avoids vaginal sex, or they use condoms, a vaginal method, or withdrawal during the fertile time. • Can be effective if used correctly. Usually only somewhat effective, however. • Usually need close cooperation between sex partners. Avoiding sex for a long time can be difficult. • No physical side effects. • Certain methods may be hard to use during fever or vaginal infection, after childbirth, or while breastfeeding.

LAM (Lactational Amenorrhea Method)	• A family planning method based on breastfeeding.
	• A breastfeeding woman uses LAM when:
	  ✣ Her baby gets little or no food or drink except breast milk, and she breastfeeds often, both day and night, AND
	  ✣ Her menstrual periods have not returned, AND
	  ✣ Her baby is less than 6 months old.
	• Effective for up to 6 months after childbirth.
	• The woman should be planning for another method when she no longer uses LAM.

Source: The essential Contraceptives Technology: A hand book for Clinic Staff, Health Care Providers Robert A. Hatcher.(2003).

Traditional Methods of Family Planning

Several family planning methods pre-date the emergence of modern birth control. Before the advent of condoms and hormone-altering drugs, men and women utilized primitive methods for preventing conception. Although some of these techniques are surprisingly effective, they require diligence and careful planning.

Many couples around the world use rituals, herbal approaches and similar practices to regulate fertility for cultural, economic or personal reasons. While many of these beliefs and practices are completely ineffective as contraceptive methods, and some are even harmful, certain aspects of these indigenous beliefs can be used to promote better family planning (FHI, 1995).

Practices that are not harmful – such as rituals or storytelling – may offer innovative ways to teach how the body works and about modern contraception, or to encourage correct and consistent use. Providers who familiarize themselves with cultural beliefs about fertility may communicate more effectively with women and men about their contraceptive options. Programs may reach new groups of clients if their services are considered part of the larger context of a community's historical understanding about fertility (FHI, 1995).

An existing Nigerian ritual, placing an object made of red feathers, called a "*reso*" on the floor, is believed to make it impossible for any man to have sexual intercourse with an adolescent girl until the spell is removed. Even simply discussing the *reso* can help women understand that family planning is not new, and that attempts to reduce childbearing have been practiced for millennia in almost every culture (Delano, 1990).

Many of these beliefs have no harmful effects on a woman's health, and may help ensure her of being in control of her own fertility. These include ineffective notions that pregnancy can be prevented when women avoid the sun or moon at certain times or wear charms, including dead spiders, children's teeth, or leopard skin bracelets (since leopards are believed to scare away unwanted pregnancy). Drinking tea made from various

harmless roots and weeds and jumping up and down or sneezing after intercourse to dislodge the sperm are other examples (FHI, 1995).

Counterproductive beliefs

Some customs and practices, however, may be dangerous or counterproductive and should be discouraged. The Nigerian belief that sex during menstruation will turn people into albinos is not harmful, but may increase the risk of pregnancy. Since menses is a time when women are typically infertile, prohibiting sex during menstruation may encourage sex at times when women are more likely to be fertile (Delano, 1990).

The harmful practice of douching with hot water, salt, vinegar, lemon or potassium after sex is common in African cultures, and should be discouraged. This ineffective technique can introduce infection into a woman's uterus and cause permanent damage, including infertility. Other potentially harmful pregnancy prevention traditions include: eating arsenic and castor oil seeds; drinking water used to wash dead bodies; and soaking cotton wool in pepper and inserting it into the vagina as a barrier method (Delano, 1990).

The 28-bead necklace

In nearly every culture, jewelry has played an important role in sexual relations, including beliefs about fertility. For centuries, amulets and charms have been used to promote romance, as well as to avoid pregnancy. The Institute for Reproductive Health (IRH) at Georgetown University in Washington, the Population Council in New York and the Center for Research of Maternal and Child Disease (CEMICAMP), a non-profit family planning organization in Brazil, plan to study the use of a 28-bead necklace to help women follow their menstrual cycle and to be aware of when the risk of conception is greatest.

The first bead of the necklace is red to indicate the first day of menses, and the next seven beads are brown, indicating a time of infertility. These are followed by 11 white beads designating the fertile window, with fluorescent beads indicating a woman's peak days of ovulation. A black rubber band marker is moved from bead to bead to follow the cycle.

The fluorescent beads for peak days of ovulation glow in the dark, a vivid reminder when the necklace is near a woman's bedside at night (IRH, 1995).

2.5 Benefits of Using Family Planning Methods

According to Planned Parenthood Federation of Nigeria (PPFN), there are four basic reasons for promoting family planning. Family planning is perceived by most people as fundamental human right which should be exercised by all voluntarily. By this rationale, the right of couples and individuals, especially women to freely and voluntarily decide on and regulate their reproductive behaviour is being directly promoted through family planning. Therefore, family planning information and practices become accessary to enable individuals and couples to choose the right way of reproductive conduct (Planfed Newsletter 1991; Singh *et al* 2003).

In addition, family planning practices promote the health of the mother, child, the father and therefore the community and nation (PPFN News 1991; Singh *et al*, 2003).) absence of family planning will imply high maternal and child mortality and morbidity from malnutrition and communicable diseases e.g measles and reduce life expectancy of the father. According to Planfed Newsletter (1991) family planning practice help to ensure that childbirth do not occur among women too early, too close, too many, too late and too costly to their lives, all of which carry tremendous amount of health risk to the mother and child.

Family planning also help by ensuring adequate regulation of births, and saving women from excessive child bearing, family planning practices gives women time to pursue their education, carriers, and other legitimate aspimtions (Singh *et al*, 2003). It also gives women more time to be involved in the socio-economic activities of their communities and the nation. According to the Planned Parenthood Federation of Nigeria Newsletter (1991) effective family planning practices enables women to share their time meaningfully between their primary roles pursuit of socio-economic reproductive life

Rapid population growth has been identified as one of the factors slowing down family and nation development and reducing the living standard of the people. Therefore, for sustainable national development to take place, the rate of economic growth (which is the rate of generating new resources) must remain consistently higher than the rate of growth of the population so that there is surplus resources to invest in infrastructure, social and economic development and vice versa (Planfed Newsletter, 1991). And therefore family planning will promote demographic and socio-economic harmony and national development.

Using family planning to meet the need for spacing and limiting births has the potential to prevent thousands of cases of maternal mortality over the next decade. The risk that a woman will die as a result of pregnancy, childbirth, or unsafe abortion is approximately one in 16 in sub-Saharan Africa. The country-specific risk of maternal death is as high as one in seven women in Angola, Malawi, and Niger (AbouZahr and Wardlaw, 2004).

Spacing and limiting births also has the potential to prevent hundreds of thousands of child deaths. In each of 16 sub-Saharan countries studied, between 72,000 and 1.1 million child deaths are expected to be averted over the next decade if all women who want to space or limit their births succeed (USAID). The use of family planning is already preventing the birth of an estimated 173,000 HIV-infected infants each year in sub-Saharan Africa (Reynolds, Steiner and Cates, 2005).

Providing women and couples access to a range of contraceptive choices protects their human rights and benefits public health. Strengthening FAPM services in Africa will also meet individual needs while contributing to more sustainable national programs for reproductive health and family planning

2.6 Factors Influencing Contraceptive Use

Understanding the factors that influence contraceptive use is critical to the efforts of programmes to increase prevalence. Much unmet need for family planning persists, even in settings where knowledge of contraceptive methods is high. Studies suggest that many potential users choose not to use more reliable methods due to misperceptions and concern about health-related risks. For example, a study in Maldives found that knowledge of family planning was universal, but only 30% of couples were using a contraceptive method. Several studies, including one from Malaysia, found that non-use of contraceptives was linked to fears about side effects (Population Reports 1999; Oyedokun 2004).

Choice of Contraceptive

The use of contraception varies widely around the world, both in terms of total use and the types of methods used. In many countries, women and couples rely largely on one or two contraceptive methods, because of government policies, the way that national family planning programs have evolved, and cultural or social preferences.

Understanding why people prefer some contraceptive methods over others can be useful for strengthening family planning programs. Having a broad range of methods available is a key element of the quality of family planning services and raises the overall level of contraceptive use (John et al, 2001; Tara et al, 2006). Family planning programs ideally should offer choices of methods for all stages of people's reproductive lives, so that they can have the number of children they want and at, when they want them.

The ability to decide freely and responsibly the number and spacing of one's children is recognized internationally as a human right (UN, 2008). There is no "best" method of family planning, because women and couples may prefer different methods and may change their preferences over time according to their individual circumstances. Having choices and balanced information increases the likelihood that women and couples will choose a method, use it effectively, and avoid unintended pregnancies (Sit, Panama, David, Maurice, 1991).

Making a wide range of methods available improves quality of care in a way that benefits family planning programs. First, offering more choices increases the number of contraceptive users, which can increase the cost-effectiveness of services (Ross et al, 2006). Second, some inexpensive methods are underused simply because people aren't familiar with them. Increasing the use of these methods can lower average service costs. There is a suitable contraceptive method for virtually everyone who wants one, but often people are unaware of their choices or don't have access to them. Broadening the range of available contraceptives requires greater program investments, including in education and counseling, to ensure that women and couples can benefit from new or additional methods and can make informed choices.

Based on past successes in family planning, programs can make new and underused methods widely available by focusing on (FHI, 2001). Women who have more contraceptive choices are more likely to start using a method of family planning, be satisfied with their choice, and continue using their method until they no longer wish to prevent pregnancy (Pariani, Heer, Van Arsdol Jr., 1999).

Female Education

Female education has been seen as a key determinant of contraceptive use (NPC and ORC Macro 2004). Better-educated women are argued to be more willing to engage in innovative behavior than are less educated women, and in many Third World contexts, the use of contraception remains innovative (Caldwell 1979; Dyson and Moore 1983, Oyedokun (2007). Better educated women are also argued to have more knowledge of contraceptive methods or of how to acquire them than are less educated women because of their literacy, greater familiarity with modern institutions, and greater likelihood of rejecting a fatalistic attitude towards life.

There is good evidence that for whatever reason, women's education does indeed promote the use of contraception in most developing countries outside of tropical Africa (Cochrane 1979). Koc (2000) founds a positive association between the educational level

of both spouses and the use of contraceptive methods in Turkey. After all individual, cultural, fertility and contextual variables were controlled, a woman's education was found to be a stronger predictor of method use and method choice than that of her husband. The study also shows that, to a great extent, contraceptive use and choice of modern method depend on the sex of a couple's living children, implying some preference for sons, although generally women prefer to have children of both sexes.

Source of Information

Access to source of information has been found to be positively related to contraceptive use and women who have adequate knowledge of family planning source are substantially more likely to be using family planning than women who do not know that facility (Ebigbola and Ogunjuyigbe 1998; Oyedokun (2007). Promoting family planning on radio or television can be an important means of raising awareness, improving knowledge nnd stimulating use of modern contraceptive methods (Feyisetan and Ainsworth 1984; Olaleye and Bankole 1994; Parr 2002, Oyedokun (2007). Current contraceptive prevalence rate in Nigeria stands at 8%, while results from the Integrated Baseline Health Survey (IBHS) indicate that contraceptive prevalence rate is still low in Nigeria and it varies by demographic and socio-economic characteristics (NPC and ORC Macro 2004, Oyedokun (2007).

Age

Several factors influence people's level of awareness and knowledge of contraceptive One of such factors is age. It is widely recognized that there exists a "U" shaped relationship between age and utilization of medical services (Fielder, 1981) quoting (A day and Eichorus 1972). This means that there is frequent use of health facilities by the very young and the very old which correspond to the age when people are frequently falling sick (Rutenbary et al 1991) reported that a woman's need for contraception changes as she passes from her initial child bearing years

However, she may welcome a pregnancy into her 30's when she is still fertile but wished to prevent or space additional pregnancies and then into her 40's when her fecundity

deadlines and she has less need of the protection from pregnancy offered by the contraceptive. Also in their qualitative study of Mexican men, Folch-Joyn et al (1981), found generally that old men were significantly less aware of methods of contraceptive than younger men. In Zimbabwe, for instance, more men above the 40 year age group had ever used a contraceptive method compared to those below the age of 40 years.

Religion

The religious views on contraceptives differ; while some people uphold the use of contraceptive methods, some object to the types of method used. In the 16th century, the reformation movement that emerged resulted in the promotion of three religious tendencies. These were the Lutheran, Calvinist and Anglican (Watch Tower Bible and Tract Society 1990).

The Anglican Episcopal movement gave birth to the Methodist, Salvation Army, Baptist, Pentecostal and Congregational Churches while Calvinism produced Presbyterian and Reformed Churches. The early Christians had pronatalist inclinations probably because the Holy Bible stressed fruitfulness (Gen. 1:28; 8: 17 and 9:1). Christianity convinced this heritage of high fertility until 1930, when a major protestant body, the Anglican Church gave qualified approval to birth control (The population Council 1968).

In fact, the protestant churches generally left the question of contraception to the conscience of the couple concerned because there was no where in the Holy Bible that birth control or family planning was discussed (Awake 1989). The Roman Catholic Church holds a contrary view on family planning. The position of the church was first upheld by Pope Pius XI in his 1930 encyclical, casticonnubii (The population Council, 1968) which stated in part: "Any use whatsoever of matrimony to exercised in such a way that the act is deliberately frustrated in its natural power to generate life is an offence against the law of God and nature and those who indulge in such are branded with the guilt of a grave sin"

This position was upheld and propagated by the succeeding Pope Pius XII. He however went further to add that under certain circumstances, the rhythm method of fertility regulation may be used (The population Council, 1968) because it does not impede the natuml processes of the human reproductive system (Hogan 1985). This method is combination of looking at the calendar and checking body fluid to see if you can get pregnant. 80% of Catholics used artificial means of birth control at some time to keep from having more children.

Other Christian denominations as well as Islam and traditional religion support large family sizes. for example the Christian's support for large number of children per couple is probably based on the old testament that exhorts as follows. "Go ye. into the world, multiply and replenish the earth" (The Holy Bible 1971) The Muslims on the other hand believed in the recorded statement of the Holy Prophet Mohammed which say give birth to the number of children you can afford so as to increase the number of my followers. (Trevor. 1975 and Udjo 1957). Traditionally, all the various ethnic groups in Nigeria believe in many deities who, if reverently worshipped, bless adherents with children (Makinwa Adebusoye 1992).

Furthermore, it has been observed that one of the most important function of the modern day adaptations of Christianity such as cherubim and seraphim, celestial church of Christ and all these substimed under the generic name of "Aladura" churches is to ensure that all their female adherents become mothers (Adebusoye. 1992).

Economic

Espenshade (1977) observed that economic considerations undoubtedly influenced a couple's attitude to family planning. In a fertility survey conducted in Thailand in 1975, 35% of husband saw no disadvantage in small family while less than 5% saw no advantage. Gallen et al (1986) and Schular and Goldstein (1956) in Nepal found that the main reason for limiting family size was economic. All but four of the 40 high caste couple and two of the 27 low caste couple stated explicitly that children presented an economic burden.

Similarly, Olusanya (1969) noted that among the Yorubas in Nigeria, couples were beginning to look upon children as financial liabilities rather than assets. Therefore, the traditional attitude that favoured excessive fertility was changing even though the means of effective control was not acceptable to the vast majority.

Shain and Jennings (1980), have observed that in most societies, the financial responsibilities of raising children fall more heavily on the man. Following the rapid socio-econonuc development occurring in most societies of the world, the financial burden of child rearing is on the increase (Gallen et al (1986) and Espenshade (1987) who observed that it was very more expensive raising children.

Education

Education is another factor wluch will be considered. Education plays a major role in shaping attitude towards contraception (Egbuna, 1989). Oni and McCarthy (1991) observed in Ilorin that one-third of the respondents in the poorest areas and with no education reported a willingness to use contraceptive in the future compared with about two-third in the most affluent areas and with the highest level of education. These findings therefore agreed with conclusion of Kalifa (1988) that there was a strong correlation between approval of family planning and education.

Studies showed that level of education is significant to the utilization of contraceptives. When man is well educated, the couple is more likely to use contraception, regardless of the wife's level of education. In Zimbabwe for instance more educated people reported significantly greater ever used of family planning (Mbizvo and Adamchak, 1991). It has been noted however that education makes the least difference to contraceptive use where family planning programme are strongly or where level of socio-economic development are high.

Oni and McCarthy (1991) in Nigeria found that although majority (90%) of the respondents without formal education claimed to be aware of at least one method of

contraception, they mentioned by far fewer specific methods of contraception compared to those with post-secondary education. Similarly, respondents who belonged to the low-income groups tended to be less aware of contraceptives methods than those in the high-income groups (Folch-lyon et al 1981).

Education plays key role in promoting equality among men and their wives in terms of initiation of discussions about family planning (Oni and McCarthy, 1991, Baah-Boakye, 1988). In Ilorin, Nigeria, Oni and McCarthy (1991) found that a majority of men with post-secondary education, discussed family planning issues with their spouse compared with those with lower level of education.

Parity

Parity is another factor that influences the use of contraceptives. It has been observed that family planning services and supplies are widely available. London et al (1985) observed that in developed countries, rates of contraceptive use increased sharply as parity rose from zero to three children but remain fairly steady thereafter. This was the result of the demographic transition that occurred in the developed countries with fertility rate of 2 to 3 births per woman.

Sex Preference

In most culture including Nigeria, there is ideology of male supremacy because male children are traditionally regarded as "Pillars" of the house so serve the dual role of saving the house from physical disintegration and immortalizing the family name following the demise of the parents. Many parents favour boys for both economic and cultural reasons. Sons are source of security for their parents in old age particularly where women have little economic independence or cannot inherit property, son are insurance for a mother against the loss of her husband's support due to death or desertion (Cain, 1980 and Ram, 1992).

Where most couples have large families' son preference has little impact on fertility level because couple will have at least one son by biological chance. As contraceptive uses

become more widespread an average family size decreases, however, in some countries the desire to have at least one son begins to affect fertility decisions. Trying to have a son, many couples have more children than they would desired (ALY, 1991; Bairagi, et al 1989; Bairagi and Langsten 1986; Campbel, 1991; Karki, 1988, Nag, 1991 and Klen 1992)

Communication between Spouses

Married couples together sometimes make decisions of various kinds, but men have been identified on having the contraceptive decision- making power even when their wives desires no more children (Joesoef et al: 1988), WHO 1982). In many places such communication is the acceptation rather than the rule. In Kenya, for example lack of communication between spouses proved to be a more common obstacle to contraceptive use than male opposition (Omondi Odhiambo, 1992). Couples who talk about the number of children they want and about family planning are more likely to use contraception and to achieve their family planning goals than those who do not (Salway, 1994).

Furthermore, female autonomy and seclusion, equality between spouses linked with spousal communication, have been argued to influence contraceptive use (Dyson and Moore (1983); Beckman (1983); Hollerbach (1983); Nerzary (2001), Oyedokun (2007). Shresiha (2000) found in a study in Nepal that spousal communication on family planning, spousal communication on family size preference, child loss, place of residence and women's involvement in income-earning activities are the significant predictors of contraceptives use in the study area.

Lack of discussion between couples has resulted in husband opposition to their wives adoption of contraception. Oni and Unuigbe (1986) in their study in Benin-city of Nigeria noted that 3.6 % of women using contraception before the next pregnancy reported that they could not continue to use it because of opposition from their husbands Also 6.8% of the women stated they would decide to use contraception until they had consulted with their husband.

Similarly, a survey of a male Nigeria students by Adamchak and Adebayo (1987). showed that males disapproval of contraceptive adoption by women without prior consent of their husbands. Also findings on male dominance in decision making were reported (Lomza. 1995; Oni and McCarthy, 1991; Green, 1990; McGinn et al 1989; 1987; Khalifa, 1988; Cook and Maine). Lack of discussion about family planning results in poor or non- adoption of contraception by couples.

In another study by Chacko in 2001, among married women, in four villages in rural West Bengal, India, it was found that factors that most influence a woman's use of contraception include her age, the number of living sons she has, and her religious affiliation. The study also showed that the availability and quality of permanent village-based government health care affected the use of modern contraception. In a study in Guatemala, it was reported that after controlling for socio-demographic factors, access to services emerged as a significant correlate of contraceptive use among Mayans (Bertrand et al. 2000, Oyedokun, 2007)

Size of Family

Olusanya (1989) and Caldwell (1987) emphasized the important of lineage and family name in perpetuating desire number of children and need to preserve the continuity of the patrilineal names. Lineage is so important to the Africans, most want large families compared to other places in the developing world where many women are content with four children. African men wanted large families due to their belief that many wives and children are a source of wealth (Caldwell 1992). They follow a social system of lineage or clan land where there is no ownership of land or tools. It is larger family with the most workers that prospers in an agricultural community.

As a result, African families are two times larger than families in the poorest Asian or Latin American countries (Caldwell 1991). Only one-ninth of the couples in Nigeria couples use birth control to prevent premarital or extramarital conception (Caldwell, 1990). In a study conduct by Orbeta (2005) highlights the enduring positive relationship

between family size and the poverty incidence. The study also indicated that the desired family size is higher among the poor.

Knowledge and attitude to use of contraceptive

Information Education and Communication (IEC) programmes have been one of the primary means of promoting family planning in the developing world. These programmes vary from one country to another depending on the level of literacy and cultural norms with regard disseminating sex-related information. Wide-spread communication and the influence of mass media in developing countries have accelerated the diffusion of ideas about family in both rural and urban environments.

It has been found out those women who listened to or watched family planning messages on radio or television were more likely than others to want smaller families and to use family planning. It was confirmed that the message about family planning contained in entertainment shows in Nigeria influenced the number of clients at family planning clinics (Bertrand, et al 1982, Robey, Rustster and Morries 1993).

Selective or preferential targeting of groups is another factor that has been found to significantly influence levels of awareness and knowledge of contraceptive methods. It has been well documented that most family planning methods and programmes are designed for females (Moigana, 1995) and therefore more attention is focused on the influence of females than males to adopt their use. This situation is particularly true in Sub-Sahara Africa (Johnson, 1987).

Husband's contraceptive knowledge, attitude and practice as well as approval play important roles in decision to practice family planning, both by himself and the wife, because of the all-encompassing involvement of man in the family and society. They must be able to provide a more realistic view about fertility related behaviour such as family planning in order for them to embrace the practice fully. Also Yoder et al (1996) found that in Zambian survey result, 38.0 percent of all the man polled reported ever using condom in 1991 while 43.1 percent of them used it in 1992 Their results suggest

moderate increase in experience with condoms for both men and women, with the levels of experience slightly greater for unmarried men and women and for those having sex outside the marriage. Thus, in 1991, 44 percent of such group used condom while in 1992 about 51 percent of them used other contraceptive methods.

Using demographic and health survey, data collected in 18 developing countries between 1990 and 1996, Bankole and Singh (1998) compared husbands and wives attitude towards fertility and contraception. Husband who knew more then one method were as follows: 16.8 percent in Cameroon, 2.3 percent Kenya, 27 percent in Niger, 20.2 percent in Senegal, and 14.3 in Pakistan. Also, husband who reported the use of any modern method were 4.8 percent in Burkina Faso, 2.1 percent in Cameroon, 2.7 percent in central African Republic, 3.6 percent in Cote d'Ivoire, 8 percent in Ghana, 10.4 percent in Kenya, 6.4 percent in Malawi.4.9 percent in Mali,1.9 percent in Niger, 3.2 percent in Senegal, 4.3 percent in Tanzania, 4.7 percent in Uganda, 12.1 percent in Zimbabwe, 8.2 percent in Bangladesh, 4.2 percent in Brazil, 2.8 percent in Egypt, 5.1 percent in Morocco and 2.1 percent in Pakistan.

Ezeh (1993) reported that in Ghana, a woman's contraceptive attitude depends not only on her individual characteristics but also on that of her husband. Her chamcteristics however, do not affect her husband's family planning attitude. Men's influence over their wives contraceptives attitudes seems to operate both through their compamtive advantage in mate selection and through cultural norms that subjugate women to men.

In Nigeria, the knowledge and use of modern contraceptive methods is not very encouraging (Ampofo 1985). Fakeye and Babanlyi (1989), pointed out that low awareness of family planning in Urban and rural areas, low availability and accessibility and male apposition to family planning was the commonest reasons for non-use of contraception in Ilorin. A study on reproductive motivation and family size preference among Nigeria men concluded that in order to change the attitude of Nigeria men to population matter and to motivate them towards the practice of family planning, a lot of

research focusing on the knowledge. Attitude and Practice (KAP) of men has to be conducted.

Lawoyin et al (2002) did a study on family planning in rural Nigeria. The result of the study showed that knowledge was high for any family planning and modern family planning methods (90.9% and 73.3%) and that ever used of family planning is promoted by high level of formal education.

Location

Sherries et al (1982) observed that the use of contraception show differentiation in urban-rural areas. Lack of access to services has been cited as an important reason for the urban-rural differential in contraceptive use (London et al 1985). This difference may be greater for condom then for some other contraceptives because the retail outlets that are the main source of condoms are concentrated in urban areas (Sherries et al 1982).

Folch-lyon et al (1981) also did a study that revealed the influence of urban rural differentiation on people's level of awareness and level of knowledge of contraception. They found out that awareness and level of knowledge of contraceptive methods was higher in urban than in rural areas. A similar finding was reported by Oni and McCarthy (1991) in Ilorin, Nigeria. This cannot be unconnected with the observation that social and health workers tend to target those in urban than in rural areas (Blakikies, 1975)

Accessibility to family planning Service

Accessibility is another factor affecting use of contraceptive choice in term of potential user's life style and stage of their productive life. Also method of delivery influence accessibility as well. for example, a method that requires the services of a physicians is clearly more expensive to deliver and therefore less accessible than a self-administered method. The resistance of physicians could interfere with attempts to improve awareness and use of any methods. This was the case in Zaire where 75 percent of clinicians interviewed believed that couple should have an average of more than five children before they considered sterilization (Bernard et al. 1990). Indeed a particular method

may not be among the method mentioned in existence by family planning service delivery system. This was the case in Kenya where vasectomy was rarely among the methods offered by clinic personnel (Miller et al. 1991).

In term of information about methods, it was found out that if client do not know where to obtain the services that exist, access is hindered (Haisley et al, 1991). Diffusion of method in terms of its acceptance could occur through information channels like word of mouth, publicity and recommendation of peers or providers. Fakeye and Babalola (1989) pointed out low awareness of family planning in urban and rural areas, low availability and accessibility and male opposition to family planning as the commonest reasons for non-use of contraception in Ilorin.

Male approval

Men are not favourably disposed to modern male methods. Condoms are typically associated with diminished sexual pleasure (Population Report, 1990; Caldwell et al, 1987). Identification of condom as a prophylactic against diseases (Karumba 1991) may be viewed as a draw back to use of condom with his wife, since this may imply unfaithfulness on his part or offend the wife because of the association of condom use with prostitute. (Schaddelee Kiggundu et al 1991; Rwabukwali, 1991). Vasectomy in its own case is associated with impotence and loss of virility (Caldwell et al, 1987).

Safety and efficacy are determinants of acceptability and use of contraceptives. Men's lack of confidence in condom, withdrawal and periodic abstinence has affected their effectiveness. Indeed, these methods are also perceived as difficult to use. Cost is also known to be a factor, such that incentives and subsidies can help equalize the appeal of exhaustive and costly methods (Da Silva et al. 1988; Cleland and Mauldin, 1991; Haws et al, 1992).

Folch-Lyon et al's ([1981) qualitative research in Mexico stated that many men expressed the fear that their wives would be unfaithful if they used contraceptives. The Mexican men feared the loss of authority over their wives and families because they felt that

contraception will confer more independence and assertiveness on their wives. They also feared loss of esteem among their peers.

The results of Joesef et al (1988) indicated that husband's approval of contraceptives use played a decisive role in Indonesia. However, the level of contraceptive use varied among cities, ranging from 34.2 percent in Ujung Pandang to 56.5 percent is Semarang. For all Indonesian cities, husband's approval was the most important determinant, followed by number of living children and wife's education.

Biddlecom et al (1997) reported that 72 percent of husbands approved the use of contraception in the Philippines while about half believed that relatives and friends approved. About 81 percent of them intended to practice contraception in the future.
On the other hand, Mahmood and Ringheim (1997) result for Pakistan showed that 74.6 percent of male urban dwellers and 62.9 percent of rural dweller approved of family planning.

Male Attitude to Contraceptive Use

Many men have negative attitude to vasectomy. In Pakistan the method was perceived as highly unnatural because it involved surgery on the sexual organ ([Kahn, 1995). Ugandan men expressed the fear that they would not be able to remarry if their wives died (Vamboze and Kakande, 1979; Lwange, 1979). Some men dislike vasectomy due to the fear of developing sexual problems after the operation such as impotence, inability to ejaculate and loss of sexual desire (Likin et al, 1983), while others viewed the method as castration (Mulgana, 1995). In Nigeria, these fears also exist among men, thereby making vasectomy a highly unattractive form of contraception. This is more so because it is believed that a man's value is measured by his ability to bear children.

In a study of the Yoruba village of Bolorunduro in Ondo State of Nigeria, Mott and Mott (1985), found that only 47 percent of husbands surveyed approved of family planning, both in monogamous and polygamous unions. In their study also, only 40 percent of them indicated that they would abstain from sex if they wished to control their

childbearing. Husbands in monogamous union were much more likely than their wives to indicate that they would use a modem contraceptive method (condom). In polygamous unions, by contrast, men were more likely to indicate that they would use other traditional methods or to "*do nothing*".

2.7 Theoretical Concepts Relevant to Contraceptive Usage

Experiences in various part of the world have shown that behavior change communication activities are more successful when they have strong conceptual or theoretical basis. The use of appropriate conceptual framework has the potential for adding significant technical value to the planning and the implementation of health promotion and/or communicatioo programmes In addition, they facilitate the analysis of public health problems. Coocceptual frameworks are useful in health promotion and behvioural change communication (BCC) practice. A conceptual frame work could be in form of a model. A model is a visual construct of the proposed casual linkages among a set of concept believed to be related to a related to a particular public health problem (Ewoigbokhan, 1992; Medaiyese, 2004) models or conceptual frameworks and public health theories facilitate the selection of variables for measurement.

Two conceptual framework were adopted to facilitate the design of this study. These were the Health Belief Model (HBM) and Adoption of innovation framework.

2.7.1 The Health Belief Model (HBM)

The Health Belief Model, formulated during the 1950s deals with readiness of individuals to comply with a set of recommended preventive health actions within the context of their perceptions of threat posed by failure to take preventive measures (Ross and Mico, 1980). This model was modified and improved upon by Becker in 1974. According to the model, an individual's action regarding a health problem is influenced by factors such as belief in susceptibility to the problem; belief in seriousness of the problem; belief that the advantages of taking actions would outweigh the associated disadvantages and cues that influence actions. Becker (1974) stated that people's perceptions could also be influenced by factors such as personal experience, communication, culture/traditional belief system

and other significant persons. The application of the tenets of the HBM to the study is presented in figure 1.

It has been noted that in general, the HBM is a rational-cognitive model that guides rational decision-making (Friemuth, 1992). Many adolescents and adults do not seem to approach family planning issue from a rational logical perspective; rather they discount to down-play the risks associated with failure to adopt family planning and optimistically perceive themselves as invulnerable. It is the state of well-being of family and community that regulates how individuals measure their state of health. This implies that the role of significant others should be acknowledged regarding decisions to adopt family planning services.

Disease threat is composed of two conditions: first, the person must perceive that he is susceptible. This implies that he believes that he personally has a reasonable chance of acquiring the disease condition. Perceived severity is the second component of disease threat. This implies that the individual should perceive that the occurrence of the disease would have a moderately severe impact on an aspect of his life. This perception varies with the degree of seriousness being seen from two points of view.

One can look at it from the physical perspective that is the impact of the problem on personal well being i.e. is there a chance of pain, suffering, deformity, disability or even death? Social consequences are the second perspective. One is concerned about the effect of the condition on work, family life and social relationships.

The other dimension to the model is the perceived barrier that forms the other side of cost-benefit analysis of the proposed action. This takes place within the individual. She weighs the effectiveness of the action with the expenses likely to be incurred by it, for instance whether there would be side effects from using contraceptives or whether contraceptives will always be available, accessible and affordable. The combines levels of susceptibility and severity provide the energy or force to act and the perceived benefits (less barriers) provide the preferred path of action.

Some stimuli may also be necessary to trigger the decision making process. These are called "Cues to action". Cues might be internal, for example, internal motivation to use contraceptives to prevent pregnancy and sexually transmitted diseases; or external such as mass media advertisements on contraceptives or inter-personal interactions with friends, co-workers and health workers.

Finally, the model assumes that modifying variables such as Age, Sex, knowledge, Attitudes and beliefs might also affects health related behavior. Knowledge of all these factors will enhance a better understanding as to why some couples who are sexually active use contraceptive why others do not.

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FIGURE 2.1:
APPLICATION OF HEALTH BELIEF MODEL (HBM)

INDIVIDUAL PERCEPTION

MODIFYING FACTORS

LIKELIHOOD OF ACTION

PERCEIVED SUSCEPTIBILITY
Problems associated with unplanned family

PERCEIVED SEVERITY

Consequences
- Ill Health
- Poverty
- Social problem

DEMOGRAPHIC VARIABLES
Age, Sex, Ethnicity, Religion

SOCIOPSYCHOLOGICAL VARIABLES
- Personality of individual
- Social status
- Peer group pressure

STRUCTURAL VARIABLES
-Knowledge of problems of unplanned family

Perceived threat to problem of unplanned family

CUES TO ACTION
- Family planning campaign programme
- Accessibility of family planning clinic
- Accessibility of family planning method
- Interpersonal communication
- Counseling

PERCEIVED BENEFITS OF ACTION
- Planned family
- Happy life
- Modifying belief of family planning
- Staying Health

PERCEIVED BARRIER
- Side effects of family planning methods
- Inaccessibility to family planning clinic
- Negative rumor about family planning
- Poor knowledge about FP methods
- Lack of communication between spouse
- Lack Husband approval
- Sex preference

Likelihood of Willingness to adopt Family Planning Method

2.7.2

Adoption of Innovation

Rogers (1962) stated that the innovation-Decision process is the mental process through which an individual passes from first knowledge of an innovation to a decision to adopt or reject and to confirm on this decision. Rogers and Shoemaker (1971) stated that innovationdecision making take place within the mind of an individual. They went further to present five stages of the adoption process as postulated by a committee of rural sociologists in 1955:

(A) Awareness: The individual learns of the existence of the new idea but lacks information about it. For example a person may hear about contraceptives through media advertisement or friends without detailed information.

(B) Interest: The individual develops interest in the innovation. As a result of interest, he may seek further information; for example from health care providers or purchase books to read more about the innovation.

(C) Evaluation: The individual applies the new idea to his/her present and anticipated future situation and decides whether to try it or not. In this case somebody that is single or married but not ready to have a child, she may then try to use contraceptives during coitus.

(D) Trial: The individual applies the new idea on a small scale in order to determine its utility in his/her situation. At this stage couple may purchase some few condoms and try to use them during subsequent coitus to determine whether it is effective in preventing unwanted pregnancy or not.

(E) Adoption: At this stage, the individual uses the new ideal regularly when there is need for it. For example, if one who has tried some contraceptive discovered that they were effective, he/she is likely to continue using them in order to prevent unwanted pregnancy or STIs. Adoption of innovation however does not occur by all people at the same time in a population. Four groups of adopters have been identified: innovators, early adopters, early majority and late majority or laggards

The primary innovators are the first group to adopt a new idea in the community. They are usually learned, well to do and are opinion leaders and socialites The early adopters learn from the primary innovators. They are the class of people that attend meetings regularly and are also learned. The early majority belongs to the middle class while the late majority or laggards belong to the poorest in the society; they are the last to adopt any new idea (Olaseha, 1996).

CHAPTER THREE

METHODOLOGY

This chapter present the methodological steps used in carrying out the study. It focuses on the description of the study area, research design, study population, sample size and sampling procedure, methods and instruments used for data collection, validity and reliability, data collection process, data management and analysis, ethical consideration and limitation(s) of the study.

3.1 Description of the Study Area

The study was carried out at the College of Medicine, University of Ibadan located in Ibadan North Local Government area of Ibadan city. Ibadan is the capital city of Oyo state located in the South Western part of Nigeria. The College of Medicine was established on 1st August 1948 under the University of Ibadan.

College of Medicine consists of four Faculties, namely faculty of Basic Medical Sciences, Clinical Sciences, Public Health and Dentistry; two institutes consist of Institute of Child Health and Institute of Medical Research and Training; one service centre; Biomedical communication, among others and the central administrative unit. There are three categories of staff in this institution which consist of the teaching staff, senior non teaching staff and junior non teaching staff. These members of staff were spread out to the faculties, institutes, service centres and administrative unit.

3.2 Research Design

The study is a descriptive survey designed to assess and document factors influencing the use of family planning methods among the non-teaching staff of College of Medicine, University of Ibadan.

3.3 Target Population

The target populations for this study were the non-teaching staff of the College of Medicine, University of Ibadan, men and women, senior and junior. They belong to different categories e.g. the technical staff for example, Technologist, Drivers, and Gardeners etc. The administrative staff also comprises of Administrative officers, Executive officers, Secretaries, Typist, Clerical officers, Messengers among others.

3.4 Sampling Procedures and Sample Size

As at the time of the research in June 2006, the total population of the non-teaching staff was five hundred (500). In order to get a sample size whose result would be generalizeable, all these people were approached and invited to participate in the study. For qualitative method fifteen people were invited to participate in Focus Group Discussion (FGD) but only the first ten participated in the FGD. A total of eight FGD were conducted with ten people in each of the group. For the quantitative method, only 371 consented to be part of the study and they administered the questionnaire and returned them.

3.5 Instrument for Data Collection

Both qualitative and quantitative methods were used to collect data for this study. The qualitative method consists of focus group discussion (See appendix One) which was conducted to solicit information on their knowledge and utilization of family planning methods. The quantitative method was a questionnnire (See appendix Two) which was designed to collect information on socio-demographic data of the respondent sex, age, marital status, ethnic group, religion, level of edueation, designation, year of service, knowledge, attitude and practice of family planning methods, utilization of Family Planning methods, current and ever used of family planning methods.

3.6 Method of data collection

a. Focus Group Discussion

Eight Focus Group Discussions (FGDs) were conducted. Four of these were for the senior Non-teaching members of staff and four among the junior non-teaching members

of staff; two sessions were held for males while two were for females; this strategy was adopted to allow gender balance for both male and female category and equal opportunity for both the senior and junior staff. 2 FGD sessions were conducted among the senior male staff and two among the junior male and two among the senior female and two among the junior female staff.

Each group comprises of 10 subjects of the same sex. The FGD was conducted by a moderator and assisted by a note taker and observer. With the aid of the FGD guide, the discussion conducted was able to address issues that are relevant to the study objectives and helped to provide more insight into the important issues of this research and to monitor the internal validity of the data generated through the questionnaire. FGD were conducted after the official closing time.

b. Semi Structured questionnaire (Quantitative data)

The instrument for quantitative data collection was pretested questionnaire. The questionnaire consisted of a combination of open- and closed-ended questions. Information obtained from the focus group discussions conducted and relevant literatures were used to develop the questionnaire.

The semi structured questionnaire was divided into four sections as follows

A. Socio-demographic characteristics i.e. sex, age, marital status, ethnic group, religion, level of education, designation, year of service.

B Awareness and Knowledge about contraceptives

C. Attitude toward the accessibility and utilization of contraceptive

D Problems and benefits associated with the use of family planning.

Two males and two females research assistants were recruited and trained to assist in FGDs and to administer the questionnaires of which the minimum qualification are Ordinary National Diploma (OND). The training session consist of ways to elicit

information from the respondents and to assure them of maximum level of confidentiality of the information given. The duration of the training was four hours. They were trained using both the FGD guide and the questionnaire. During the training, the trainees were paired to role-play the exercise. Comments, observations and corrections were made so as to enable them to collect quality data.

3.7 Validity and Reliability

In order to ensure that the instrument measured what it was intended to measure both the FGDs and questionnaires were first pretested among the non-medical staff of the University College Teaching Hospital (UCH) that has the same characteristics as the study area. Four FGD sessions were conducted among the UCH non-medical staff junior and senior, male and female group. This was done to validate the guide. In the same manner, forty questionnaires were equally pre-tested among another set of the same group, after the pre testing of the questionnaire, the following amendments were made based on the responses from the participants.

The question on the source of information about family planning was included in the final instrument. Other amendments made were questions on types of contraceptive method, provision of options to some of the questions, asked question on the availability of family planning clinic in their area and their observation about the family planning clinic. The pretested FGD was translated to Yoruba, which was later discovered not necessary since all the subjects were able to understand and read the questions with little or no assistance.

After pretest, the result indicated that the instrument could still be used with little change in the wordings and structure of the questionnaires. Therefore, some questions were reconstructed for better understanding and some were made open ended for the respondents to provide answers.

Reliability was ensured by asking the questions in an uncomplicated way with the permission to explain any difficult areas for some respondents. The recruitment of only experienced research assistants that has been working on this type of study also ensures

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reliability of the questionnaire. To ensure confidentiality, the questionnaire was self-administered and the research assistants asked the respondents not to identify themselves. The respondents were also instructed to answer the questions anonymously.

Similarly, to ensure validity and reliability of the study instruments, well-trained research assistants were used to assist in the FGDs and administering of the questionnaires. Training was conducted for the hired research assistants (RAs) to ensure that they had adequate understanding of the instrument prior to the commencement of data collection. The training focused on the objectives and importance of the study, sampling process, how to secure respondent informed consents, basic interviewing skills and how to review questionnaire to ensure completeness. The research assistants were involved in the pre-testing of the questionnaires in order to create an opportunity for them to acquire practical interviewing skills. The researcher checked the questionnaires administered daily and problems discovered during data collection were resolved immediately.

3.8 Data Management and Analysis

The data obtained were manually sorted out, edited and coded before they were fed into IBM Computer for statistical analysis using the Statistical Package for the Social Sciences packages. Data analysis was done using both inferential and descriptive statistics. The results were presented mainly in Frequency tables.

3.9 Ethical Consideration

Oral informed consent was sought from each of the research participants. This was done after they had been briefed about the nature of the study and their right to participate or not to participate. Participants were given the choice to withdraw their consent freely if they so choose at any time. Assurance of confidentiality of participants responses were maintained during and after the conduct of the interview. In order to ensure anonymity of responses, names of respondents or any identifiers were not included on the questionnaire.

3.10 Limitations of the Study

The researcher relied on reports, attitudes and practices of the respondents. The respondents were expected to report on whether or not they have used and are still using any contraceptive methods for birth control which is a sensitive and complex issue. There was no way of ascertaining whether their claims were true or false. To minimize this problem, the respondents were assured of confidentiality of the information provided and their identity would not be reflected on the copies of the research materials.

It was obvious to the researcher at the field that many respondents did not like discussing issues of family planning that they thought was personal to them. Time factor was another limitation to the study and money.

CHAPTER FOUR

RESULTS

This chapter presents the result of both the qualitative and quantitative data. The result of the qualitative was presented prior to that of the quantitative while the results of quantitative were presented in sub-section which consists of the following: Demographic characteristics, awareness and knowledge of the respondents about contraceptives, accessibility and utilization of family planning. Attitude towards the use of contraceptives, problems and benefits associated with the use of contraceptives.

4.1 Result from Focus Group Discussion

4.1.1 Methodology

A total of eight focus Group Discussion were conducted, four among male group and four among female members of staff respectively. Each discussion lasted between forty minutes and 1hour. The discussions were held at the College of Medicine Coffee room. Ten participants took part in each of the discussion and a total of eighty (80) members of staff participated in the discussions. The discussion came up at the end of the closing hours. This was due to the fact that the authority would not allow the staff to leave their office for any activities. The discussions were carried out with the help of a moderator, a note taker/observer. In addition a tape recorder was used for effective documentation of the discussion.

4.1.2 Awareness and knowledge of family planning

The participants were asked about the reproductive health problems. Several problems were mentioned by the participants. Among the reproductive health problems mentioned include infertility, abortion, promiscuity, miscarriage among others. Specifically, the female group mentioned Sexually Transmitted Diseases (STDs), fibroid, sexual

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dissatisfaction. Vesico Vagina Fistula (VVF) and fallopian tube blockage while their male counterpart were of the opinion that stress, poverty, abortion and promiscuity.

When asked about what they know concerning family planning, several explanation or meaning was given to the term. The general meaning given to it include: *to have only the number of children you can cater for; to reduce rate of having babies. to prevent unwanted pregnancy or to regulate child spacing*. Other explanation of family planning given include was that Family planning brings about sexual satisfaction for the couples and it also help women to have enough rest before next pregnancy and prevent STI.

Participants were able to state different types of family planning methods available. These include condom, withdrawal method, Oral Contraceptives (Pills), Safe period (Natural Family Planning) and IUCD. The female groups added Norplant, injection, diaphragm, and vasectomy popularly referred to as *pariola* while use of traditional method was mentioned by few group. The participants identify condom and pill as the most popular methods of family planning while very few said the withdrawal method is most popular.

4.1.3 Practices and utilization of family planning

When asked about the categories of people who should adopt family planning, majority of the participants were of the opinion that all adult, married, both poor and rich should be using family planning. Other categories of people mentioned include *"those that cannot do without having sex or with high libido"; "after birth satisfaction"; "those who already had large family size"; "students/unmarried or people of low income earners"*.

The participants identified some of the factors that may influence the adoption of family planning. Among the factors mentioned include *economic factor, health factor, level of education, social facto, religion and "number of children already had"*. Other factors mentioned include, *"the nature of job one is doing"; "accessibility to the facilities" and cooperation between the couple or partners"*.

4.1.4 Problems and benefits of family planning

The participants listed some of the problems associated with the use of family planning among women. According to them, the following were the major problem mentioned by the participants: "*women will gain more weight*", *Hemorrhage*", "*Infertility*", *Irregular menstruation/excessive bleeding*" and "*breakage/slipping of condom*". Other problems mentioned mostly by male group were "*Family planning reduces sexual enjoyment*" and "*increases sexual immorality*".

On how they cope with the problems associated with family planning, the participants said they consult family planning health care centres, listen to health talk or undergo a periodic test. The participants also said agreement about family planning is very crucial and ones there is agreement, there would not be any problem that they cannot cope with. According to them, "*if there is a strong agreement between the couples they would be able to cope with any family planning problems*".

Several benefits were mentioned by the participants. According to them, family planning help to reduce unwanted pregnancy thereby prevent over population. Other benefits mentioned include "*family planning help to achieve one goal*"; "*can lead to long life for women*"; "*increase the standard of living*" and "*help to plan for one's family*".

The participants have several things that they would like to know about family planning among those things were "*Why some methods fail? Why condoms always break during use? Does family planning causes early menopause or delay menopause? Why infertility occur after adoption of family planning? Causes of infertility?*"

4.2 Section A: Socio Demographic Information

The majority of the respondents were males accounting for (62.5%) The overall mean age of the respondents is 42.2 years (SD± 9.22). Majority of the respondents fall between the ages of 30-39 years representing 35.0% of the population. The study shows that majority 312 (84.1%) of the respondents were married, 51 (13.7%) were single, 6 (1.6%) were widowed while both divorcee and separated have equal number 1 (0.3%) respectively.

As expected from the geographical location of the institution, large number 333 (89.8%) of the respondent were Yorubas followed by Igbo which accounted for 4.0% and others as shown in Table 2. Christianity is the predominant religion practice by 332 (89.7%) follow by Islam 37 (10.0%). The distribution of the respondents according to their level of education revealed that slightly above average 196 (55.8%) had tertiary education. 96 (27.4%) had secondary education while 59 (16.8%) had primary education as shown as shown in Table 4.1.

Two hundred and eleven (56.9%) of respondents were senior members of staff. Administrative unit had the highest population 83 (22.4%) among the respondents followed by Faculty of Basic Medical Sciences 76 (20.5%) while 75 (20.2%) were from the faculty of Clinical Sciences. Others as shown in table 4.2.

Table 4.1

Some Socio Demographic Information of the respondents

Socio Demographic Variables	No	Percentage
Sex:		
Male	232	62.5
Female	139	37.5
Age Distribution:		
20-29	25	6.7
30-39	130	35.0
40-49	108	29.1
50-59	108	29.1
Marital Status:		
Married	312	84.1
Single	51	13.7
Widowed	6	1.6
Divorced	1	0.3
Separated	1	0.3
Ethnic Group:		
Yoruba	333	89.8
Igbo	15	4.0
Hausa	1	0.3
Others	22	5.9
Religion:		
Christianity	332	89.5
Islam	37	10
African Traditional Religion	1	0.3
No response	1	0.3
Level of education:		
Tertiary	196	52.8
Secondary	96	25.9
Primary	59	15.9
No response	20	5.4
Designation:		
Senior	211	56.9
Junior	160	43.1

Table 4.2

Distribution of the respondents by their Faculty/Unit

Faculty/Unit	No	Percentage
Administrative Unit	83	22.4
Faculty of Basic Medical Science	76	20.5
Faculty of Clinical Sciences	75	20.2
Faculty of Public Health	32	8.6
Faculty of Dentistry	30	8.1
Finance and Audit	25	6.7
Library	15	4.0
Biomedical Comm. Centre	13	3.5
Institute of Child Health	12	3.2
Institute of Medical Research and Training (IMRAT)	10	2.7
Total	371	100

Section B: Level of awareness and knowledge of respondents about contraceptives

Out of the total 371 interviewed, 98.7% had heard about the word family planning while only 1.1% had not. Electronic media (television and radio) was particularly popular among the respondents as a main source of information on modern contraceptives 43.2% followed by print media 10.3%, religious organization 7.1%, and health institutions 17.4% while 14.6% got their information from friends and family (Table 4.3).

Table 4.4 shows that majority of the respondents (91.1%) were able to define family planning correctly among which 62.4% were males. From further analysis, above average 57.2% of those who could correctly defined family planning had tertiary education while 58.6% of them were senior member of staff. Slightly above average 52.0% mentioned safe period method as one of the natural family planning while 43.7% and 29.9% mentioned withdrawal method and periodic abstinence as natural family methods and only 7.5% were able to identify lactation amenorrhea (Table 4.5). Table 4.6 shows that male condom was the most popularly known contraceptives method as mentioned 65.8%, follow by oral pills 18.5% and injectible 39.9% while diaphragm was the least method known.

Table 4.3

Sources of information on contraceptives

Source of information	No	Percentage
Television	207	24.5
Radio	161	18.9
Health Workers	148	17.4
Friend	101	11.8
Newspaper	88	10.3
School	52	6.1
Church	48	5.6
Family	24	2.8
Mosque	12	1.4
Others	12	1.4

- Multiple Responses

Table 4.4

Definition of Family Planning by Sex, Level of Education and Designation

Variables		Correct (%)	Incorrect (%)
What do you understand by family planning		338 (91.1)	33(8.9)
Sex	Male	211 (62.4)	21 (63.6)
	Female	127 (37.6)	12 (36.4)
Level of Education	Secondary Edu.	139 (42.8)	16 (61.5)
	Tertiary Education	186 (57.2)	10 (38.5)
Designation	Senior	198 (58.6)	13 (39.4)
	Junior	140 (41.2)	20 (60.6)

Table 4.5

Types of Natural Family Planning

Types of natural Family Methods	No	Percentage
Safe Period	193	52.0
Withdrawal Method	162	43.7
Periodic Abstinence	111	29.9
Lactation Amenorrhia	28	7.5

*Multiple Responses

Table 4.6

Types of Modern Contraceptives Method Known

Modern Contraceptives	No	Percentage
Male Condom	244	65.8
Oral pills	180	48.5
Injectable	148	39.9
IUCD	132	35.6
Foaming Tablet	69	24.8
Norplant	56	15.1
Vasectomy	42	11.3
Tuberligation	27	7.3
Diaphragm	26	7.0

*Multiple Responses

Majority of the respondents 360 (97.0%) agreed that family planning is necessary while only 11 (3.0%) disagreed with the necessity of family planning. Further analysis shows that more men 227 (63.1%) agreed with the necessity than women. Similarly, more senior members of staff 209 (55.1%) agreed with family planning and those with post secondary education accounted for 191 (56.0%) has positive perception about family planning (Table 4.7).

Large majority of the respondents 342 (93.4%) reported that both husband and wife should make decision about family planning practice. 18 (4.9%) said only husband should take decision and 6(1.7%) supported wife alone to take decision. Table 4.8 indicates the various situations when family planning method should be used. To prevent unwanted pregnancy was the top most time when people should adopt family planning as was said by 158 (42.9%) of the respondents. When desire number of children had been achieved was also mentioned by 122 (32.9%) while other time mentioned include when want to delay next pregnancy; to prevent STI/HIV and when health of the wife is in danger.

Out of the 371 respondents interviewed 235(63.3%) reported to have received counseling on family planning, (36.7%) had not. Among those that reported to have received counseling, 178 (48%) reported to have been counseled by health workers followed by 32 (14.9%) counseled by friends / colleagues. 10 (2.7%) were counseled by spiritual leaders, 9(2.4%) were counseled by their spouse (Table 4.9).

Table 4.7

Respondent's perception about contraceptives by Sex, Level of Education and Designation

Variables		Yes (%)	No (%)
Is family planning necessary?		360(97.0%)	11(3.0%)
Sex	Male	227 (63.1)	5 (45.5)
	Female	133 (36.4)	6 (54.5)
Level of Education	Secondary Education	150 (44.0)	5 (50.0)
	Tertiary Education	191 (56.9)	5 (50.0)
Designation	Senior	209 (55.1)	2 (18.2)
	Junior	151 (41.9)	9 (81.8)

Table 4.8

Respondents perceived reasons for using contraceptives

Reasons	No	Percentage
To prevent unwanted pregnancy	158	42.9
Desire number of children achieved	122	32.9
Want to delay next pregnancy	51	13.3
To prevent STD/HIV	16	4.3
When wife health in danger	14	3.8
Others	9	2.5
Total	371	100%

- Others include want wife to finish education, too old to have children again and still single

Table 4.9

Persons who counseled the respondents about Family Planning

Persons who Counseled the respondents about Family Planning	No	Percentage
Health workers	178	77.7
Friends/Colleagues	32	14.0
Spiritual Leaders	10	4.4
Spouse	9	3.9
Total	229	

Section C: Accessibility and utilization of family planning

Two hundred and ninety three (79.0%) reported to have family planning clinic in their area. Out of this only 191(51.5%) respondents reported they had visited a family planning clinic. Two hundred and twenty nine (61.7%) claimed that it would take them less than 30 minutes to get to family planning clinic (Table 4.10).

Sixty-five (33.1%) respondents observed that patients were given enough privacy at the family planning clinic while 54 (27.5%) observed that attitude of the health workers were satisfactory. Other observations made by the respondents include availability of different methods of contraceptives, services are affordable, clinic too far and services not available at all time among others as shown in Table 4.11.

Table 4.10

Availability, Visitation and time to get to Family Planning Clinic (N=371)

	No	Percentage
Availability of FPC: Yes	293	79.0
No	78	21.0
Visitation to FPC: Yes	191	51.5
No	180	48.5
Time to get to FPC: < 30mins	229	78.2
30mins - 1 hour	48	16.4
> 1 hour	16	5.4

Table 4.11

Respondent's observation at Family Planning Clinic

Observations	No	percentage
Patients are given enough privacy	65	33.1
Satisfactory attitude of the health workers	54	27.5
Availability of different methods of contraceptives	39	19.9
Services are affordable	18	9.2
Clinic too far	9	4.6
Service not available at all time	3	1.5
*Others	8	4.1
Total	196	100

* They now sell drugs; Service not affordable/too high; No personal attention; dissatisfied attitudes of the health workers and Health workers refused to give information.

Utilization of Contraceptives

More than half 249 (67.4%) of the respondents indicated that they have used contraceptives before. Analysis of those that had ever used contraceptive before by their sex, age group and designation indicated that male respondents had the highest percentage (62.3%) than their female counterpart and it was also significantly higher among those aged 40-49 (33.3%) ($p<0.05$) and among the senior members of staff (64.3%) ($p>0.05$) (Table 4.12).

Table 4.12

Ever-Utilized Contraceptives by Sex, Age group and Designation (N=249)

Variables	Frequency	Percentage
Ever Used Contraceptives	249	67.1
Sex: Male	155	62.3
Female	94	37.7
Age group: 20-29 years	10	4.0
30-39 years	80	32.1
40-49 years	83	33.3
50 and above	76	30.5
Designation: Senior Staff	160	64.3
Junior Staff	89	35.7

Majority of the respondents 252 (79.2%) reported to be using contraceptives currently and 66 (17.8%) said they are not using any type. The result also showed that more males are currently using contraceptives than their female counterpart. It also revealed that majority of those that are currently using it fall within the age bracket of 30-39 years. Moreover, more than half of those that claimed to be currently using contraceptives are senior members of staff as shown in Table 4.13. Among the contraceptives that are previously and currently being used, male condom was the major contraceptive being used as mentioned by respondents according to gender (previous: male 121 (71.2%) and female 49 (28.8%) while those that are currently using condom accounted for 82 (77.4%) among male and 24 (22.6%) for female. Withdrawal method is another method accounted for by 63 (69.2%) male and 23 (30.8%) female while among the current use of the method male accounted for 21 (70.0%) and female 9 (30.0%) as showed in table 4.14.

Table 4.13

Proportion of People currently using Contraceptives by Gender, Age group and Designation (N=252)

Variables	No of current use	Percentage
Current use of Contraceptives	252	79.2
Sex: Male	173	68.7
Female	79	31.3
Age group: 20-29 years	13	5.2
30-39 years	86	34.1
40-49 years	81	32.1
50 and above	72	28.6
Designation: Senior Staff	149	59.1
Junior Staff	103	40.9

Table 4.14

Types of Previous and Current Contraceptives by gender

Type of Contraceptive Method	Previous		Current	
	Male (%)	Female (%)	Male (%)	Female (%)
Condom	121 (71.2)	49 (28.8)	82 (77.4)	24 (22.6)
Withdrawal	63 (69.2)	23 (30.8)	21 (70.0)	9 (30.0)
Safe Period	57 (63.3)	33 (36.7)	15 (57.7)	11 (42.3)
Oral Pills	36 (59)	25 (41.0)	11 (68.8)	5 (31.2)
Periodic Abstinence	33 (75.0)	11 (25.0)	14 (73.7)	5 (28.3)
Foaming Tablet	28 (71.8)	11 (28.2)	5 (100.0)	0 (0.0)
Injectible	24 (63.2)	14 (36.8)	11 (68.8)	5 (31.2)
IUCD	15 (28.8)	37 (71.2)	11 (44.0)	14 (56.0)
Norplant	4 (40.0)	6 (60.0)	1 (25.0)	3 (75.0)
Tuberligation	3 (50.0)	3 (50.0)	2 (50.0)	2 (50.0)
Diaphragm	3 (100.0)	0 (0.0)	2 (40.0)	3 (60.0)
Vasectomy	2 (50.0)	2 (50.0)	0 (0.0)	1 (100.0)

*Multiple responses

Among the respondents that claimed not to be using contraceptives, 50 (48.5%) reported that they have no reason for not using any method. Twenty (19.4%) said because of side effect while 18 (17.4%) claimed that they needed to have more children and 2 (1.9%) said because of the price and others as shown in the table 4.15. Majority 122 (51.6%) of the respondents reported to be utilizing contraceptives through their personal decision. Among this people, 82 (67.2%) of them were male 62 (26.2%) are using it because of the recommendation from the health workers and 41 (66.1%) were of them male. While 33 (13.9%) are using it through the recommendation of their spouse. Only 17 (7.2%) said they are using contraceptives because of the advice received from their co-workers and friends (Table 4.16).

Among those that are using contraceptives 70 (28.1%) said that the method they chose are easily available while 59 (23.7%) said because it is highly effective and another 52 (20.8%) considered the price of the commodity being cheap as shown on the Table 4.17. Majority 139 (37.5%) of those that utilize contraceptives reported to procure it from hospital while 93 (37.5%) obtained their products from chemist and 8 (3.2%) respondents got their services from market (Table 4.18).

Almost all the respondents 364 (98.9%) said that family planning should be provided at the health centre while only 4 (1.1%) said it was not necessary. The majority of the respondents 353 (95.1%) agreed that information and provision of family planning services will enhance its usage while 3.3% did not agree with the idea (Table 4.19).

Table 4.15

Reasons for not utilizing contraceptives

Reasons	No	Percentage
No reason	50	48.5
Because of side effect	20	19.4
Need to have more children	18	17.4
Cost too much	2	1.9
Dissatisfied with the method/ method not comfortable	1	0.9
Not effective	1	0.9
*Others	11	10.6
Total	103	100

* *Others: I am single, too old, reached menopause*

Table 4.16

Person who suggested use of contraception by sex of respondents

Who recommend contraceptive	Male	Female	Total
Personal decision	82 (67.2%)	40 (32.8)	122
Health workers	41 (66.1)	21 (33.9)	62
Spouse	13 (39.4)	20 (60.6)	33
Co-Workers/friends	12 (70.6)	5 (29.4)	17
*Others	1 (50.0)	1 (50.)	2
Total	149(63.1)	87(36.9)	236

P-value = 9.646

*Others: My Boss and my grandfather

Table 4.17

Respondents reasons for using the chosen method

Reason for choosing the type of contraceptive used	No	Percentage
It is easily available	70	28.1
It is highly effective	59	23.6
It is cheap	52	20.8
My sexual partner likes it	51	20.5
Other reasons	17	6.8
Total	249	100

*Other reasons: My husband traveled, I am single, I don't want to have children again; it gives me good health; Because of my age; personally like the method, no side effects etc

Table 4.18

Sources of Contraceptives Services

Outlets	No	Percentage
Hospital	139	56.0
Chemist	93	37.5
Market	8	3.2
Friend	6	2.4
Birth attendants	2	0.8
Total	248	100

Table 4.19

Opinion about where Family Planning should be provided

Do you think it is Importance to providing FP services in health centres	No	%
Yes	364	98.1
No	4	1.1
Do you think Information and provision of FP will enhance its usage		
Yes	353	96.7
No	12	3.3

SECTIONS D AND E:

Problems and benefits associated with the use of contraceptives

Out of those that had ever used contraceptives, sixty-six (26.2%) said they encountered one problem or the other while using it. Excessive bleeding 12 (20%) was the most common problem mentioned followed by disappointment of the method and headache having the same percentage 7(11.6%). Other problems mentioned include irregular menstruation, loss/gain of weight, partial enjoyment while using condom and others as shown in the table 4.20.

Concerning the most common problems associated with the use of contraceptives which could refer to as general problems that they have heard from people using contraceptives or heard from other sources like radio, television, news papers etc. the most common problem mentioned or identified was irregular bleeding by 51 (30.5%) while loss/gain of body weight was mentioned by 47 (28.7%) excessive bleeding and psychological problems were mentioned by 29 (17.4%) and 19 (11.4%) among others (Table 4.21).

Concerning the benefits associated with the use of contraceptive, 114 (30.7%) respondents said that using contraceptives would prevent unwanted pregnancy while another 91 (24.5%) said using contraceptives is good for better living standard of the family. Other benefits of contraceptive are reflected in the table 4.22.

Table 4.20

Problems encountered by the respondents who had used contraceptives

Type of problems	No	Percentage
Excessive bleeding	12	20.0
Disappointment of the method	7	11.6
Headache	7	11.6
Irregular menstruation	6	10.0
Loss/gain of weight	6	10.0
Partial enjoyment with the use of condom	4	6.7
Infertility / delay of pregnancy	4	6.7
IUCD and Condom irritation	3	5.0
Withdrawal method is difficult to control	3	5.0
Condom slip or burst during intercourse	2	3.3
Not comfortable with the use of condom	2	3.3
*Others	4	6.6
Total	66	100

*Others: Make me older than my age, Prolong ejaculation with condom, abdominal pain and Psychological problem

Table 4.21

Common problems associated with the use of family planning relating to personal experience and information from others

Most common problems	No	Percentage
Irregular bleeding	51	30.5
Loss/gain of weight	47	28.1
Excessive bleeding	29	17.4
Psychological problem	19	11.4
Headache	13	7.8
Infertility	8	4.8
Total	167	100

Table 4.22

Benefits of using Contraceptives

Benefits	No	Percentage
To prevent unwanted pregnancy	114	30.7
For better living standard of the family	91	24.5
To regulate/Plan/control number of children	68	18.3
For child spacing	42	11.3
For family to enjoy good health	16	4.3
Allow couple to enjoy sex without fear	13	3.5
To prevent STD/HIV/AIDS	10	2.7
Safe from embarrassment	9	2.4
To control or reduce over population	9	2.4
Help to maintain good family	7	1.9
To give long life to the mother	7	1.9
Women will have more time for her children	5	1.3
*Others	9	2.4
**Total	400	

*Others: to reduce poverty; reduce promiscuity; to give peace of mind; to have happy family among others.

**Multiple responses

Testing of Hypotheses

Further analysis to test Hypothesis 1 indicated that there is no significant association between the level of education of the respondents and their practice of contraceptive with a P-value >0.05 (P-value=3.673) as shown in table 4.23. In the light of this. hypothesis number one which stated that "there is no significant association between respondent's level of education and practice of contraceptive" is therefore accepted.

Similarly test of the Hypothesis 2 indicated that there is no significant association between the respondents socio-economic status which is their designations and their adoption of contraceptive with a P-value=<0.05. In the same manner. hypothesis two which stated that "there is no significant association between respondent's socio economic status and their adoption of contraceptive" is accepted (Table 4.23).

Testing of hypothesis 3 showed that there is no relationship between the sex of the respondents and their contraceptive utilization with a chi-square value of 0.175 with a P-value of 0.916 as indicated in table 4.23. Hypothesis 3 is therefore accepted.

Finally, the hypothesis 4 showed that there is no relationship between the knowledge of the respondents and their contraceptive usage. Though the respondents have good knowledge of contraceptive, the chi-square value is 1.824 and p-value which is greater than 0. 05(Table 4.23). Therefore, hypothesis 4 which stated that there is no relationship between knowledge and use of contraceptives is therefore accepted.

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Table 4.23

Relationship between use of Contraceptives by Sex, Level of Education and designation of respondents

Variable	Ever used contraceptives		X^2	Df	P-Value
	Yes	No			
Sex: Male	155	77	0.175	2	0.916
Female	94	45			
Education:					
Primary	39	20	3.673	6	0.721
Secondary	63	33			
Tertiary	132	64			
Designation:					
Senior	160	51	18.280	2	0.000
Junior	89	69			
Knowledge of family planning					
Incorrect	18	14	1.824	2	0.402
Correct	230	108			

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

This chapter is organized into five sub-sections as follow: Socio-demographic information, Awareness and knowledge of contraceptive, accessibility and utilization of contraceptives methods, attitude toward the use of contraceptives, problems and benefits associated with the use of contraceptives.

Socio-demographic characteristics of the respondents

The findings of the study revealed that socio-demographic characteristics in respect of sex showed that out of three hundred and seventy one (371) respondents, majority 232 (62.6%) were males given a sex the ratio of almost ratio 2 to 1. Also some of the female staff did not show interest in the study because they did not want to discuss their sex affairs which they belief is personal to them.

As regards age profile of the respondents, the study shows that a large proportion of the respondents, minimum age is twenty years (20) while the maximum age is fifty-nine (59) years. The wide range is due to the fact that the minimum age for employment into any government establishment is 18 years and retirement age is 60 years old and 35 years in service. Majority of the respondents (84.19%) were married. This was not surprising since they are working class with stable job. It is advisable for male or female who cannot do without having sex to get marry than to be having extra-marital affairs.

The marriage may not necessarily have legal backing, it may be in accordance with Islamic, Christian or Traditional rite, which is also acceptable. Regarding nationality, almost all 370 were Nigerians, while just one (1) person was a Ghanaian. Three hundred and thirty three (89.8%) respondents were from Yoruba origin. There was however a small percentage of other ethnic groups among the staff. This is expected because the

institution is located in the Yoruba community expected majority of the workforce should come from the locality.

The overall attainment of the respondent's level of education shows that majority had tertiary education (52.8%) followed by those that had secondary education (25.9%) and (15.9%) with primary education. This must be as a result that most of them are working in an academic institution where they are encouraged to participate in continue education, a requirement for promotion.

Awareness and knowledge of contraceptives

Level of awareness about contraceptives was high among the respondents. Majority of them claimed that they have heard about it before. Generally the respondent's level of awareness about contraceptives is very encouraging, majority 98.1% were aware of contraceptive methods. Both married and single, old and young reported to be aware of contraceptive but level of awareness of married people was higher than those of unmarried with p-value >0.05 (p-value = 0.765) which is not statistically significant.

All the respondents were able to mention at least one contraceptives method. This result corroborates the survey by the Demographic Health Survey (DHS) in 2003, where more than three-quarters of women can name at least one modern method of contraception spontaneously that is, without prompting. Also Rutemberg et al (1991) found that twice as many urban women know about one form of family planning and therefore concluded that in such situation, urban women may have better access to modern methods of contraception while rural women will rely more on traditional methods.

While in several Sub-Saharan countries, many married women are not able to name any modern family planning method after prompting. In Nigeria, for example, the 1990 NDHS reported that only 44% of married women recognized any family planning method, modern or traditional, even after being prompted while in 1999, the proportion had grown to 64% (NPC, 2000).

Factors accounting for the high level of awareness could be due to their level of education and the fact that they work in a health-related institution the Federal Government advice that a woman should not give birth to more than four children. This could have been as a result of them hearing about family planning since 1980's through jingles on family planning on radio and television.

The result also shows that majority of those that have tertiary education are the senior members of staff and this had helped them to adopt the use of contraceptive compared to their junior counterpart. This is in line with the findings of Rhonda, Lori, Jay and Donna (2009) which concluded that in most societies, the poorest women are least likely to use contraception. These women are also the least likely to be able to pay for family planning services. Thus, public funds are most wisely spent on providing family planning to the poorest population groups. All too often, however, the subsidies that governments provide for family planning are "captured" by the wealthiest people, because wealthier couples typically want smaller families and seek out and use available services.

Knowledge about family planning was high as almost all the respondents in the study area reported to have heard of the word "Family Planning". This result was higher than what was reported for rural Nigeria by the NDHS (1999) and also higher than what was obtained in the Southeast, Northeast and Northwest regions of Nigeria. The findings are similar to what was found by Kerral et al 1997, Nibizo and Adamchak 1990, Lawoyin et al 2002, Oyediran Isholu and Fayeseran 2002; NPC 2003 and Obinu 1980. This may be due to the impact of the media in disseminating information on family planning.

Majority of the respondents (91.1%) could correctly defined family planning and a high proportion knew the different methods of modern contraceptives. Furthermore, majority of the respondents were able to mention at least one advantage of contraceptives methods. From the study, the senior members of staff (63.0%) have higher knowledge of contraceptive than the junior members of staff. The study also showed that respondents with tertiary education had wider knowledge compared to respondents with secondary and primary education. Similarly, respondents that are Christians are well knowledgeable

about contraceptives than their counterparts that are Muslim or traditional religious though the difference is not significant (p-value>0.05).

The condom (male condom) was the most popular contraceptives method known because it is a cheap, readily available which does not require prescriptions. It is also safe, easy to use contraceptive which serves a dual purpose namely prevention of pregnancy and sexually transmitted infections. This finding is similar to what had been obtained in studies carried out by Lawoyin et al 2002, Felder, Tucker 1998 and Awageni et al 1998.

Majority of the respondents were aware of the family planning clinic in the University College Hospital (UCH) the study location where they worked and the family planning services near their residents. This result is similar to the finding of Piotrow et al (1992) and Johnson (1987). This is because of the high level of campaign on family planning via the radio and television, which the respondents were exposed to.

The study shows that electronic media was the main source of information for contraceptives, followed by health workers. This result is similar to what was obtained by Gulluly and Moore, (1986); Dunchak and Mbizvo (1991). However, the finding in this study was higher than what was obtained for Southwest in the NDHS (2003). This might be as a result of increase in the level of the respondent's education compared with the Northern part of the Country.

The study similarly revealed that majority of the respondents knew the correct time to utilized contraceptives. Moreover, (63.3%) of the respondents reported to have been counseled about the use of contraceptives and some of those have not received counseling showed their willingness to receive counseling about contraceptives. Only few respondents said they are not interested due to their religion or because they are still single and because they had reached menopausal age.

Accessibility and Utilization of family planning

Despite the fact that a large number of the respondents knew of family planning clinic around them only 51.5% reported to have such facility in order to receive services. More respondents that visited family planning clinic for services observed that patients were given enough privacy in the clinic, some observed the attitudes of the health workers, others observed that different methods of contraceptives were available, some observed the cost and distance of the clinic to their area.

On who should make decision on contraceptive use, majority (92.2%) reported that both couple should make decision about the use of contraceptives. This is contrary to the study done by Joesufe et al (1988) in a study conducted in Indonesia where it was found the husband's approval of contraceptive use play a vital role in the adoption of any family planning methods and Kuraiya (1988) where male dominance in decision making was pronounced. This appears to be new and highlight the fact that changes are occurring which might be due to increase in level of communication between the patterns and this will enhance usage of contraceptives.

This study revealed that previous use of contraceptives was fairly positive (67.1%) among the respondents. It was significantly higher among those aged 30 – 49 and also among the senior members of staff. This was in contrast to the data from Nigeria Demographic Health Survey 1999 which reveals an overall use of family planning methods, among all women, at about a quarter (27%) have ever used a method and less than a fifth (17%) have used a modern method. The percentage of married women who ever used a contraceptive method is highest among the 30-34 age groups (36%) (NPC 2000 and NPC and ORC Macro, 2004).

The current contraceptive is high among male respondents (74.6%) with those aged 30-39 (60.2%) and senior members of staff (70.6%). This finding is not surprising because, condom seems to be the most popular method being heard of on the radio and television programme. Besides, previous studies indicated that people believe that condoms are effective for preventing STDS/HIV infection and their perception of peer-approval of

Condoms has tremendously led to the increase in the adoption of this method among the target population (Hingson et al 1990 and Kegeless et al, 1989, Sonenstan et al, 1989, Forrest et al, 1990.

This finding is consistent with the result of Alan Gultmacher Institute (1990). Study New York, which revealed that Condoms were the mostly used method among their study group. The result is equally similar to the findings of Ekele et al (1989), study in Jos, Nigeria in which they discovered that the most commonly used methods among the respondents (both males and females) were Condom.

It was also noted that a substantial number of the respondents who are users of contraceptive methods are in monogamous marriage compared with non users. This might be a function of increase sexual demand on those in monogamous marriage that could compel them to look for contraceptive assistance to avoid frequent unwanted pregnancy.

Majority of the respondent's beliefs that information and provision of family planning services would enhance it usage while 12(3.2%) people reported not to support the idea. The few people that had different opinion may be those that are not utilizing the service or those that lack the importance of the service. Also this may be because of their religion.

Problems and benefits of Contraceptive

Only few respondent reported to have contacted one problem or other as a result of using contraceptive method while majority 293(79%) claimed not to have contacted any problem before. However the key problems identified by these respondents include bleeding, headache, and disappointment/failure of the method used, irregular menstruation loss/gain of weight etc. It is possible that these problems may cause failure of using the service or reduce the level of its utilization. Also almost all the respondents that are using the services and non-users were able to mention one correct benefit of contraceptive. This result shows that people knows the benefits of the service

Conclusion

This study shows that there is high knowledge on contraceptives method and the condom is the most popular modern contraceptive method known and used by the respondents. Attitude to the use of contraceptive was generally positive but few of them still had unfavourable perception about contraceptives as well as wrong information about contraceptives.

Condom was the most popularly mentioned and used method of contraceptives Most people used it to prevent unwanted pregnancy and some used it to prevent Sexually Transmitted Diseases STDs including HIV. Diaphram was not popular among the female respondents. Also majority of the respondents preferred natural family planning, which does not, involved any medical attention. The ever and current use of contraceptive were promoted by awareness, high knowledge and increase in the level of education, availability of different methods, privacy, satisfactory attitude of the health workers and low price of the service promote the use of contraceptive method according to the report of the respondents.

An appropriate strategy to stimulate increased use of modern contraception is educating potential users on the benefits of family planning, the types of methods available, the relative effectiveness and side effects of the various methods. Different strategies may have to be adopted to reach potential users in different circumstances and settings, including the health facilities.

In conclusion, women of reproductive age in Nigeria and their partners should be the focuses of interventions aimed at improving awareness of the benefits of modern contraceptive methods with the ultimate goal of helping women (with the cooperation of their partners) make informed and responsible choice about their use. Improving the educational and economic status of the women and educating men, and planning programmes that will improve discussions at the family level on fertility-related issues will likely improve the level of use of modern contraceptives. Also, emphasis should be placed on the dynamics of childbearing and on parental aspirations for the children.

Reference to the economic conditions and demands of modern society, and indeed, the hardships a father faces in the process of bringing up his children will likely appeal to men, and this should be part of the information, education and communication (IEC) programmes.

Recommendations

The recommendations based on the findings of the study are as follows.

1. There is the need to develop good communication strategies and outreach programs that raise awareness, dispel myths and misperceptions, and create a positive perception of the methods.

2. Training providers in the new methods to increase their skills and overcome biases. Although obstacles to providing family planning in Africa persist, many of these challenges can be overcome. To reach this end, policy-makers and program managers must promote an enabling environment through evidence-based policies and guidelines, improved provision of services, and the education of health providers, communities, and individuals.

3. Advocate for family planning at all levels of government and with donor agencies to ensure that family planning is included in budgeting and planning. This can be done by providing evidence to persuade decision makers to include family planning in poverty-reduction strategies, sector-wide approaches, country strategic plans, and national health budgets.

4. Work to ensure that family planning is included as an essential health service in national and district-level plans for primary health care. Identify and support champions for family planning among leaders who are willing to influence their peers. These champions include leaders in Ministries of Health, Nongovernmental organizations, Donor agencies, Health facilities, and Communities.

5. Emphasize that family planning saves lives, helps in the light against HIV/AIDS, and helps achieve many other development goals.

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APPENDIX I

English Version

FOCUS GROUP DISCUSSION (FGD) GUIDE

FACTORS INFLUENCING ADOPTION OF MODERN FAMILY PLANNING AMONG THE JUNIOR MEMBERS OF STAFF OF THE COLLEGE OF MEDICINE, UNIVERSITY OF IBADAN, IBADAN.

INTRODUCTION

Greetings: You are all welcome to this discussion. We are from the department of Health Promotion and Education, Faculty of Public Health, University of Ibadan. We would like to discuss about Family Planning with you. There is no right or wrong opinions on issues to be discussed. As a moderator, my job is to make sure that we talk about the issues and everybody has a chance to participate in the discussion. As participants your job is to tell me what you honestly think and feel about family planning. Remember there is no right or wrong answers. We will also want our deliberations recorded on tape. This will help us to remember what has been discussed today.

Participants Introduction

I would like you to introduce yourself. Please tell us your name and your department. Time I will ask each of you to speak in order after introducing yourself. Please feel free to speak whenever you have something to say but also pay attention to others in the group.

1. What are some of the reproductive health problems among the junior staff of University College Hospital (Probe for Abortion, Birth control, Infertility, Sexual dysfunction, S.T.D etc).
2. What do you understand by family planning?
3. State the different methods of family planning you know?
4. In your opinion, which of these methods do you think are popularly used?
5. What category of people should adopt family planning method (probe for Age, size of the family, financial status, cadre of Staff etc?

6. What are the factors that may influence the adoption of family planning (Probe for factors within the home, Issues of education, Socio-economic status, accessibility, availability)?

7. What are the problems associated with the use of family planning among men and women?

8. How are you coping with family planning problems?

9. What are the benefits of family planning?

10. What do you want to know about family planning?

APPENDIX 11

Yoruba Version

FOCUS GROUP DISCUSSION (FGD) GUIDE

FACTORS INFLUENCING ADOPTION OF MODERN FAMILY PLANNING AMONG THE JUNIOR MEMBERS OF STAFF OF THE COLLEGE OF MEDICINE, UNIVERSITY OF IBADAN, IBADAN.

Ikinni Mo ki gbogbo eniyan ti o wa nibi kabo sibi ifi oro jomitoro oro yi. Awa ti e nwo yi wa lati eka ti nri si Agbega ati Idnnileko eto ilera ti ile eko giga Unifasiti, Ibadan. A fe ba yin so nipa eto somobibi

Lori eto fetosomobibi, ko si ero okan ti a le so pe beeni tabi beeko lori oro ti a so yi. Gegebi oludari iforojomitoro oro yi. Ojusemi ni lati ri pe gbogbo eniyan ti o wa nibi yi lo kopa ninu iforojomitoro oro yi. Gegebi olukopa, ojuse yin ni lati so gbogbo otito ero yin ati iha ti a ko si eto yi. E ma gbagbe pe ko si ero okan ti a le so pe beeni tnbi beeko. A o si fe ki gbogbo ijiroro wa o wa lori fonran oyinbo fun oni ati ilo iwaju.

Ng o fe ki e so nipa ara yin. Kin ni oruko yin. Nibo ni eti nsise. Igba akoko niyiti ng o gba ki enikokan laye lati soro. Ng o fe ki enikookan yin soro lori ohun ti e ti gbo yi ni sise ntele. E jowo e ma tiju lati soro nigbakigba ti o ba kan enikooknn wa. Gbogbo wa ni a ni ohunkan tabi omiran sugboo a ni lati fetí si ohun ti elomiran na nso.

1. Kinni awon isoro ti o ro mo ilera ati ibimo laarin awon osise ile ise yi (ronu nipa oyun sise, feto somo bibi, niromobi. anu ibalopo ati bee-bee-lo)
2. Kinni e mo nipa fetosomobibi ?
3. Orisi fetosomobibi melo ni a mo ati pe ewo ni a o pe awon eniyan gba, ti won sin lo julo?
4. Ni ero tire, ewo ninu awon fetosomobibi wonyi ni o lero pe awon eniyan mu lokunkundun ju.
5. Iru awon eniyan wo ni o nlo awon orisirisi fetosomobibi yi (Ripe o bere nipa ojo ori. ipo molebi (iye), ipo oro oye ati Alaba won lenu ise.
6. Awon nkan wo lo nse atokun sisse fetosomobibi (Bere nipa awon ohun atokun ninu ile, oro eto eko. oto oye ati amuludun. irorun atise ati niwaloraoto.

7. Kinni awon ewu ti o ro mo eto fetosomobibi?
8. Bawo ni a se nfunada awon isoro wonyi?
9. Kinni awon anfani ti o wa ninu eto fetosomobibi?
10. Kinni awon nkan ti o wu wa lati mo nipa fetosomobibi?

APPENDIX III

FACTORS INFLUENCING ADOPTION OF FAMILY PLANNING AMONG THE NON TEACHING MEMBERS OF STAFF OF THE COLLEGE OF MEDICINE, UNIVERSITY OF IBADAN

QUESTIONNAIRE

Dear Respondent, I am a Postgraduate student of the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan. Investigating the afore – mentioned Research topic. You are required to please answer all questions honestly. All information provided will be treated with utmost confidentiality. Thank you for your cooperation.

SECTION A: SOCIO DEMOGRAPHIC CHARACTERISTEICS

1. Sex: 1. Male 2. Female
2. How old are you now? _____ Years.
3. What is your marital status? 1. Married 2. Single
   3. Divorce 4. Widowed 5. Separated
   If Single, go to question 6
4. How many wives do you or your husband has? _____
5. How many children do you have? _____
6. Which is your ethnic group?
   1. Yoruba 2. Hausa 3. Igbo
   4. Others (Please specify _____)
7. What religion do you practice? 1. Christianity 2. Islam
   3. African Traditional Religion 4. Others (Specify _____)
8. What is the highest level of Education you have achieved? _____
9. What is your designation? 1. Senior 2. Junior
10. Which is your Department/ unit/faculty? _____
11. How long have you been working in the College of Medicine? _____

SECTION B: KNOWLEDGE ABOUT FAMILY PLANNING

12. Have you ever heard about the term "Family Planning" before?

1. Yes ( ) 2. No ( )

13. If yes how did you hear about it?

1. Television 2. Radio 3. Friend 4. Family 5. Church
6. Mosque 7. Newspaper 8. School 9. Health Worker
10. Other (please Specify_____)

14. What do you understand by Family Planning?

_____

_____

15. What types of modern Family Planning methods do you know?

(Please list all that you known)

1_____ 2_____
3_____ 4_____
5_____ 6_____
7_____ 8_____

16. Which type of natural Family Planning methods do you know?

1. Abstinence 2. Withdrawal 3. Safe Period
4. Lactational Amenorrhea

17. Who should make decision of whether or not to practice Family Planning in the family? 1. Husband Alone 2. Wife alone 3. Both husband and wife

18. When should family planning methods be used? (Tick✓ the most correct answer)

1. When wife's health in danger
2. Want to delay next pregnancy
3. Desire number of children achieved
4. Wants wife to finish education
5. To prevent STD/HIV AIDS
6. To prevent unwanted pregnancy
7. Others (Specify_____).

19. Have you been counseled about Family Planning before?

1. Yes ( ) 2. ( ) (If No skip to Q 21)

20. If yes, who counseled you? 1. Yours spouse 2. Friends/Colleague

3. Health Workers 4. Spiritual Leader

21 If No, would you like to receive counseling on Family Planning?

SECTION C: ACCESSIBILITY AND UTILIZATION

22. Is there any Family Planning Clinic in your area?

1. Yes ( ) 2. No ( )

23. If Yes, how many minutes would it take you to get to the Family Planning Clinic? 1. Less than 30 minutes 2. 30 minutes - 1Hour

3. More than 1 hour

24. Have you ever visited any Family Planning Clinics? 1. Yes 2. No

25. What are your observations about the clinic?

1. Patients are given enough privacy 2. Clinic too far

3. Satisfactory attitude of the health worker

4. Different methods of contraceptives are available

5. Services are affordable 6. Services not available at all time

7. Other (Please specify:_____)

26. Do you think Family Planning is necessary? 1. Yes ( ) 2. No ( )

27. Have you ever utilized Family planning before? 1. Yes ( ) 2 No ( )

28. If yes, tick all the types you have ever utilized before

1. Condoms 2. Oral Pills 3. Safe Periods 4. IUCD

5. Foaming tablets 6. Withdrawal methods 7. Periodic abstinence

8. Injectables / Injestions 9. Vasectomy 10. Norplant

11. Diaphragm 12. Tubal Ligation

29. If no give reason for not utilizing Family Planning method

1 Need to have more children 2. Dissatisfied with the method not Comfortable 3. Side effect 4. Not effective 5. Cost too much

6. No reason 7. Other (Please Specify:_____)

30. At whose recommendation did you utilize Family Planning?(in the past or current)

1. Personal decision ( ) 2. Spouse ( ) 3. Co-workers /friends ( )

4. Health Workers ( ) 5. Others (Please specify_____ _____ ___)

31. Which of the Family Planning methods are you utilizing now? 1. Condoms

2. Oral Pills 3. Safe Periods 4. IUCD 5. Foaming tablet

6. Withdrawal Method 7. Periodic Abstinence 8. Injectibles/Injections

9. Vasectomy 10. Diaphragm 11. Tubal Litigation 12. Norplant

13. None

32 Why have you chosen this method?

1. It is cheap 2. It is easily available 3. My sexual partner likes it

4. It helps me to enjoy sex 5. It is highly effective

6. Other reasons_____

33. How long have you been utilizing this method? _____

34. Where do you obtain or get Family Planning Services (i.e. Contraceptives)

1. Market 2. Hospital 3. Friend 4. Chemist

5. Other (Please Specify_____)

35. Do you think it is important to provide Family Planning services in the Health Centre? 1. Yes ( ) 2. No ( )

36. Do you think information and provision of Family Planning service would Enhance its usage 1. Yes ( ) 2. No ( ).

SECTION D and E: PROBLEMS AND BENEFITS ASSOCIATED WITH FAMILY PLANNING METHODS

37. Have you ever encountered any problem with respect to use of Family Planning?

1. Yes ( ) 2. No ( ) (If No Go to Q 39)

38. What are these problems?_____

_____

_____

39. What is the most common problem associated with the use of Family Planning among men or women (Please answer for your gender/sex only)

1. Psychological trauma/ problem
2. Irregular Menstruation
3. Excessive Bleeding
4. Loss/gain of weight
5. Infertility
6. I don't know
7. Headache
8. Other (Specify _____

40. Mention one benefit that can be derived from using Family Planning?

_____

_____

_____