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FACTORS AFFECTING THE UTILIZATION OF FAMILY PLANNING SERVICES BY MARRIED WOMEN AT PAIKON KORE MARKET, GWAGWALADA, FEDERAL CAPITAL TERRITORY, ABUJA

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CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Family planning is known to be one of the most popular practices of birth control worldwide, (WHO, 2009). It is the ability of individuals and couples to attain their desired number and spacing of their children through contraceptive use. It is one of the most cost-effective public health interventions and is pivotal to reducing the country's rate of child birth. It was further stated that the rate of child birth decline is a means of achieving a demographic dividend, with the consequent potential of reducing poverty, boosting economic growth and contributing to the overall well-being of families and societies.

Nigeria, the seventh most populous nation in the world, contains a calculable population of 186 million that was projected to achieve 285 million by 2050 (United Nations 2013). There was an estimated 35 million women of reproductive age in the country, with an annual number of births of approximately 7 million and annual population growth of 2.9% per annum. The country's

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rapid population growth was attributable to a high total fertility rate (TFR) of 5.5 children per woman (National Population Commission 2014).

It has been estimated that in Nigeria a reduction in rate of child birth by one child per woman would lead to a 13% increase in Gross Domestic Product (GDP) per capita within 20 years and improve maternal health (Ashraf, Weil, & Wilde 2013). Contraception as a method of family planning promotes survival of infants as it supports birth spacing and reduces high-risk pregnancies. Achieving adequate birth spacing could reduce child mortality by 20 percent or more, particularly in developing countries with myriads of socio-economic problems (World Health Organization (WHO), 2014).

Contraceptives, especially pills, contain a small amount of man-made estrogen and progestin hormones. These hormones work to inhibit the body's natural cyclical hormones to prevent pregnancy. Pregnancy can be prevented by a combination of factors. The oral contraceptive usually stops the body from ovulating. Hormonal contraceptives also change the cervical mucus to make it difficult for the sperm to go through the cervix and find an egg. Hormonal contraceptives can also prevent pregnancy by changing the lining of the womb so it is unlikely the fertilized egg will be implanted.

Contraception has been used worldwide since ancient times. Writings in Egyptian papyri, the Bible, and Greek and Roman texts indicate the usage of various herb and root preparations for contraception and abortion (Agboola, 2006). Decisions regarding the timing of pregnancy and control over family size continue to be important issues for all adults.

When families use modern contraception methods, they are empowered to determine the timing, number and spacing of their children, reducing deaths and improving the health of both mothers and their babies. Family planning also involves ensuring access to preferred contraceptive methods for women and couples is essential to securing the well-being and autonomy of women, while supporting the health and development of families and communities.(Johns Hopkins Center For Communication, 2018). In many cultures, even discussing modern contraception is off-limits

There are different methods of contraception including, long acting reversible contraception such as the implant or intra uterine device (IUD), Hormonal contraception such as the pill or the

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Depo-Provera injection, Barrier methods such as Condoms, Emergency Contraception, Fertility awareness, Permanent contraception such as vasectomy and tubal ligation.

Despite, the campaign on the usefulness of family planning services in having smaller and healthier families, (Studies by National Population Commission (NPC) Nigeria 2014) indicated that contraceptive use is still low in many developing countries, including Nigeria where 23.7% of currently married women had ever used one. Fortunately, majority of Nigerian women are aware of family planning, but very few of them make use of it for birth control (Lasisi, Bassey, Ita & Awoyemi, 2014).

Family planning studies have identified a number of factors as significant variables in a couple's decision about family planning (Undelikwo, Osonwa, Ushie & Osonwa, 2013). The more common variables are degrees of communication between couples, a couple's educational level and whether they are resident in urban or rural area. While such factors are likely to influence family planning decisions universally, there are culture-specific factors such as adherence to traditional ideals like number of living children and male child preference, and expectations which, in the case of several African groups, may override the universal variables.

Traditional values feature prominently because the cultural valuation of children is evident in studies which vindicate that among Nigerians, "having fewer than five surviving children negatively affected the use of family planning methods" (Lawoyin, Osinowo, Babatunde, Bajomo, Betiku, Biakolo, Busari & Fehintola, 2002). Such inverse relationship may derive from traditional valuation of children not only as economic and political assets, but as indicators of status relative to other members of a community. Traditionalism is further compounded by the perception of husbands who may see their wives use of contraceptives as undermining their roles as household /heads or as likely to encourage promiscuity (Oni & McCarthy, 1991). In that respect, family planning decisions excludes the wife who not only succumbs to marital expectations, but also to communal ideas of valuation of child birth.

Experts believe that the healthiest interval between a woman's previous birth and her new pregnancy is at least two years and by preventing closely spaced births, family planning could save the lives of more than 2 million infants and children annually. It has also been shown that babies born less than two years after the next oldest sibling are more than twice as likely to die in

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the first year compared to those born after an interval of three years (Undelikwo *et al.*, 2013). It was further stated that like many other developing nations, majority of Nigeria's population (about 70%) live in the rural communities, these rural communities have very high fertility rate with low contraceptive prevalence rate (CPR) 8% as compared with 18% in the urban areas in Nigeria as many rural women are reluctant to accept artificial method of contraception.

1.2 Statement of the Problem

Population growth in Nigeria continues to increase at an alarming rate. The population growth rate is estimated to be 2.9 per cent per year (National Population Commission NPC 2006) which still remains high as per the government target. This is an indicator that utilization of family planning services is low and needs to be addressed with great attention to avert the situation. NPC (2004) reported that Nigeria adds about 3.5 million people to its population annually. If this growth rate is not checked, the population will double in about 24 years and this will have enormous implications on the economy and the overall development of the country.

In rural areas where poverty levels are high, the situation is likely to be worse. Lasisi *et al* (2014) demonstrated that education, marital status, woman's income, and other demographic and socio-economic factors affect utilization of family planning services, the significance of these factors have not been determined for the married market women living in Paikon Kore. It is on this premise that this study will examine the factors affecting the utilization of family planning services by married market women in Paikon Kore Gwagwalada, FCT Abuja. It was also stated that with the alarming increase in population growth (child birth) and the rising prevalence of health related cases such as abortion, child birth mortality, maternal mortality, child birth complications hypertension, (Lasisi, Bassey, Ita & Awoyemi, 2014). This study investigated on the factors affecting the utilization of the family planning facilities among the married women at paikon kore market, Gwagwalada, FCT Abuja. The study area is Paikon Kore Gwagwalada, FCT Abuja to study the factors affecting the utilization of family planning service.

1.3 Objective of the Study

The main objective of this study is to assess the factors affecting the utilization of family planning services by married women at Paikon Kore market, Gwagwalada, FCT Abuja. The specific objectives are to:

1. Determine the level of knowledge of married market women on family planning;

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2. Ascertain the level of motivation of married market women towards the utilization of family planning services and

3. Determine the level of self-efficacy of married market women on the utilization of family planning services.

4. Describe the proportion of married market women using family planning services

1.4 Research Questions

1. What is the level of knowledge of the married market women towards the utilization of family planning services?
2. What is the level of the market women motivation towards the utilization of family planning services?
3. What is the level of the market women self-efficacy towards the utilization of family planning services?
4. What proportion of the market women are using family planning services?

1.5 Hypotheses

H_1: There is a significant association between the utilization of family planning and the knowledge of family planning services by the married market women of paikon kore.

H_1: There is a significant association between the utilization of family planning services and the motivation of the married market women in Paikon Kore Gwagwalada, FCT Abuja.

H_1: There is a significant association between the utilization of family planning services and the self-efficacy of married market women in Paikon Kore Gwagwalada, FCT Abuja.

1.6 Justification for the Study

Population growth in Nigeria continues to increase at an alarming rate. Currently the population growth rate is estimated to be 2.6% (National Population Commission 2014). Which still remain the highest as per the government target. This is an indicator that utilization of family planning services is low and needs to be addressed with great attention to avert the situation.

Government and other agencies have come up with various strategies and policies but these have fallen short of achieving the intended objectives. This can be attributed to these policies and

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strategies failing to focus on essential and key determinants and how to address these hindering factors associated with non-use of family planning services among women of reproductive age.

Results obtained from this study would therefore enable policy makers, programme designers and other interested stakeholders to come up with interventions that are result oriented hence improving accessibility and utilization of family planning services, reducing maternal and infant mortality rate, improving maternal health and controlling population growth for economic development Lasisi *et al* (2014).

1.7 Scope of the Study

The study is confined to the married market women of Paikon Kore Gwagwalada, FCT Abuja. The study is delimited to determining the factors affecting the Utilization of family planning services.

1.8 Significance of the Study

This study was significant in the following ways:

1. The findings of this study would provide vital information on the awareness and utilization of Contraceptives in Paikon Kore community thus contributing to the existing body of knowledge.
2. The findings of this study would be beneficial to married women of reproductive age, to understand the importance and significant of utilization of contraceptives
3. The findings of this study would be beneficial to public health workers in the area, to know what is at stake and adopt strategies that would be beneficial to the public.
4. The findings of this study would help couples reach their reproductive intentions, thereby improving an array of social and economic outcomes on a population level.
5. Finally the findings of this study would enable policy makers, programme designers and other interested stakeholders to come up with interventions that are results oriented hence improving accessibility and utilization of family planning services, reducing maternal and infant mortality rate, improving maternal health and controlling population growth for economic development.

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Operational Definition of Terms

The following terms defined was used in this study:

1. **Contraceptive:** A device, drug, foam, etc that is used with the intention to prevent conception or pregnancy
2. **Family planning:** The ability of individuals and couples to attain their desired number of children and plan the spacing and timing of their births through use of contraceptive methods.
3. **Family planning services**: Educational, comprehensive medical or social activities which enable individuals, including minors, to determine freely the number and spacing of their children and to select the means by which this may be achieve
4. **Utilization:** To put to use, turn to profitable account
5. **Perception**: Conscious understanding of something.

CHAPTER TWO
REVIEW OF LITERATURE

This chapter discussed on Conceptual review, theoretical review, empirical review and gap in Literature. Text books, journals, and internets were used to review this study. Family planning, both men and women practice this method to prevent pregnancy, and, when practiced correctly, it is up to 99.9% birth control effective (Worku, 2008). Though, the methods does not protect against sexually transmitted diseases, including HIV (the virus that causes AIDS). The latex male condom provides the best protection from most STDs (WHO, 2014).

2.1 Conceptual Review

2.1.1 The Concept of Family Planning

Family planning is defined as the ability of individuals and couples to attain their desired number of children and plan the spacing and timing of their births through use of contraceptive methods (WHO, 2014). Family planning simply means preventing unwanted pregnancies by safe methods of prevention. This is considered to be part of the basic human rights of all individuals or couples as it was endorsed by the International Conference on Population and Development in Cairo in 1994 (Worku, 2008). Over the last 30 years, as women in the developing world have

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increasingly desired smaller families, contraceptive use has risen and child birth rates have fallen. In spite of these, demographic surveys indicate that the actual family size in most developing countries remains greater than the desired family size. This gap between the real and the ideal persists even in Sub-Saharan Africa, which still retains a preference for larger families and has the highest fertility rates in the world (Barot, 2008).

2.1.2 Family Planning Services

Family planning services are defined as educational, comprehensive medical or social activities which enable individuals, including minors, to determine freely the number and spacing of their children and to select the means by which this may be achieved (Cooper, 2012). It provides benefits of good health and wellbeing of women and families throughout the world. This keeps the prospective parents healthy and without a child until a time of their choice. Family planning also includes teaching teens and children about sexuality and reproduction to keep them from having children before they are ready and providing contraception (Worku, 2008).

2.1.3 Contraception and Fertility Control

Contraception and fertility control or birth control is a method or device used to prevent pregnancy. Birth control has been used since ancient times, but effective and safe methods of birth control only became available in the 20th century (Cooper, 2012). Planning, making available and using birth control is called family planning. Some cultures limit or discourage access to birth control because they consider it to be morally, religiously, or politically undesirable. The most effective methods of birth control are sterilization by means of vasectomy in males and tubal ligation in females, intrauterine devices (IUDs), and implantable birth control. This is followed by a number of hormone based methods including oral pills, patches, vaginal rings, and injections. Less effective methods include physical barriers such as condoms, diaphragms and birth control sponges and fertility awareness methods. The least effective methods are spermicides and withdrawal by the male before ejaculation. Sterilization, while highly effective, is not usually reversible; all other methods are reversible, most immediately upon stopping them (WHO, 2014). It was also stated that safe sex practices, such as with the use of male or female condoms, can also help prevent sexually transmitted infections. Other methods of birth control do not protect against sexually transmitted diseases. Emergency birth control can prevent pregnancy if taken within the 72 to 120 hours after unprotected sex. It was also stated

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that some argue not having sex as a form of birth control, but abstinence-only sex education may increase teenage pregnancies if offered without birth control education, due to non-compliance (Worku 2008).

About 222 million women who want to avoid pregnancy in developing countries are not using a modern birth control method (Cooper 2012). Birth control use in developing countries has decreased the number of deaths during or around the time of pregnancy by 40% (about 270,000 deaths prevented in 2008) and could prevent 70% if the full demand for birth control were met. By lengthening the time between pregnancies, birth control can improve adult women's delivery outcomes and the survival of their children. In the developing world women's earnings, assets, weight, and their children's schooling and health all improve with greater access to birth control. It was also stated that birth control increases economic growth because of fewer dependent children, more women participating in the workforce, and less use of scarce resources.

2.1.4 Contraceptive Methods

Gribble (2012) identified methods of contraceptives which include barrier methods, hormonal birth control, intrauterine devices (IUDs), sterilization, and behavioural methods. They are used before or during sex while emergency contraceptives are effective for up to a few days after sex. Effectiveness is generally expressed as the percentage of women who become pregnant using a given method during the first year and sometimes as a lifetime failure rate among methods with high effectiveness, such as tubal ligation. It was also stated that the most effective methods are those that are long acting and do not require ongoing health care visits. Surgical sterilization, implantable hormones, and intrauterine devices all have first-year failure rates of less than 1% (Gribble, 2012). Hormonal contraceptive pills, patches or vaginal rings, and the lactational amenorrhea method (LAM), if used strictly, can also have first-year (or for LAM, first-6-month) failure rates of less than 1%. With typical use first-year failure rates are considerably high, at 9%, due to incorrect usage. Other methods such as condoms, diaphragms, and spermicides have higher first-year failure rates even with perfect usage. The American Academy of Pediatrics recommends long acting reversible birth control as first line for young people.

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While all methods of birth control have some potential adverse effects, the risk is less than that of pregnancy. After stopping or removing many methods of birth control, including oral contraceptives, IUDs, implants and injections, the rate of pregnancy during the subsequent year is the same as for those who used no birth control (Cooper 2012).

In those with specific health problems, certain forms of birth control may require further investigations. For women who are otherwise healthy, many methods of birth control should not require a medical exam—including birth control pills, injectable or implantable birth control, and condoms. Specifically, a pelvic exam, breast exam, or blood test before starting birth control pills do not appear to affect outcomes and, therefore, are not required. In 2009, the World Health Organization (WHO) published a detailed list of medical eligibility criteria for each type of birth control.

Approximately 38% of the 210 million pregnancies that occur throughout the world each year are unintended, a figure that is appallingly high (Sedgh, 2014). This is a serious problem, as unintended pregnancies often have significant long-term negative health consequences for both mother and child. Upon discovering they are pregnant, women have three options: continuing the pregnancy, abortion, or alternative care-arrangements (e.g., adoption). Of all the unintended pregnancies worldwide, an estimated 50% end in abortion (Sedgh, 2014). While abortions in legal, sanitary spaces are generally safe, they can still cause lasting emotional and physical strain such as depression, risk of subsequent preterm delivery (Thorp, Hartmann, & Shadigan, 2003). What is even more concerning is that half of all abortions are performed illegally; these operations pose a definitive threat to maternal survival (Sedgh, 2014).

One proposed method of addressing the issue of unintended pregnancy is through contraception (Klima, 1998). Contraception, also referred to as birth control, is an umbrella term used to describe methods or devices designed to prevent pregnancy. There are many different methods of contraception available today, and many of them are safe and effective if used properly. Given the large range of contraceptive methods and devices it is surprising that rates of unintended pregnancies remain high. The numbers become less surprising when viewed alongside the information that 26% of women in the world have an unmet need for contraception, a percentage that rises to 73% in developing countries (Singh, 2012). A multitude

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of factors contribute to these unmet needs: high cost, lack of access, fear of side effects, and inadequate knowledge about methods (Dixon et al., 2014). In order to make headway with against unintended pregnancy, these barriers must be addressed. It is of critical importance that women receive reproductive health care and services. Close to 800 women die every day from preventable causes related to pregnancy and childbirth (World Health Organization [WHO], 2014). While the global maternal mortality rate is half of what it was in 1990, this number remains unacceptably high. In order to reduce maternal mortality and improve overall health, women need continuing and improved access to reproductive health care (WHO, 2014). At this point, however, it is not enough to continue to address the reproductive needs of only women.

Even if access to contraceptive methods is improved through the removal of obstacles, the role of men in reproductive health needs to be addressed. Present-day contraceptive developments and family planning programs worldwide overwhelmingly target women (Kalmuss & Tatum, 2007). Both men and women contribute equally to pregnancy, and yet there is a large discrepancy between the number and kinds of contraceptive methods available to men versus those available to women – there are many more options and of greater variety for women than for men. Additionally, most reproductive health services are offered in clinics visited primarily by women, and offer limited services for men (Green et al., 2006). The narrow focus of family planning programs on women has consequently led to the exclusion of males in discussions of reproductive health, relegating men to the role of 'sperm producers' who do not have a say in fertility control (Maharaj, 2000). Even though women are the ones who actually become pregnant, they cannot be held solely responsible for their own reproductive health: men are hugely influential in fertility and contraceptive use decisions (Maharaj, 2000; Gage, 1998).

And yet, despite findings that the involvement of men in reproductive health programs can increase utilization (Greene et al., 2006; Ezeh, 1993), the focus of such interventions and developments remains on women. In order to investigate why, it is necessary to go back to the beginning of modern-day contraceptives.

The first modern contraceptives were barrier methods intended to prevent sperm from passing through a woman's cervix and reaching the uterus. Condoms are the classic example of a barrier method, and remain today one of the only contraceptive devices available to men.

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Diaphragms and cervical caps were among the first barrier methods of birth control available to women. These methods are reasonably effective with perfect use (95% and 75%, respectively), but rely highly on proper user behavior and as such often fail to prevent pregnancy in real world situations (Trussel et al., 2009). Vaginal sponges have also been popularly used to block and absorb sperm, but are similarly ineffective to other barrier methods (80% effective with perfect use, 75% with typical use). Even though barrier methods are not always effective, they are vastly better than not using any device and do help women to control their family sizes (Trussel et al., 2009).

For women, the path to safe, reliable contraception began with a small pill, taken daily. The new pill was the first medical contraceptive available to women, and the first effective non barrier form of birth control. Approved for contraceptive use in 1960, the pill's development and marketing of was arguably one of the most important innovations in reproductive health in the twentieth century (Dhont, 2010). It revolutionized the way the world saw both family planning and women's roles in society (Goldin & Katz, 2000). Ninety-one percent effective with typical use, the pill enabled women to take almost complete control over their own fertility (Trussel, 2011). Indeed, over the years the pill's effectiveness coupled with its ease of use has made it the most popular contraceptive in the United States (Jones, Mosher, & Daniels, 2012). By 2010 four out of every five sexually experienced women in the United States had used the pill at some point. The pill has also influenced the global approach to contraception and reproductive health, paving the way for other non-permanent long-term methods of contraception, such as intrauterine devices (IUDs), the patch, injectibles (e.g., Depo

Provera, injected once every three months), and vaginal rings. As a consequence of the development of the first pill, women today have a large variety of highly effective contraceptive methods open to them.

There has been no such advance in contraceptive methods for men. The only non-behavioral forms of contraception available to men today are condoms and vasectomies, two options that are both flawed. Condoms rely heavily on user behavior and require the interruption of a highly sexually charged moment; additionally, many men and women consider them to be uncomfortable (MacPhail & Campbell, 2001). While male condoms are 98% effective with

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perfect use, probability of failure with typical use is 17% (Kost et al., 2008). Vasectomies, although highly effective (Trussel, 2011), involve an operation that requires surgery and is not recommended for men who might ever want children in the future (Sharlip et al., 2012)4. In short, there is a huge discrepancy between the availability of safe and reliable contraceptive methods available to men versus women.

This disparity is important because, as discussed above, birth control is essential in the fight to reduce unintended pregnancies and their associated consequences. If men are excluded from contraceptive discussion, they cannot contribute helpfully to conversations surrounding reproductive health. A new form of long-acting reversible contraception for men could change the global approach to reproductive health in a similar way that the pill did for women. Such a development would certainly reduce unintended pregnancies, and could inspire an increased inclusion of men in reproductive health programs, services, and policies – which would improve overall reproductive and maternal health (Biddlecom & Fapohunda, 1998). There is promising new contraceptive method for men, not yet on the market, that could provide such a spark.

2.1.5 Men and Contraception

The limited options that men have for contraception, in addition to their current exclusion from reproductive health education and services, means that there has been insufficient research into potential attitudes towards a new form of male contraception. A few studies have, however, attempted to investigate whether men are interested in taking charge of their own fertility. These studies have generally shown that men view new contraceptive developments favorably. Middle and upper class men in the United States have been interested in a new form of male contraception since the 1970s, when 70% of men interviewed in a study said that they would use a newly developed male contraceptive (Keith et al., 1975). The most popular option was a once a month shot or pill, but 19% indicated that they were in favor of an option for a reversible vasectomy. However, it is important to note that all of the men interviewed were over 30 years old and had higher levels of education than the general public (Keith et al., 1975). In fact, an earlier study found that among lower-class married men in the south-east United States, 47% objected to the mere idea of a male pill and 59% objected to vasectomies (Balswick et al., 1972).

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Consistent with these findings, a survey of a wide variety of men – from high school and college students to dentists and physicians –found that men who were either married, highly educated, or both had more favorable attitudes toward developments in long-acting male birth control than their counterparts. Married men tended have more positive attitudes toward a male birth control pill than unmarried men, and education – long thought to create more liberal and egalitarian social attitudes – was associated with more positive attitudes towards birth control (Weinstein &

Goebel, 1979). The above research indicates that while men of high socioeconomic status have viewed new forms of male contraception favorably for decades, it is likely that their social and marital statuses impacted their attitudes.

Although far from conclusive, the research from the 1970s suggests that men, particularly those of education and a certain class, would not be wholly unreceptive to the development and promotion of a new LARC designed for men. Thus, although men today have often been excluded from discussions on fertility, it may be due to a lack of options rather than disinterest on their part. Additionally, a recent cross-cultural survey on attitudes toward male fertility control found that across nine countries and four continents, 55% of men expressed willingness to use a new method of male fertility control6. For the United States alone, the percentage of men willing to try a new contraceptive shrank slightly to 49%. Higher education was again significantly associated with more positive attitudes towards new methods of male contraception (Heinemann et al., 2004)7. The available evidence suggests that more than half of all men would try a new contraceptive; the development of such a method could alter how the world views reproductive health and men's roles in it.

Despite the fact that the aforementioned findings indicate that men would utilize a new contraceptive, there are significant limitations to the research thus far. The majority of the studies on men's attitudes towards contraceptive developments (Weinstein & Goebel, 1979; Balswick et al., 1972; Keith et al., 1975) were published more than 25 years ago. Moreover, the previous research has been predominantly descriptive in nature; the investigations were not based on theoretical models. Consequently, while these studies provide vital data about women attitudes towards and willingness to use new contraceptives, they do not provide useful information regarding psychosocial correlates that could be used to predict those same attitudes

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and intentions. Without theoretical structure based on previous research, it is difficult to try to understand health behavior, let alone predict it.

2.1.6 Benefits of Family Planning

The benefits of family planning have become increasingly recognized worldwide, including improved health, economic, and social outcomes for women and families, as well as public health, economic, and environmental benefits at the population-level. At the individual level, the health benefits for women and infants include the prevention of pregnancy related health risks and deaths in women, reductions in infant mortality and the rate of unsafe abortions, the prevention of the transmission of HIV/AIDS from mother-to-child (PMTCT), and prevention of sexual transmission of HIV and sexually transmitted infections (STI) between partners (WHO, 2014). Family planning also has significant economic benefits for families and for society as a whole. By slowing the growth of a population, women have more earning potential and families are able to devote more resources to each child, resulting in reductions of poverty (Gribble, 2012). Despite the known benefits of family planning, globally more than 120 million women aged 15 to 49 who are married or in a union have an unmet need for family planning (United Nations, 2013).

An unmet need for family planning refers to women capable of reproducing who are not using contraception, but wish to postpone their next birth or to stop childbearing all together. According to WHO (2014), meeting the unmet need for family planning and maternal and newborn health care in sub-Saharan Africa is estimated to result in a 69 percent reduction in maternal deaths and 57 percent drop in newborn deaths. Women in developing nations are disproportionately affected by an unmet need for family planning, with the highest need in sub-Saharan Africa.

2.2 Factors influencing utilization of Family Planning services

2.2.1 Age and Family Planning use

Rob, Baschieri, Steve, Monique and Nyovani (2007), in their study on contextual influences on modern contraceptive use among women in six countries in Sub-Saharan Africa that included Kenya, Malawi, Tanzania, Ivory Coast, Burkina Faso, and Ghana, showed that younger age especially age group (20-29) years was more likely to be associated with use of modern

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contraceptives. For example findings in Tanzania the likelihood of contraceptive in age group (20–29) years was higher [OR=1.88: 95% CI 1.35-2.62] compared to age group (15–19) years [OR=1.47: 95% CI 0.85-2.55] and age group (40–49) years [OR=0.61: 95% CI 0.41 -0.90].

2.2.2 Parity and Family Planning use

Todd, Michelle, Malalay, Pashtoon, Faridullah and Smith (2008) in their study on factors associated with contraceptive use among hospitalized obstetric patients reported that contraceptive use was independently associated with having a greater number of living children.

2.2.3 HIV Seropositivity, Care and Family Planning use

A study to explore the impact of HIV/AIDS on sexual and reproductive lives of women living with HIV in Zimbabwe showed that contraceptive and condom use increased markedly after HIV diagnosis, especially among those attending support groups (Feldman and Maposhere 2003).

2.2.4 Educational level and Family Planning (FP) use

There have been studies showing a strong trend toward declining fertility and increasing utilization of contraceptives among those more educated, middle-class population. Lasisi *et al.* (2014) observed the uptake of modern contraceptive methods was high among women with post-tertiary education.

2.2.5 Culture and family planning use

Individual factors that determine a person's use of services such as Family Planning are mediated by the characteristics of the community in which the individual lives. It is important to look beyond individual factors when examining Family Planning use or non-use. Cultural norms and expectations are varied and include among others; fatalism attributed to HIV disease, fear of infecting the unborn child, gender roles designated by society such as the role of women in child bearing and the demand for bigger families (Lasisi *et al.* 2014).

2.3 Involvement of Men in Family Planning

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Toure (2006) observed that, given the elevated position of men in African society, involving them and obtaining their support and commitment to family planning is of crucial importance in the African region. Khan and Patel (2005) reported that husband-wife communication on contraception and their reproductive goals suggests and egalitarian relationship between husbands and wife. There are several studies, mostly carried out in 60‟s and 70‟s, revealing that couples who talk or discuss among themselves about the number of children they should have or the use of family planning, are more likely to use a contraceptive and achieve their reproductive goals than those who do not.

2.4 Theoretical Framework

The Information Motivation and Behavior (IMB) theoretical framework was developed by Fisher *et al.* The framework has been used and validated extensively.

2.4.1 The Information Motivation and Behavior Model (IBM)

The model posits that utilization of family planning services is a function of individual's information about family planning services, pregnancy related knowledge, attitude and motivation towards sexual activity, and subsequently, the behavioral skills essential to utilize family planning services effectively, while minimizing the negative consequences that may be associated with the refusal. On the basis of this reasoning, using the IMB model, information on how unintended pregnancy and the social economic and psychological consequences of the married market women are prerequisites for informed discussion about family planning utilization (Sales 2006). However, adequate information has not been found to promote family planning utilization. Assessing a person's level of knowledge provides only a partial information on how behavior is influenced (Bazargan 2006). Highly informed individuals may have high or low motivation not to utilize family planning services while highly motivated individuals may or may not be highly informed about the utilization of family planning services. Conceptually, information and motivation are both thought to influence the use of behavior skills, to engage in the utilization of family planning services.

According to the IMB model, behavioral skills refer to the possession of the requisite skills to utilize family planning service. The model further assumes that factors such as perceived costs

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and benefits of risky sexual behaviors may also affect motivation to engage in a given activity. Clearly, in developing an effective intervention, it is vital to determine and fully identify the behavior targeted to change. The IMB model views health behavior modification as a process of providing relevant detailed information while understanding culture practices and norms in order to carefully create an atmosphere conducive to the consideration of an alternative practice. Enhancing the motivation for the modification of behavior and providing culturally acceptable skills that will ultimately lead to promoting alternative behaviors.

In this study, we test a predictive theoretical model using constructs from the IMB model enhanced with key demographic variables of age, gender, and ethnicity.

Developmentally, it is expected that the older married women will utilize family planning services. It is also expected that the married market women with low socio economic status, there would adhere to the utilization of family planning service. It is positioned that information and motivation components of the model as proximal predictors of the non-utilization of family planning services.

2.4.2 Self-Efficacy

The final psychosocial level of the IMB states that in order to enact behavioral change, an individual must believe that he or she is capable of taking action (Glanz, Rimer, & Viswanath, 2008). An individual must believe that engaging in a particular behavior will achieve a desired outcome, and in his or her ability to perform that behavior. The belief in one's own capacity to perform a behavior is referred to as self-efficacy. Self-perception of one's capabilities is often more predictive of behavior change than actual ability to make the change, and as such is a vital component of the IMB.

The connection is generally supported by literature regarding the influence of selfefficacy on contraceptive use. Research into the relationship between self-efficacy and married women contraceptive behavior has found that women with low contraceptive self-efficacy, significantly more than women with high contraceptive self-efficacy, described conflicted feelings regarding sexual activities, which in turn contributed to self-reported ineffective and inconsistent

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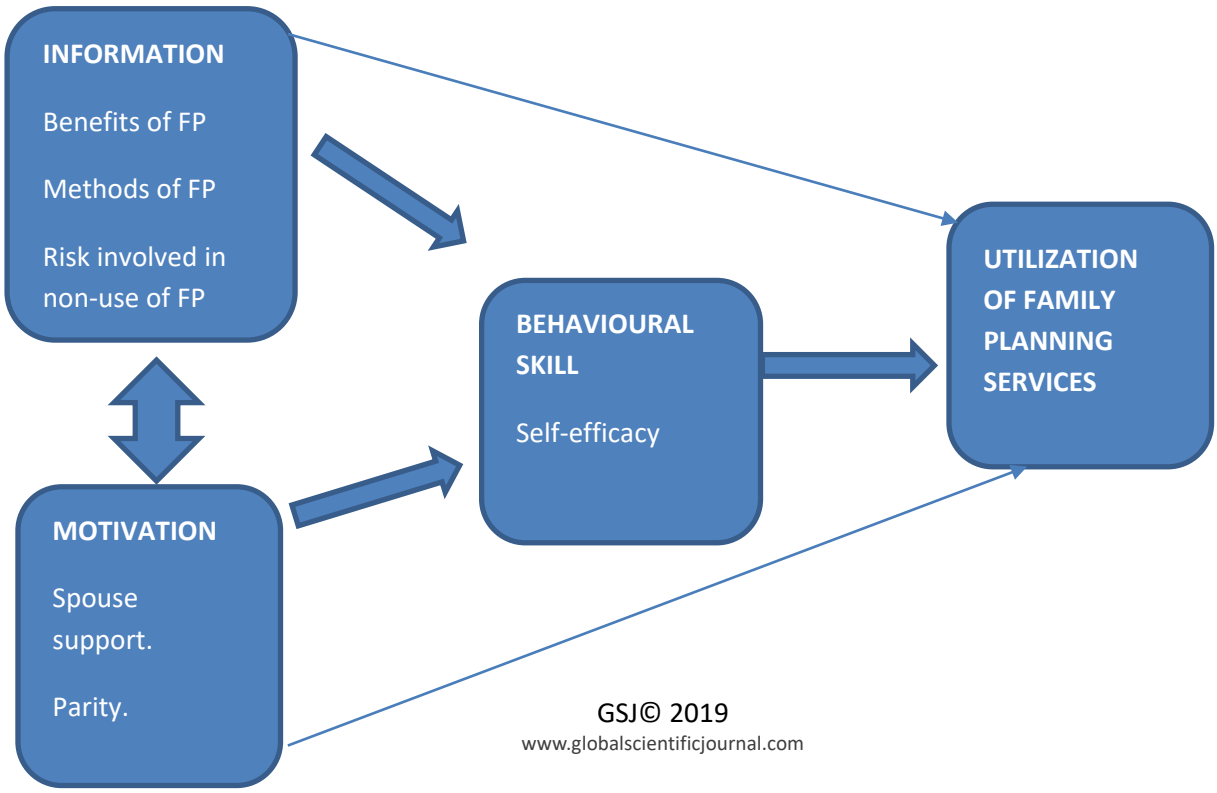
contraceptive use (Strecher et al., 1986). Additionally, contraceptive self-efficacy was found to be a significantly predictive factor for intentions to use condoms in a large sample of male and female college students; students who reported higher contraceptive self-efficacy were more likely to report intent to use condoms in the future (Joffe and Radius 1993). Furthermore, among unmarried, female, and sexually active college students, contraceptive self-efficacy has been found to be significantly associated with effective contraceptive use (Heinrich, 1993). More recently, contraceptive self-efficacy was found to be a significant predictor of positive intent to use condoms in sexually inexperienced adolescents and of reported consistency of condom use in sexually experienced adolescents (Baele, Dusseldorp and Maes 2001).

Longmore et al. (2003) found that adolescents of both sexes who had higher contraceptive self-efficacy were also more likely to use a contraceptive method (condom or other) than to use no method of contraception. Thus, contraceptive self-efficacy was able to effectively predict contraceptive use regardless of method (Longmore et al. 2003). This finding, in conjunction with the extensive research on how contraceptive self-efficacy pertains to condom-use, provides convincing evidence that self-efficacy as a psychological construct can predict contraceptive intentions and use

2.4.3 Conceptual Model



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KEY: Family planning (FP)

Figure 2.1 The information-motivation-behavioral skills model (Fisher and Fisher, 1992)

CHAPTER THREE

METHODOLOGY

This chapter presents the following: research design, area of study, population of this study, sample and sampling technique.

3.1 Research Design

The research design adopted for this study was Cross sectional design. This study involved married market women in Paikon kore Gwagwalada, FCT Abuja. According to Osuala (2005) Cross sectional design gives the accurate assessment of the characteristics of the whole populations of people. It is also more realistic than the experiment in that it investigates phenomena in their natural setting.

3.2 Population

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The population of this study comprised of married market women at Paikon kore market. The research population included married women, at the location and who were willing to participate in the study.

Inclusion criteria are as follows:

1. Married market women
2. Aged between 14-49 years
3. Willingness to participate
4. Informed Consent

Exclusion criteria are as follows:

1. Women that were not available.
2. Married market women who declined to participate.

3.3 Sample size and sampling Technique

The sample size determination for the study was derived from the formula below; (Oluwoye *et al.,* 2016).

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

S = the desired sample size

Z = the standard normal deviate usually set at 1.96 which corresponds to 95% confidence level.

P = prevalence of current use of any family planning services (married women 15-49) in Nigeria = 15% (Nigeria Demographic and Health Survey (NDHS) 2013).

D = degree of accuracy desired, set at 0.05

$$\text{Therefore } S = \frac{1.96^2 (0.15) (1-0.15)}{0.05^2}$$

S = 196

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Sample size was 196 women of reproductive age and 10% will be added to the sample size to take care of attrition, making it 215 respondents

Sampling technique

Multi stage sampling technique was adopted in this study.

i. Stage 1: Simple balloting was employed to select forty three sheds, out of the eighty numbered sheds in the paikon kore market, gwagwalada, Abuja.
ii. Stage 2: Simple random sampling was employed to select five participants among the women under each shed.

3.4 Instrument for Data Collection

Structured instrument was designed and was used to elicit information from the respondents on the topic of study. The items in the instrument were generated from the literatures reviewed based on the objectives set for the study.

3.5 Validity of Instrument

The face and content validity of the questionnaire was carried out by myself with the help of my supervisor. The items were examined in line with purpose, objectives and the hypotheses set for the study. The language used for developing the instrument was also assessed, considering the cultural location of the target participants, necessary modifications were made. Items were rearranged according to the item response group. The final draft of the instrument was submitted to the related field experts who approved it after effecting the due corrections.

3.5.1 Reliability

A pilot test was carried out using 10% of the estimated sample size. Same characteristics as the intended study population i.e married women of reproductive age between 14-49 years at Paikon Kore Market, Gwagwalada, FCT, Abuja. The sample was drawn from kwali market, kwali LGA, Abuja, where the research instrument was randomly administered to 20 market women.

The data gotten was statistically analyzed via Cronbach alpha standard score test for reliability of the data. The reliability of the data was 0.8. Necessary adjustments were made to ensure the instrument is reliable for the assessment of the situation of concern.

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3.5.2Instrument for Data Collection

This study made us of self-administered questionnaires as instrument for data collection. The variables to be studied include:

i. Section A: Demographic data
ii. Section B: Knowledge of family planning
iii. Section C: Motivation of married market women towards family planning services
iv. Section D: Self efficacy of the married market women towards family planning services
v. Section E: Types of family planning methods used

3.6 Ethical Considerations

Permission to conduct the study was obtained from the Babcock University Research Ethics Committee (BUHREC). Informed consent was obtained from all respondents before administering questionnaires to them, only those who agreed to participate were included, and they were given permission to withdraw from the study if need be without any loss of benefit or penalty. Anonymity was assured, confidentiality also assured if participant required assistant in filling the questionnaire. Information obtained was used for the purpose of the research only.

3.7 Data Analysis

Statistical Package for Social Science (SPSS) version 21.0 was used. The data collected was analyzed using descriptive statistics of frequencies and percentages. Correlation analysis was carried out using the data collected to test for relationships between the dependent and independent variables as identified in the research hypothesis.

The result obtained was presented in the appropriate tables, figures and charts easy understanding of the factors affecting the utilization of family planning services among married market women in Paikon Kore Gwagwalada, FCT Abuja.

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CHAPTER FOUR

DATA ANALYSIS, RESULTS AND DISCUSSION OF FINDINGS

4.0 Introduction

This chapter describes the analysis of data, results and discussions of findings. The findings answered the research questions adequately and test hypothesis that guided the study. Each section of the questionnaire will evaluate the stated variables (Knowledge, motivation, self-efficacy and current family planning method). The questionnaire had five sections (A, B, C and D) with a total of 46 questions.

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1. Section A, measured demographic characteristics of the respondents such as Age, religion, ethnic origin, level of education, number of children, monthly income, husbands monthly income.
2. Section B, measured knowledge of family planning with options of Yes and No.
3. Section C, measured Motivation of married market women towards family planning services with options of Strongly Agree, Agree, Neutral, Disagree and Strongly Disagree.
4. Section D, measured self-efficacy of the married market women towards family planning services with options of Strongly Agree, Agree, Neutral, Disagree and Strongly Disagree.
5. Section E, measured types of family planning methods used with options of Yes and No.

The study focused on the factors affecting the utilization of family planning services by married women in Abuja. A total of two hundred and fifteen women were recruited from a market in Paikon -Kore market, Gwagwalada, Abuja. The response rate from the market women was 99.5% (214).

4.1 Data Analysis

Data gotten from the completed questioner was computed and analyzed using Statistical Package for Social Science (SPSS) version 22.0. The variables was computed and scores was allocated according to the rating scale for each variable. Descriptive statistics and correlation was evaluated to test for the research hypothesis.

4.2 Distribution of Socio-Demographic Characteristics

The findings from the study reveal that the age group 26 – 30 years had the highest proportion of women (66; 30.8%) while there were 30 (14.0%) women who were still adolescents among the women (Table 4.1). There were 45 (21.0%) women who reported to have no formal education, 82 (38.3%) women had a secondary school education while only 20 (9.3%) women had a tertiary education. Eighty nine (41.6%) women reported to be affiliated with the Christianity religion while 36.0% were Muslims (Table 4.1).

The ethnic distribution of the market women showed that over half (122; 57.0) were from the Gwarri tribe; 20 (9.3%) women were Igbos and 29 (13.6%) were Yoruba's (Table 4.2). Over half

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of the women reported that they had a monthly income of > N5000 and only 12 women (5.6%) had above N50, 000 (Table 4.2). Over half of the women stated that their husbands had a monthly income of N5000 or less while 20(9.3%) received between N20, 000 and N50, 000 (Table 4.2). A little over half of the women (39.3%) reported to have 2 children while 12.1% had 4 children (Figure 4.1).

4.3 Knowledge of Women on Family Planning

The women's knowledge about family planning was assessed and the responses presented in Table 4.3. Majority of the women (176; 82.2%) reported that family planning helps in limiting the number of children a woman can have and helping in spacing of child birth (180; 84.1%). However, when asked about their awareness of general family planning services, only 54.2% of the women affirmed. About two-thirds of the women (143) reported that family planning may not prevent pregnancies while 163 women had knowledge of condoms' effectiveness in preventing Sexually Transmitted Infections (STIs) (Table 4.3). About a third of the women (67.3%) reported that they knew the nearest places to access family planning services and only 72.4% (155) were aware of the stores to get male condoms from. The items which measured knowledge were computed to an 11-point rating scale. The scale was graded to low and high ratings with a mean (SD) of 6.95(1.87) (Table 4.4). Forty four (20.6%) women have a low level of knowledge while 79.4% (170) had a high level of knowledge (Table 4.4).

Table 4.1: Distribution of socio-demographic characteristics of the respondents: Age, Level of Education and Religion

Items	Frequency	
Age	**N**	**%**
14 – 20	30	14.0
21 – 25	51	23.8
26 – 30	66	30.8
31 – 35	37	17.3
> 35	30	14.0

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Level of Education	45	21.0
None	61	28.5
Primary	82	38.3
Secondary	20	9.3
Tertiary	6	2.8
Post-Tertiary		
Religion		
Christianity	89	41.6
Islam	77	36.0
Traditional	45	21.0
Others	3	1.4

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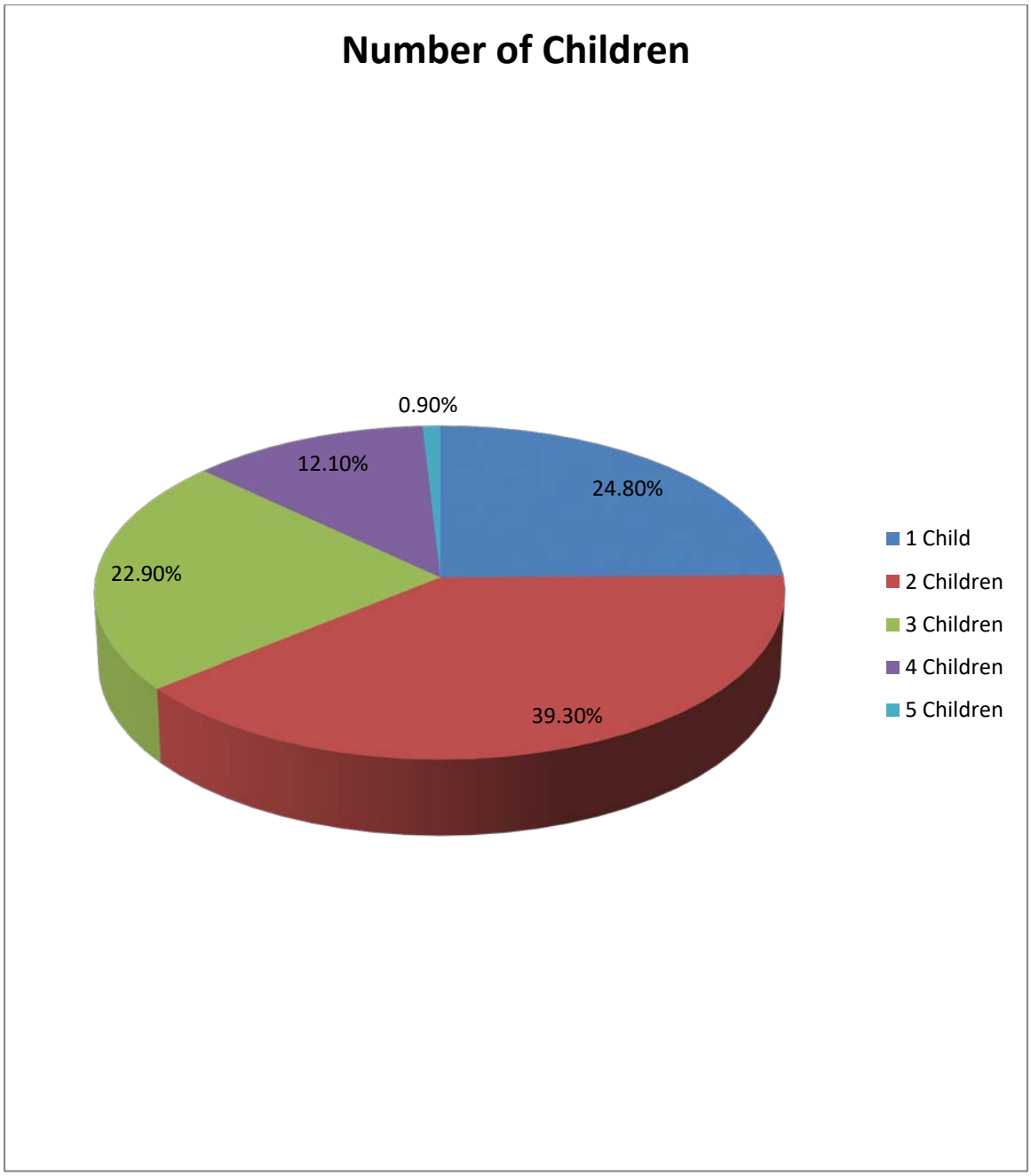

Figure 4.1: Distribution of the Respondents' Number of Children

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Table 4.2: Distribution of socio-demographic characteristics of the respondents: Ethnicity

Items	Frequency	
	N	%
Ethnicity		
Igbo	20	9.3
Hausa	21	9.8
Yoruba	29	13.6
Gwarri	122	57.0
Igala	12	5.6
Tiv	5	2.3
Idoma	5	2.3
Monthly Income		
< 5,000	127	59.3
5,000 – 20, 000	50	23.4
20,000 – 50, 000	25	11.7
> 50, 000	12	5.6
Husband's Monthly Income		
< 5,000	114	53.3
5,000 – 20, 000	64	29.9
20,000 – 50, 000	20	9.3
> 50, 000	16	7.5

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Table 4.3: Knowledge of Women on Family Planning

	Items	Yes	%	No	%
1	Family planning helps me to limit the number of children	176	82.2	38	17.8
2	Family planning helps in spacing of child birth.	180	84.1	34	15.9
3	Family planning services would not prevent unwanted pregnancies	143	66.8	71	33.2
4	Condom use can prevent sexually transmitted infections.	163	76.2	51	23.8
5	Family planning is a means of reducing population.	152	71.0	62	29.0
6	I am not aware of family planning services	116	54.2	98	45.8
7	Contraceptive use could make me infertile for a lifetime	130	60.7	84	39.3
8	I know the nearest places to access family planning services	144	67.3	70	32.7
9	Family planning services are not easily accessible in my area	129	60.3	85	39.7
10	Female condoms are readily available in stores around here	117	54.7	97	45.3
11	Male condoms are readily available in stores around here	155	72.4	59	27.6

Table 4.4: Scale of Knowledge on of Women on Family Planning

Knowledge	N	%	Mean(SD)
Low	44	20.6	6.95(1.87)
High	170	79.4	
Total	**214**	**100**	

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4.4 Motivation to Utilize Family Planning Services

The women agreed that their religion encourages their use of family planning methods. Over a third (76; 35.5%) agreed that family planning can promote promiscuity while 5.6% of the women were indifferent about the statement (Table 4.5). The statement which inquired about the side effects of family planning methods such as women looking sick had a combination of 125 women agreeing to that. The proportion of women who strongly agreed that their cultural norms do not support the use of family planning was 22.4% (48) and 44.9% (96) respectively. Regarding the cost of procuring the family planning services, 36 (16.8%) women strongly agreed that family planning is not affordable to them while 31.8% of the women agreed. Seventy seven women reported that their husbands did not approve of a use of family planning method.

The motivation of women to use family planning methods was computed on a 40-point rating scale with a mean (SD) of 17.35(6.076). Most of the women (72.4%; 155) had a low level of motivation to use family planning methods (Table 4.6).

4.5 Self-Efficacy to Utilize Family Planning

The women's self-efficacy to use family planning was assessed using a 9-item likert scale. Eighty six women (40.2%) agreed that they were confident in discuss family planning with their husbands while 25.7% of the women strongly agreed. About a third of the sample of market women reported that they could confidently use a female condom while 21.5% disagreed. Only 21.5% of the women reported confidently that they could access family planning services while 24.3% of the women disagreed. The proportion of women who strongly agreed to being able to advice friends and family on the utilization of family planning was 24.8% (53) and only 24 women (11.2%) strongly disagreed to being able to do this. Eighty women (37.4%) reported that they were not afraid to approach health workers to discuss family planning while 19.6% (42) of the women strongly disagreed. About the negotiation of family planning with spouses, 20.6% (44) of the women strongly agreed that they could while 13.6% (29) disagreed (Table 4.7).

The items which sought information of the self-efficacy of women to use family planning methods were computed on a 36-point rating scale. The mean (SD) of the women's self-efficacy was 20.40(6.328). About half of the women reported to have moderate level of self-efficacy 120 (56.1%), while 66 (30.8%) women had a high level (Table 4.8).

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Table 4.5: Distribution of Women's Motivation for Family Planning Utilization

	Items	SA	A	N	D	SD
1	My religion encourages me to use family planning services.	50(23.4)	101(47.2)	8(3.7)	24(11.2)	31(14.5)
2	I believe that family planning can promote promiscuity.	76(35..5)	76(35.5)	12(5.6)	31(14.5)	19(8.9)
3	I feel that family planning usage could make me look sick.	45(21.0)	80(37.4)	5(2.3)	49(22.9)	35(16.4)
4	Contraceptives usage makes me look sickly and weak	36(16.8)	91(42.5)	13(6.1)	45(21.0)	29(13.6)
5	My village norms and culture do not support the use of family planning services.	48(22.4)	96(44.9)	18(8.4)	38(17.8)	14(6.5)
6	Family planning is not accepted in my marital life setting.	40(18.7)	61(28.5)	28(13.1)	55(25.7)	30(14.0)
7	Family planning is costly to do, I cannot afford it	36(16.8)	68(31.8)	30(14.0)	52(24.3)	28(13.1)
8	Family planning is not easily accessible in my locality	38(17.8)	82(38.3)	22(10.3)	44(20.6)	28(13.1)
9	Contraceptives is not easily accessible in my locality	39(18.2)	92(43.0)	19(8.9)	42(19.6)	22(10.3)
10	My husband does not approve my usage of F.P	48(22.4)	77(36.0)	26(12.1)	39(18.2)	24(11.2)

Table 4.6: Motivation of Women to Family Planning Utilization

Motivation	N	%	Mean(SD)
Low	155	72.4	17.35(6.076)
High	59	27.6	
Total	214	100	

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Table 4.7: Distribution of Women's Self-Efficacy to Utilize Family Planning Methods

S/N	Items	SA	A	N	D	SD
1	I will be confident to discuss family planning with my husband	55(25.7)	86(40.2)	11(5.1)	34(15.9)	28(13.1)
2	I am confident I can use the female condom without assistance.	28(13.1)	70(32.7)	24(11.2)	46(21.5)	46(21.5)
3	I can help my husband apply his condom	36(16.8)	82(38.3)	12(5.6)	50(23.4)	34(15.9)
4	I can access where to obtain family planning services	46(21.5)	77(36.0)	19(8.9)	52(24.3)	20(9.3)
5	I can advise my friends and family about family planning	53(24.8)	80(37.4)	9(4.2)	48(22.4)	24(11.2)
6	I can become sterile after adopting any family planning method	56(26.2)	71(33.2)	10(4.7)	42(19.6)	35(16.4)
7	I am not afraid to approach health providers in the clinics to discuss family planning.	60(28.0)	80(37.4)	10(4.7)	22(10.3)	42(19.6)
8	I am confident I can discuss family planning with my friends	55(25.7)	88(41.1)	25(11.7)	23(10.7)	23(10.7)
9	I am confident about negotiating condom use with my husband	44(20.6)	88(41.1)	12(5.6)	29(13.6)	41(19.2)

Table 4.8: Self-Efficacy of Women on Utilization of Family Planning

Self-efficacy	N	%	Mean(SD)
Low	28	13.1	20.40(6.328)
Moderate	120	56.1	
High	66	30.8	
Total	214	100	

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4.6: Utilization of Family Planning Services

During the study, less than half of the market women stated that they used a family planning method. Over half of them (53.7%) used oral contraceptives. 43% (92) used condoms, 71 women (33.2%) used injectable while 30.4% reported to use implants (Table 4.9).

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Table 4.9: Respondents' distribution on family planning utilization

S/N	Items	Yes	%	No	%
1	Do you use any form of family planning method?	144	67.3	70	32.7
2	Do you use Oral contraceptive Pills?	115	53.7	99	46.3
3	Do you use Intra uterine device (IUD)?	58	27.1	156	72.9
4	Do you use Condom?	92	43.0	122	57.0
5	Do you use Injectables?	71	33.2	143	66.8
6	Do you use Spermicides?	29	13.6	185	86.4
7	Do you use Implants?	65	30.4	149	69.6
8	Ever done tubal ligation?	33	15.4	181	84.6

Table 4.10: Summary of Descriptive Statistics

Variables	N	Points	Mean	SD
Knowledge	214	11	6.95	1.867
Motivation	214	40	17.35	6.076
Self-Efficacy	214	36	20..40	6.328

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4.7 Test of Hypothesis

4.7.1 Research Hypothesis 1: There is a significant association between the utilization of family planning and the knowledge of family planning services by the married market women of Paikon Kore.

The relationship between the women's level of knowledge and the utilization of family planning services was assessed using the correlation analysis. There was a negative correlation ($r = -0.189$, $p = 0.005$) between level of knowledge and the utilization of family planning services (Table 4.11). This indicates that there is an inverse relationship between the level of knowledge and the utilization of family planning services. As the knowledge of the women increases, there level of utilization decreases. However, this correlation was statistically significant.

4.7.2: Research Hypothesis 2: There is a significant association between the utilization of family planning services and the motivation of the married market women in Paikon Kore Gwagwalada, FCT Abuja.

The relationship between the level of motivation and the utilization of family planning services was assessed and a Pearson Product correlation value of ($r = -0.185$, $p = 0.007$) was generated. This shows that there was a negative correlation between the two variables (Table 4.11). The higher the motivation of the women is, the lower the utilization of the services. This inverse relation however is statistically significant.

4.7.3 Research Hypothesis 3: There is a significant association between the utilization of family planning services and the self-efficacy of married market women in Paikon Kore Gwagwalada, FCT Abuja.

The bivariate relationship between self-efficacy of women and the utilization of family planning services was tested using a Pearson correlation analysis. The result shows that the correlation was negative indicating the inverse relationship($r = -0.131$, $p = 0.055$). The relationship was not statistically significant (Table 4.11).

4.7.4: Research hypothesis 4: There is a significant relationship between the socio-demographic characteristics (number of children, level of education and monthly income) of market women in Paikon Kore Gwagwalada and the utilization of family planning services.

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The selected socio-demographic characteristics – monthly income, level of education and number of children were tested to determine the association with the market women's utilization of family planning services. The results show that monthly income had a positive relationship (r = 0.106, p = 0.123) with the utilization of family planning services (Table 4.12). The correlation however was not statistically significant. Level of education also was reported to have a correlation with utilization of family planning services (r = -0.153, p = 0.002). The relationship was significant at (Table 4.12). The market women's monthly income also had a correlation (r = 0.104, p =0.526) with utilization of family planning services but the relationship was not statistically significant (Table 4.12).

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Table 4.11: Relationship between Knowledge, Motivation and Self-efficacy with the Utilization of Family Planning Services

S/N	Variable	Df	R	p-value
1	Knowledge	214	-0.189	0.005*
2	Motivation	214	-0.185	0.007*
3	Self-Efficacy	214	-0.131	0.055

*significant at $p<0.05$

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Table 4.12: Relationship between Selected Socio-Demographic characteristics (Number of Children, Monthly income and Level of Education) and the Utilization of Family Planning Services

Variables	FP Utilization		Total	χ^2	p-value
	Yes	No			
1. **Monthly income**					
< 5,000	93	34	**127**	0.106	0.123
5,000 – 20,000	26	24	**50**		
20,000 – 50,000	19	6	**25**		
> 50,000	6	6	**12**		
Total	**144**	**70**	**214**		
2. **Level of Education**					
Uneducated	24	21	**25**	-0.153	0.002*
Primary	39	22	**47**		
Secondary	61	21	**102**		
Tertiary	18	2	**195**		
Post-Tertiary	2	4	**31**		
Total	**144**	**70**	**214**		
3. **Number of Children**					
1	35	18	**53**	0.104	0.526
2	61	23	**84**		
3	29	20	**49**		
4	19	7	**26**		
5	0	2	**2**		
Total	**144**	**70**	**214**		

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4.8 Discussion of Findings

This study explored the factors influencing the uptake of family planning services. The level of knowledge, motivation and self-efficacy were the factors accessed based on the Information, Motivation and Behavioral Skills Model.

Among the 214 women included in this study, 45 had no formal education and the most represented age group was 26 – 30 years. The findings of the study show that a little over a third of the women to have only two children. This proportion had the highest frequency for the number of children the women had. Fertility rate around the world have drastically dropped from five children per woman in the early 1950s to 2.5 children per woman. This success is largely due to growing uptake and compliance with modern contraceptives, especially in the developed world.

The level of knowledge of women on family planning was good with most of the women reporting to have information about family planning. A high level of knowledge was also reported from findings in a study conducted by Sultan, Ali, Bardai, Kanpurwala, Punjwani (2018). Majority of the women stated that they knew one of the major benefits of family planning which is helping women to limit their number of children.

The findings of this study showed that there was no correlation between the uptake of family planning and the women's number of children. A study in Zambia conducted by Imasiku, Odimegwu, Adedini, & Ononokpono (2014) showed findings that there was a negative correlation between number of previous children or pregnancies and the women's unmet need for family planning. This indicates that as the number of children of the woman increases, so does her unmet need reduce. This shows that the more children she has, the higher her exposure to family planning is. This could be due to the quality of information she receives from the health facility during her pre-natal visits. Also, the multiparous women would be older unlike their counterparts who have 3 or less children. The women with more children could have less frequent sexual activities and this could influence their interest to use contraceptives. The findings of a study conducted by Ijarotimi *et al.,* (2013) show that women of low parity used more contraceptives in Osun State compared to the older women.

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Findings showed that two-third of the women currently used a family planning method. In comparison with a study carried out by Nasir, Tahir, Zaidi (2010), the level of the utilization of a family planning method among the women is lower than that of this current study. The most commonly used method was the condom, followed by the implants. The use of modern contraceptives such as implants and injectables is an encouraging finding. The choice of contraceptive could easily be due to cost variations of the options available to the women, religious belief and misinformation. This is similar to the study conducted by Imasiku, Odimegwu, Adedini, & Ononokpono (2014).

The level of motivation of the women to use family planning was low. The women reported some misconceptions which could have generated from lack of adequate information about family planning. There were over a third of the women who strongly believed that using a contraceptive would make them promiscuous.

The level of education had a negative correlation with the utilization of family planning services. The result indicates that the higher the level of education, the lower the women's utilization will be. The finding is in contrast to the results from a study carried out by Miller (2009) in which the level of education increased the women's autonomy and financial decision. Also, they women could have better to information which will reinforce their uptake of family planning.

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CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Summary

Family planning is an essential tool in the efforts to control births, space children and reducing maternal mortality. The goal of reproductive health for women is to improve access to health care, reduce costs of services and ultimately achieve health status for women. The result of this study revealed the factors affecting the utilization of family planning services among the participants. The Motivation and Self efficacy of the women was quite inadequate.

5.2 Conclusion

This study revealed that the women had a high levels of knowledge on family planning services. Majority of the women reported to have the knowledge that family planning helps limiting the number of children a woman can have and helping in spacing of child birth. The level of motivation of women to use family planning methods was low. The level of self-efficacy of women to use family planning methods was low. About half of the women reported to have moderate level of self-efficacy.

5.3 Recommendations

Based on the findings from this study, the following recommendations are hereby made

1. Effective family planning counseling especially for women of lower levels of education should focus on the benefits of modern contraceptives. More attention should be drawn to the modern contraceptives and birth spacing services. In addition, the women should have adequate information on the possible side effects.
2. More surveys should be carried out with larger populations to evaluate the barriers to uptake and perception about the different perceptions and attitudes of this population.
3. Health care providers' should intensify efforts to demystify the wrong information women have especially regarding modern contraceptives.
4. The provision and delivery of family planning services for all women should be a priority to the achievement of this goal, hence, efforts should be focused on massive promotion of facilities through which family planning services could be easily accessible

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5. Programs can be organized to involve men in the sensitization of community members on family planning.
6. The media would be an important tool in the dissemination of information because of the increase in use of the internet.

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Appendix I

Informed Consent Form

Please read this document properly before you decide to participate in the study.

My name is Egbunu Victor Ocheje, from the Department of Public Health, Babcock University, Ilishan-Remo, Ogun state. The title of my dissertation is factors affecting the utilization of family planning services by married women at Paikon Kore, Gwagwalada, FCT, Abuja.

The purpose of this study is to determine the factors affecting the utilization of family planning services by married market women in Paikon Kore Gwagwalada, FCT Abuja.

What you will be expected to do, as a participant in the study, is to provide responses about the factors affecting the utilization of family planning services by married market women in Paikon Kore Gwagwalada, FCT Abuja. You will be expected to fill an instrument by responding appropriately to the questions that will be asked.

Be informed that the time you will spend for participating in this study will be about 20minutes.

There is no risk in participating in the study. The findings of this study will provide vital information on the knowledge and utilization of Contraceptives in Paikon Kore community thus contributing to the existing body of knowledge.

Please note that your identity will be kept confidential, any information you give will be assigned a code number which will be kept confidential. Your participation in the study is completely voluntary.

Please note that there is no conflict of interest in the study.

If you have any question about the study, please feel free to contact:

Name: EGBUNU VICTOR O. Department: PUBLIC HEALTH.

Phone Number: 09078675801 Email Address: iduvic91@gmail.com

If you wish to participate in this study, please sign in the space provided below. Your signature will indicate willingness to participate.

Signature _____

Date _____

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Appendix II

Questionnaire On Factors Affecting The Utilization Of Family Planning Services By Married Market Women At Paikon Kore Market, Gwagwalada, FCT Abuja.

Instruction: please read the question carefully and answer them sincerely

Section A: Socio-demographic characteristics

Kindly fill or mark ( ) the following statements appropriately.

1. Age in years (a) 14-19 ( ) (b) 20-25 ( ) (c) 26-31 ( ) (d) 32-37 ( ) (e) 38 and above
2. Highest level of education attained: (a) None ( ) (b) Primary ( ) (c) Secondary ( ) (d) Tertiary ( ) (e) Post tertiary ( ).
3. Religion: (a) Christianity ( ) (b) Islam ( ) (c) Traditional ( ) (d) Other *(Specify)*……...
4. Tribe: (a) Igbo ( ) (b) Hausa ( ) (c) Yoruba ( ) (d) Gwarri ( ) (e) Igala ( ) (f) Tiv ( ) (g) Idoma ( ) (h) Other *(*Specify _____
5. Number of Children: (a) 1-2 ( ) (b) 3-4 ( ) (c) 5-6 ( ) (d) 7 and above ( )
6. Monthly income: (a) less than 5,000 (b) 5,000 – 20,000 (c) 20,000 – 50,000 (d) 50,000 and above.
7. Husbands monthly income (a) less than 5,000 (b) 5,000 – 20,000 (c) 20,000 – 50,000 (d) 50,000 and above.

Section B: Knowledge

In this section, with the use of a biro pen, which one of the following statements apply to Family planning; choose Yes or No for each of the listed question, by ticking ( )

8.	Family planning helps me to limit the number of children	Yes ( )	No ( )
9.	Family planning helps in spacing of child birth.	Yes ( )	No ( )
10.	Family planning services would not prevent unwanted pregnancies.	Yes ( )	No ( )
11.	Condom use can prevent sexually transmitted infections.	Yes ( )	No ( )
12.	Family planning is a means of reducing population.	Yes ( )	No ( )

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13.	I am not aware of family planning services.	Yes ( )	No ( )
14.	Contraceptive use could make me infertile for a lifetime	Yes ( )	No ( )
15.	I know the nearest places to access family planning services.	Yes ( )	No ( )
16.	Family planning services are not easily accessible in my area	Yes ( )	No ( )
17.	Female condoms are readily available in stores around here	Yes ( )	No ( )
18.	Male condoms are readily available in stores around here.	Yes ( )	No ( )

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Section C: Motivation						
With the use of a biro pen, Kindly tick (X) in the appropriate column to indicate **SA**= Strongly Agree; **A**= Agree; **N**= Neutral; **D**=Disagree; and **SD**= Strongly Disagree						
	Statements	**SA**	**A**	**N**	**D**	**SD**
19	My religion encourages me to use family planning services.					
20	I believe that family planning can promote promiscuity.					
21	I feel that family planning usage could make me look sick.					
22	Contraceptives usage makes me look sickly and weak					
23	My village norms and culture do not support the use of family planning services.					
24	Family planning is not accepted in my marital life setting.					
25	Family planning is costly to do, I cannot afford it					
26	Family planning is not easily accessible in my locality					
27	Contraceptives is not easily accessible in my locality					
28	My husband does not approve my usage of F.P					

Section D: Self-efficacy						
With the use of a biro pen, Kindly tick (X) in the appropriate column to indicate **SA**= Strongly Agree; **A**= Agree; **N**= Neutral; **D**=Disagree; and **SD**= Strongly Disagree						
	Statements	**SA**	**A**	**N**	**D**	**SD**
29	I will be confident to discuss family planning with my husband					
30	I am confident I can use the female condom without assistance.					
31	I can help my husband apply his condom					
32	I can access where to obtain family planning services					

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33	I can advice my friends and family about family planning					
34	I can become sterile after adopting any family planning method					
35	I am not afraid to approach health providers in the clinics to discuss family planning.					
36	I am confident I can discuss family planning with my friends					
37	I am confident about negotiating condom use with my husband					

Section E: Current use of Family planning methods.

In this section, with the use of a biro pen, which one of the following statements apply to Family planning; choose Yes or No for each of the listed question, by ticking ( )

Family planning methods		**Yes**	**No**
38.	Do you use any form of family planning method?	Yes ( )	No ( )
39.	Do you use Oral contraceptive Pills?	Yes ( )	No ( )
40.	Do you use Intra uterine device (IUD)?	Yes ( )	No ( )
41.	Do you use Condom?	Yes ( )	No ( )
42.	Do you use Injectables?	Yes ( )	No ( )
43.	Do you use Spermicides?	Yes ( )	No ( )
44.	Do you use Implants?	Yes ( )	No ( )
45.	Do you use tubal ligation?	Yes ( )	No ( )

46. Others (Specify) _____