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Socio-Demographic Characteristics and Acceptance of Family Planning Methods among Married Persons in Ebonyi State, Nigeria

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Abstract

Family planning acceptance remains a global health challenge especially in Sub-Saharan Africa where culture, religion, lack of knowledge and ignorance determine FPMs acceptance. The study investigated the differences in levels of acceptance of family planning methods among married persons in Abakaliki Education Zone of Ebonyi State by socio-demographic variables of education, gender, religion and location. Multi-stage sampling procedure was used to select four Local Government Areas from Abakaliki education zone (2 urban, 2 rural) and 1,098 married persons for the study. Data were collected using a structured questionnaire titled Acceptance of Family Planning Methods Questionnaire (AFPMQ). The instrument was subjected to face validity. The reliability score of the instrument was 0.75 using Cronbach alpha. Data were collated and analyzed using mean and standard deviation, criterion mean score of 2.50. Inferential statistics of t-test and Analysis of Variance (ANOVA) statistics were used to test the hypotheses at alpha level of 0.05. The results of the study showed that there was low level of acceptance of all family planning methods (Mean values < 2.50). Results also showed that level of acceptance of family planning methods differed significantly among married persons by education, gender, religion and location ($p < 0.05$). The study concluded that acceptance of FPMs among married person in Abakaliki Education Zone was generally and recommended, that family planning programme designs must incorporate all shades of belief, values and convictions in program planning and that government at all levels should partner with religious organizations and traditional rulers to help create more awareness of FPMs through intensive health education, as this will help to increase the level of acceptance of FPMs

Keywords: Family planning methods, acceptance, gender, age, education, location, married persons

1. Introduction

Family planning permits people and married persons to foresee and achieve the size of their family. Large numbers of married persons are ignorant about different methods of family planning and its benefits including side effects respectively. However, common misconceptions and misinformation about side effects of FPMs, is still prevalent among numerous married persons. According to World Health Organization (WHO, 2013), family planning is a responsible, non-mandatory resolution taken by people or married persons pertaining to the number of children in their family, as regards to how and when to have babies. Family planning is accomplished by the implementation of birth control. Married person's capacity as to when and what time to increase the number of children to have a direct effect on the health and welfare the mother, child and the family. Although awareness of family planning by married persons is paramount. Adequate information on FPMs should be given by health educators, letting them know the complications that may follow unplanned pregnancies and the consequences associated with use of these FPMs (WHO, 2013).

The relationship between adequate understanding and use of FPMs is very important because good FPM awareness decreases the fear of misconceptions and increases knowledge of the benefits of FPMs (Trussel, 2011). It also increases the chance of making and informed decision based on knowledge, belief and good conscience.

Acceptance of FPMs by married persons is often limited, due to lack of knowlegde of how modern methods work or the misconception that some methods have consequences for subsequent conceptions. These therefore result in poor acceptance of family planning methods (Prata, 2007). Acceptance is an individual's approval to a circumstance; it is an action of consenting to undertake or receive something that is offered (Abanobi 2005). In this study, acceptance is a conscious process of consenting to use FPMs by married persons, like using a particular type of FPM with your whole heart. It is a straight forward concept yet a difficult attitude. This is why despite the age long development of family planning, it has failed to gain universal acceptance especially among married persons (Sonfield, Hasstedt & Gold, 2014).

Nigeria Demographic Health Survey (2008) noted that reduced acceptance level of FPMs among married persons is the main reason for the rise in fertility and population growth rate. It also leads to high maternal and infant mortality rates, under development and poverty. According to World Population Reference Bureau (WPRB) (2001) Nigeria, presents a very high population which will adversely affect the socio-economic development of the country. For example, from 1960 to 2001 Nigerian population rose from 56 million to 127 million people. This is likely believed to reach 204 million in 2025 (WPRB, 2001). This presents an increase rate of 126.79% and 60.63% for the periods separately. The implication is that Nigeria's populace will continue to record high growth rate with its socio economic consequences, like high level of unemployment, poverty, high maternal mortality, and infant mortality and disease burdens. This observed implication is one of the factors that define the need for this study. Acceptance of family planning helps to reduce about one-third of maternal deaths and 44% of infant deaths. In acceptance of FPM, two years birth intervals are necessary to reduce complications during childbearing, pre-term babies, malnutrition and underweight children (Dorothy, 2010).

There are socio-demographic variables that may influence married person's acceptance of family planning methods, Anca and Anital (2011) suggested some to include location, level of education, gender and religion. The level of FPMs acceptance was observed to be higher in urban areas with 21% than rural areas with 9% (NDHS, 2008). This inclination was generally seen in all current FPMs. People with higher educational attainment tend to accept FPMs better. For instance, contraceptive use increases with educational attainment as was also observed in the 2008 NDHS. Married persons with secondary education had 37%, while those with no formal education had 3%.

Influence of gender was noted in a survey conducted by Audu, Yahya and Bassi, (2006) where gender had a significant role on the choice and acceptance of FPMs. More than half of the male respondents used condoms while less than half of female respondents did not accept any method with the opinion that acceptance would encourage promiscuity. Opinions of religious bodies on family planning differ a lot, but some of these religion have their own peculiar ways of accepting some FPMs. Universally most religion acknowledge the benefits of family planning methods (Isah & Nwobodo, 2009).

There is a relative paucity of information on acceptance of contraceptive methods by married persons in Nigeria especially in the South-East, and there is no recorded research avaliable to the researchers on FPMs acceptance among married persons in Ebonyi state. The present study is therefore designed to fill the identified gaps. Therefore, the study is designed to determine the influence of some selected socio-demographic characteristics (level of education, gender, religion and location) on acceptance of FPMs among married person's in Abakaliki Educational Zone of Ebonyi State. This study will provide evidence to design interventions that will represent preferences defined by belief, knowledge, culture, conscience and convictions which will improve the uptake of FPMs and improve the wellbeing of mothers and their families.

2. Method

This research adopted a descriptive survey design. The sample size for the study was 1098 marries persons selected through a multi-stage sampling procedure which was used to select four Local Government Areas from Abakaliki education zone (2 urban, 2 rural) and 1,098 married persons for the study

The instrument for data collection was a self-structured questionnaire tittled, Acceptance of Family Planning Methods Questionnaire (AFPMQ). The items in the instrument were structured in line with the research questions and also based on the ideas and information obtained from reviewed literature. The instrument consisted of three sections A and B. Section A elicited information on the socio-demographic data of the respondents while Section B sought information on the acceptance of FPMs using a four-point scale of Not Accepted (NA), Partially Accepted (PA), Moderately Accepted (MA), Highly Accepted (HA).

The face validity of the instrument was ascertained through the judgment of five experts in health education and measurement and evaluation. The suggestions of the experts were incorporated in the final draft of the questionnaire. To establish the reliability of the instrument, thirty copies of the questionnaire were administered to respondents from Afikpo Education Zone of Ebonyi State which is not part of the study area. Cronbach Alpha was used to determine the internal consistency of the instrument and the reliability co-efficient was $r = 0.75$. This index was considered high enough to judge the instrument as being highly consistent, hence it was used for the study.

The researchers gained access to the respondents through community and religious administer the questionnaire to them. The researcher employed the help of four research assistants. These assistants were helpful in administration of the AFPMQ. To ensure that research assistants discharged their duties properly, basic training was organised for them during which the researcher explained the objectives of the study, the content of the research instrument and how the assistants were expected to function and give interpretation during data collection exercise. The administration of the AFPMQ by the assistants was closely supervised by the researcher and completed copies of the questionnaire were collected on the spot. A total of 1,098 copies of questionnaires were distributed to the respondents and 1,097 were returned.

The returned copies of the questionnaire were cross checked for completeness of responses. Copies of the questionnaire that were properly completed were used for data analysis. Data collected were analyzed using Statistical Package for Social Sciences (SPSS) version 20.0 for windows. Mean ($\bar{x}$) and standard deviation (SD) were calculated for the purposes of description and to answer the research questions. A criterion mean of 2.50 was set for the study which was derived by adding up the sum of the scale values and dividing the sum by number of scale option. Any mean score equal to or above 2.50 was considered high level of acceptance but any mean score below 2.50 was considered low level of acceptance of FPMs. The hypotheses were tested using t-test for variables with two mean scores, while one-way analysis of variance (ANOVA), at 0.05 level of significance, was used to test the variables with more than two mean scores.

3. Results

Table 1: **Mean, Standard Deviation and Summary of Analysis of Variance (ANOVA) on Level of Acceptance of FPMs among Married Persons by Level of Educational Attainment**

Variables	NFE (n = 222)		PE (n = 87)		SE (n = 317)		TE (n = 471)				
	$\bar{x}$	SD	$\bar{x}$	SD	$\bar{x}$	SD	$\bar{x}$	SD	F-value	p-value	Decision
Hormonal	1.70	0.67	1.78	0.66	2.04	0.68	2.05	0.73	11.657	0.000	S
Barrier	1.64	0.81	1.72	0.82	2.48	0.94	2.29	0.93	16.927	0.000	S
Permanent	1.27	0.60	1.62	0.87	1.74	0.94	1.78	0.85	28.198	0.000	S
Traditional	1.94	0.69	2.08	0.64	2.34	0.65	2.27	0.57	23.616	0.000	S
Grand Mean	1.63	0.69	1.80	0.74	2.15	0.80	2.09	0.77	20.100	0.000	S

NFE = No Formal Education, PE = Primary Education, SE = Secondary Education, TE = Tertiary Education, S = Significant at $p < 0.05$

Table 1 showed that respondents mean scores and standard deviation obtained in hormonal type of FPM by level of education were: no formal education had 1.70 ± 0.66; primary education had 1.78 ± 0.66; secondary education had 2.03 ± 0.68; tertiary education had 2.05 ± 0.72. For barrier type of FPM respondents with no formal education had 1.64 ± 0.80; primary education had 1.72 ± 0.81; secondary education 2.48 ± 0.94; while tertiary education 2.28 ± 0.92. Permanent types of FPM recorded 1.27 ± 0.60 for no formal education; primary education had 1.62 ± 0.86; secondary education had 1.74 ± 0.92; tertiary had 1.78 ± 0.84. For traditional types of FPM no formal education had 1.93 ± 0.69. Primary education had 2.08 ± 0.63; secondary education had 2.33 ± 0.64; tertiary had 2.27 ± 0.57. The mean scores obtained are below the criterion mean of 2.50 set for the study. Therefore there was a low level of acceptance of FPMs among married persons in Abakaliki education zone of Ebonyi State by level of education.

The table also indicated that there was a significant difference in the level of acceptance of FPMs among married persons in Abakaliki Education Zone of Ebonyi State by level of education ($p < 0.05$). This result also showed that even though there was a general low level of acceptance of FPMs among married persons according to their level of education, the higher their level of educational attainment, the higher their level of acceptance of FPMs, as was recorded in hormonal type of FPM thus: TE, $\bar{x}$ = 2.05 > SE, $\bar{x}$ = 2.04 > PE $\bar{x}$ = 1.78 > NFE $\bar{x}$ = 1.70. However, Table 9 shows a p-value that less than 0.05. This indicates a significant difference exists, therefore the hypothesis is rejected.

Table 2: **Mean, Standard Deviation and Summary of t-test Analysis on Level of Acceptance of FPMs among Married Persons by Gender**

Variables	**Male (n = 453)**		**Female (n = 644)**				
	$\bar{x}$	**SD**	$\bar{x}$	**SD**	**t-value**	**p-value**	**Decision**
Hormonal	1.90	0.71	1.99	0.71	2.048	0.041	S
Barrier	2.24	0.92	2.11	0.76	2.178	0.030	S
Permanent	1.60	0.87	1.70	0.83	1.983	0.048	S
Traditional	2.18	0.67	2.23	0.62	1.278	0.072	NS
Grand Mean	1.98	0.79	2.00	0.73	1.870	0.040	S

NS = Not Significant at $p > 0.05$

Table 2 showed that the respondents mean scores and standard deviation obtained in hormonal type of FPM by gender were: Male had 1.90 ± 0.70; female had 2.10 ± 0.71. For barrier method, male had 2.24 ± 0.92; female had 2.11 ± 0.97. For permanent method of FP male had 1.59 ± 0.86; female had 1.69 ± 0.83 and for traditional FPM, male had 2.17 ± 0.63; female had 2.22 ± 0.61. The mean scores obtained were below the criterion mean of 2.50 set for the study, therefore there was a low acceptance of FPMs among married persons in Abakaliki education zone of Ebonyi State by gender. The table further indicated that there was a significant difference in the level of acceptance of FPMs among married persons in Abakaliki Education Zone of Ebonyi State by gender except in traditional FPMs. The result also showed that even though there was general low level of acceptance of FPMs, the female married persons has a slightly higher level of acceptance of hormonal and permanent FPMs than the male; while the male married persons has a higher acceptance of barrier FPMs than the female. However, the overall p-value is 0.04 < 0.05 therefore the hypothesis of no significant difference in level of FPMs acceptance based on gender is rejected.

Table 3: **Mean, Standard Deviation and Summary of Analysis of Variance (ANOVA) on Level of Acceptance of FPMs among Married Persons by Religion**

Variables	**Catholic (n = 393)**		**Protestant (n = 231)**		**Pentecostal (n = 53)**		**Muslim (n = 471)**		**Traditional (n = 149)**				
	$\bar{x}$	**SD**	$\bar{x}$	**SD**	$\bar{x}$	**SD**	$\bar{x}$	**SD**	$\bar{x}$	**SD**	**F-value**	**p-value**	**Dec.**
Hormonal	1.81	0.73	2.01	0.72	2.23	0.60	1.69	0.72	1.81	0.62	11.657	0.000	**S**
Barrier	1.92	1.02	2.26	0.80	2.64	0.78	1.62	0.83	1.98	0.93	16.927	0.000	**S**
Permanent	1.71	0.92	1.30	0.69	1.90	0.88	1.51	0.83	1.28	0.64	28.198	0.000	**S**
Traditional	2.29	0.64	2.20	0.56	2.24	0.53	1.95	0.66	2.02	0.83	23.616	0.000	**S**
Grand Mean	1.93	0.82	1.94	0.69	2.25	0.69	1.69	0.76	1.77	0.75	20.090	0.000	**S**

Table 3 shows that respondents mean scores and standard deviation obtained in Hormonal type of FPM by religion were: catholic had 1.81 ± 0.73; protestant had 2.01 ± 0.72, Pentecostal had 2.23 ± 0.60; Muslim had 1.69 ± 0.72; while traditional religion had 1.81 ± 0.62. For barrier FPM, Catholic had 1.92 ± 1.02; protestant had 2.26 ± 0.80; Muslim had 1.62 ± 0.83; while traditional had 1.90 ± 0.93. For permanent type of FPM, Catholic recorded 1.70 ± 0.92; protestant had 1.53 ± 0.69; Pentecostal had 1.90 ± 0.88; Muslim had 1.51 ± 0.833 and traditional had 1.28 ± 0.64; for traditional type of FPM, Catholic had 1.56 ± 1.01; protestants had 1.71 ± 1.10; Pentecostal had 1.69 ± 1.06; Muslim had 2.32 ± 1.28; and traditional religion recorded 1.89 ± 1.13. all the mean scores obtained are below the criterion mean of 2.50 set for the study except for barrier FPM where Pentecostal has a slight high level of acceptance ($\bar{x}$ = 2.64 > 2.50) however, the grand mean score for barrier FPM is $\bar{x}$ = 2.16 which was below the criterion mean of 2.50 set for the study. Therefore there was a low acceptance of

FPMs among married persons in Abakaliki education zone of Ebonyi State by religion the table also showed that there was significant difference in the level of acceptance of FPMs among married persons in Abakaliki Education Zone of Ebonyi State by religion ($p < 0.05$). The result also showed that even though there was general low level of acceptance of FPMs in every religion, except Pentecostal that accepted barrier FPMs (mean value >2.50), the Pentecostal accepted hormonal, barrier and permanent FPMs more than any other religion, while the Catholic accepted traditional FPMs more than any other religion. The overall p-value is $0.00 < 0.05$) therefore the hypothesis of no significant difference in level of acceptance of FPMs based on religion is rejected.

Table 4: **Mean, Standard Deviation and Summary of t-test Analysis on Level of Acceptance of FPMs among Married Persons by Location**

Variables	**Rural (n = 550)**		**Urban (n = 547)**				
	$\bar{x}$	**SD**	$\bar{x}$	**SD**	**t-value**	**p-value**	**Decision**
Hormonal	1.76	0.70	2.15	0.66	2.048	0.011	S
Barrier	2.08	0.95	2.35	0.92	2.178	0.030	S
Permanent	1.31	0.61	2.00	0.91	1.983	0.048	S
Traditional	2.07	0.62	2.44	0.56	1.278	0.074	NS
Grand Mean	0.80	0.72	2.23	0.76	1.870	0.040	S

Table 4 shows that respondents mean scores obtained in hormonal type of FPM by location were rural ($\bar{x}$ = 1.76), urban ($\bar{x}$ = 2.15). Barrier types of FPM are rural ($\bar{x}$ = 1.98), urban ($\bar{x}$ = 2.34). Permanent type of FPM were rural ($\bar{x}$ = 1.31), urban ($\bar{x}$ = 2.00), traditional type of FPM were rural ($\bar{x}$ = 1.97), urban ($\bar{x}$ = 2.44). The above mean scores obtained were all below the criterion mean of 2.5 set for this study, suggesting a low level acceptance of FPMs by location. The table also indicates that there was significant difference in the level of acceptance of FPMs among married persons in Abakaliki Education Zone of Ebonyi State by location except in traditional FPMs. This shows that even though there was general low level of acceptance of FPMs, the married persons in urban area has higher level of acceptance of FPMs than the married persons in rural area with an overall p-value is 0.04 which is less than 0.05 therefore the hypothesis is rejected.

4. Discussion

Results of the study in tables I showed that the level of acceptance of FPMs was low. The result indicated that the higher the level of educational attainment of the respondents, the higher their level of acceptance of FPMs. This result is in line with findings of Clifford (1999) who reported a low level of FPMs acceptance among married persons by level of education in Nigeria (primary education 22%, secondary 32% and tertiary education 37%). The overall low level of acceptance of FPMs across all educational levels might be an indication of the low convictions about the usefulness of most of the FPMs and therefore, spells the need for interventions to improve FPMs uptake to be focus on preferences of the couples as it concerns their convictions and not merely by recommendation of health workers. This can be achieved through effective education of married persons on the benefits and consequences of FPMs.

The level of acceptance of FPMs by married persons of different educational levels, were compared statistically using Analysis of variance (ANOVA) as indicated in Table 1, significant difference was observed in the level of acceptance. Although the result of the research findings indicated also that married persons significantly differed in their levels of acceptance of FPMs, the higher their educational attainment the better their level of acceptance of FPMs. This result is consistent with the findings of Dorothy (2010) which showed that higher educational attainment was an important factor in the level of acceptance of FPMs hence the result of this present study is not misleading and confirms the assertion that people with higher educational status are likely to have more knowledge and acceptance FPMs more than less educated ones (Dorothy, 2010).

Results of level of acceptance of FPMs by gender as indicated in table 2 revealed that there was low level of acceptance of FPMs. The result also showed that even though there was a general low level of acceptance of FPMS the female married persons had a slightly higher level of acceptance of hormonal and permanent FPMs than the male, while the male married persons had a higher acceptance of barrier FPMs than the female. This

result is expected and not surprising because during data collection, it was observed that female married persons preferred using the pill and intrauterine device (IUCI) while male married persons preferred using condoms which is a barrier type of FPM. This preference of barrier method by males might be as a result of awareness created on radio and television on the use of condoms to prevent sexually transmitted diseases like HIV/AIDS. Also this finding is an indication of males' active involvement in FPMs choice an important finding to maximize the authority of the males to improve FPM uptake among married persons.

This result corresponds with the findings of National Demographic Health Survey (2008) where perceived benefits of FPMs for both male and female married persons were high in Nigeria (male 77% and female 76%). The finding also agrees with the findings of Carathy (1990) which reported of low level of acceptance of FPMs among married persons by gender in Northern Ethiopia (male 29%, female 22.6%). When the hypothesis of no significant difference in level of acceptance of FPMs by married persons was tested by gender using t-test, significant difference was observed in the level of acceptance of FPMs. Although this study did not investigated why acceptance of FPMs is low, it is possible that some married persons shy away from accepting FPMs because of misconceptions about side effects and how various FPMs work.

Findings on the level of acceptance of FPMs by religion as indicated in table 3 revealed that there was a general low level of acceptance of FPMs. The results also indicated that even though there was general low level of acceptance of FPMs in every religion, Pentecostal accepted barrier FPMs more than any other religion, while the catholic accepted traditional FPMs more than any other religion. This finding is expected and therefore not surprising because of influence of religion on family planning in our environment which had remained a delicate issue that is reluctantly accepted based on religious convictions (Isah & Nwobodo, 2009). Pentecostal having higher level of barrier method of acceptance could be for the fact that, as one of the modern religion groups, with a large number of younger persons may likely accept modern teachings on FPMs, especially barrier methods like condoms, to plan their families than older religious groups. The study in table 3 also indicated that Catholics had a higher acceptance for traditional methods more than any other religion. This result is expected because Catholics faith only allows the use of traditional FPMs, like ovulation methods and safe periods in our society as the other methods go against the teachings and convictions of the church.

However the result of this finding is related to that of Nura (2011) who conducted a study carried out in Kano Nigeria that Muslim , catholic and traditional religions had low levels of acceptance of FPMs due to influence of their religious beliefs. This finding implies that programmes for improving FPMs must take into considerations these religious convictions and design programmes which will accommodate these convictions since according to Isah and Nwobodo (2009) every religion supports one form of FPM or the other.

Results of level of acceptance of FPMs by location as indicated in table 4 recorded that there was low level of acceptance of FPMs. This result also indicated that though there was general low level of acceptance of FPMs, the married persons in the urban area had higher level of acceptance of FPMs than the married persons in rural area.

The result of low level of acceptance of FPMs both urban and rural areas in this study is contrary to the findings of (NARHS, 2005) that conducted a study on acceptance of FPMs in Western Nigeria which showed that acceptance of FPMs were higher in urban area (76%) than rural areas (40%). Result of the present study may have been influenced by the fact that there was no clear cut demarcation between Abakaliki urban and rural areas. When the hypothesis of no significant difference in levels of acceptance of FPMs by married persons was tested statistically using t-test significant difference was observed. This significant difference noted in this finding is expected and therefore not surprising because of the higher educational levels associated with those in the urban area. However the findings of this study is similar with the study carried out by (Prata, 2007) where there was significant difference on acceptance of FPMs between urban and rural dwellers in India.

5. Conclusion and Recommendations

Level of family planning methods acceptance was found to be low among married persons in Abakaliki Education zone of Ebonyi State by gender, location and religion, but was better accepted with increased educational level. Level of perceived benefits of FPMs was found to be high in all the socio-demographic variables studied. Generally, the level of acceptance of FPMs was low while the level of perceived benefits was high among married persons in Abakaliki Education Zone of Ebonyi State. Based on these conclusions the study made the following recommendations:

- Family planning programme designers must incorporate people's beliefs, values and convictions in the design of their programmes to accommodate divergent convictions which will improve uptake of acceptable FPMs among married persons.
- Policy makers at both state and local government levels should partner to create more awareness on FPMs at both urban and rural areas of the state, the partnership should involve religious organizations and traditional rulers. These groups of people have great influence on their followers and understand their subjects better, which might help to increase the level of acceptance of FPMs.
- All the three levels of government; federal, state and local government should build and integrate more health services, Non-governmental and Church based organizations in conducting family planning activities in all tertiary, secondary and primary health care centres. This is because with increased family planning services, there will be increased usages and acceptance, therefore will result to proper timing and spacing of births, decrease in poverty, ignorance, illiteracy, maternal and infant mortality as well as reduction of mass production of babies with little or no future.
- Government at all levels should train more qualified health workers especially in family planning services; they should be posted out to urban and rural areas, to help in FPMs advocacy, information and health education. This will encourage the increase in the level of acceptance of FPMs.

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