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Contraceptive Use among Married Women in Zaria, Northwest Nigeria

Anyebe, EE*
RN,RNT, BScN, PGDPA,MSc, FWACN Chief Nurse Tutor, School of Nursing, ABU Teaching Hospital Zaria,Nigeria, P.O. Box 704, Zaria-Nigeria

Olufemi, S.K.
RN,RM,ICN, CRNA, ADPA Asst Chief Nurse Anaesthetist, Department of Nursing Services, ABU Teaching Hospital, Zaria

Lawal, H. RN
Paediatric Unit, Department of Nursing Services ABUTH, Zaria
*Correspondence: anyem_2@yahoo.com

Abstract
In modern days, the need to control child birth and maintain a manageable family size is a fact of life. This is due to social and economic realities in the contemporary world system. The practice of contraception has continued to receive attention because of this fact. This study was undertaken to evaluate this in Zaria, an important educational and historical centre in Nigeria. Two hundred and seven-six randomly selected married women from three selected districts were involved in this study. Data were collected using a 4-section-self-constructed-administered questionnaire. Data collected were analysed using descriptive and inferential statistics (chi-square set at 0.05). Findings showed a high level of knowledge and awareness lof contraceptive methods but with relative low contraceptive uptake. The age of women, their religious affiliations and levels of education were correlated with the use. Socio-cultural determinants such as religious and cultural beliefs as well as spouse disaproval still remain the main obstacles to contraceptive use. It was therefore suggested that religious and community leaders should form a deliberate target of family planning enlightenment progrgammes and advocacy. A family-centred approach to family planning services involving husbands will likely further strenghten use of such services.
Keywords: Practice**,** Family planning, contraceptives , married women, child spacing, birth control.

INTRODUCTION

Contraception or family planning can be used to limit the size of a family as well as to sufficiently space the intervals between child birth (Himes, 1963). The act of controlling child birth is as old as Man. The first written document on contraception was in 1850 BC in Egypt. The Egyptians used vaginal plug formed from crocodile and honey into effective vaginal pessaries. Later, magic portions, seeds, herbs, and coitus interruptus were used. Some other preventive methods were sex taboos, limiting the time and frequency of sex, prolonged lactation and delayed marriages and celibacy. Conception control was thus both magical and rational.

In South Africa, prevention of conception was by coitus interruptus, abstinence from coitus until the baby began to crawl, the end of which was marked a ceremonial rite. Keown(1977) had stated that some of these were dropped either due to their inefficiency or possible dangers to the life of women that used them. Some methods were then modified, paving way for the development of new more effective ways of contraception.

The International Movement of Family Planning, started by Margaret Sanger, an American nurse, published an article on contraception and later opened the first Family Planning Centre in Brookly in 1966, for which she was later jailed. Her counterparts (Dr. Alleta Jacob in Holland, Dr. Mary Stopes in England, later Mrs. Elis Offensen Jense of Sweden and Lady Oheranthus Ramaran of India) centred their concern on the health and welfare of women and children in their campaign. In 1952, they, along with others in Birth Control Movement, together formed the International Planned Parenthood Federation (IPPF). By the end of 1968, the IPPF had grown to include organization in 54 countries, including 36 less developed countries. Nigeria was one of them.

In Nigeria, traditional family planning predates modern methods, can be traced back to the 1950s, an era of abandoned children and criminal abortions, both of which occurred at an alarming rate (Andrew, 1997). The Marriage Guidance Council in Lagos, disturbed by this situation, established the first Family Planning Clinic in Lagos, following the recommendations of the committee it had set up (Adeniyi,1958). The visit of Miss Edith Gate to Nigeria in 1967 revived interest in family planning. With finance from London, Family Planning Clinics were established in Lagos. The Family Planning Council in Nigeria was formed in 1964; this later metamorphosed into the present-day Planned Parenthood Federation of Nigeria (PPFN).

In the modern days, child spacing could be achieved via natural or artificial methods. According to Dudley and Bernard (1998), the natural methods include prolonged breastfeeding (i.e. lactational amenorrhoea),

the rhythm/calender method, Billing's method, coitus interruptus (withdrawal method), abstinence, basal body temperature and combined method. The reported advantages of natural methods include absence of physical and physiological side effects, inexpensive, and requires no much technical assistance from a health worker (Andrew, 1997). However, they have their own disadvantages, among which are high rate of non-compliance with abstinence and lack of commitment among users, high failure rate, and non-protection against sexually transmitted diseases.

The artificial methods, on other hand, are categorised as barrier, hormonal, and sterilization methods (Andrew, 1997). The barrier methods prevent contraception by putting an obstacle on the way of the spermatozoa, preventing the entry of sperm into the cervix. They include chemical barriers (i.e. spermicidal agents) such as foaming tablets, vaginal pesseries, creams, jellies, and douching; and mechanical barriers including condoms, cervical diaphragm or cap and intra-uterine contraceptive device (IUCD). Effectiveness rate is between 75%-90%. Disadvantages include allergy, irritation, discomfort, unpleasant odour, etc.

Homornal contraceptive methods such as combined oral pills, parenteral hormonals (injectives) like the depo-provera and noristerate, and norplant (implant) contain progesterone and oestrogen preparations. They have 100% effectiveness. Hormonals act by inhibiting ovulation, thickening cervical mucus, and making the uterine cavity unfavourable for implantation. Disadvantages include weight gain, risk of high blood pressure, cerebro-vascular accident, risk of developing cancer of the endometrium, uterine fibroid, benign breast tumours, among others. In addition to these, the use of emergency contraceptive can be an option within 48 hours when unprotected sex occurs (Haggai 2003). The sterilization methods, which are voluntary surgical procedures/contraceptions, involve the occlusion of the fallopian tubes in females or vas deference in males. They usually irreversible, more suitable for couples who have completed their family size.

Generally, there are various benefits of family planning: promoting the health of mother and child, enhancing good living conditions, enabling parents to save funds for old age, investing in good education, and less fear of unwanted pregnancy, abortion, maternal death and psychological stress (Bongarts 1995). Family planning also helps to keep the family happy as well as grant couples opportunity and leisure to enjoy each other's company. Nationally, family planning also helps to attain and maintain a balancce between the provision of social amenities and population size. However, there factors that negatively affect its acceptance; among which are culture and tradition, religion, occupation, value placed on children, sex preference especially male children, and level of education.

In many parts of Africa including Kenya, Ghana and Zambia, wide gap exists also between the high knowledge of family planning (over 90%) and low contraceptive practice (Lasee, 1997). Illiteracy was associated with high fertility and the economic status: the poor and lowly educated were concerned more with survival than with family planning (Burgard, 2004). There were some who believed that the death of a child was a normal phenomenon and was not in any way linked with the number or spacing of children. Most believed they would rely on their children to look after them in future, and viewed family planning as a foreign intrusion and a way of depriving them of their future hope for survival (Bongarts 1995).

Studies conducted in Abuja, Nigeria revealed that the practice of family planning among married women was low (45%), compared to the high knowledge of family planning by respondents (84%). This even decreased in younger ages (15-24 years) and older ages (35-44years) respectively, especially in late marriages. Most respondents used injectables and oral pills as convenient methods. A significant number of women (47%) considered six children and above an ideal family size while only 23.6% and 15.5% of women considered four and five children as ideal respectively. Majority of respondents irrespective of religion considered two to three years as ideal birth interval; only few (2.6%) women with four, six and more living children out of the 231 married women desired to stop child bearing, out of this number only one considered sterilization as the preferred family planning choice.

Other studies in Nigeria concluded that male dominance and patrilineal tradition supported large family size and that men reproductive motivation to a large extend affected the reproductive behaviours of their wives (Isuigbo-Abanihe,1994; Biddlecom. 1997). Factors affecting men's reproductive intentions were therefore considered important for the fertility transition in Nigeria. Different reasons were given by men for their disaproval of birth spacing and use of different family planning methods: some feared negative health consequencies, others religious or cultural reasons while yet others saw it as a deliberate attempt to limit the number of birth in the future. But the majority believed that women had no right to make reproductive related decision on their own.

According to Charles (1987), family planning decisions should be made on a completely voluntary basis of thoroughly informed choice on the part of the individual or couples, considering the pattern of sexual activity, access to medical care, cost of contraceptive, co-operation between the partners and the number of children the client had before making a choice. The family planning provider has the responsibility to explain the most appropriate methods.

In view of the health benefits of family planning associated with child spacing and the use of specific

methods in protecting the lives of infants and children, women and the family as a whole (UNFPA 1997; Burgard, 2004), there is need to further look into the issues surrounding women and contraception in Sabon Gari Local Government of Kaduna State since recent documentation of knowledge, attitude and practice of contraception in this area has not undertaken.

METHODS AND MATERIALS

A descriptive community study aimed at assessing the knowledge, attitude and practice of contraception among married women in Sabon Gari Local Government Area, Zaria. The Local Government Area, as one of the largest local government areas of Kaduna state, was purposely selected. The area is made up of diverse ethnicity, cultural and religious beliefs. The area is endowed with educational institutions (both government and private): primary, secondary, university and other tertiary institutions. Various health facilities of Local, State and Federal governments are situated in this area. The residents are mainly engaged in business and trading, civil service and farming.

Three districts namely Samaru, Sabon-gari and Hanwa of the six districts in Sabon Gari Local Government Area were randomly selected. The target population was married women from each house hold. Nine villages/settlements, comprising of four (4) from Samaru district , three (3) from Sabon-Gari and two (2) from Hanwa respectively were randomly selected. From these villages, 93 households were systematically selected for the study. This was however relatively more difficult in Hanwa due to the town structure of the district. A total sample size of 276 married women were involved in the study: 112 women from Samaru, 103 from Sabon-Gari and 61 from Hanwa. A four-section questionnaire, made up of both open and close ended questions, was used to obtain information from the respondents: Section A - Respondents' personal profile, Section B - Knowledge, Section C - Attitude and Section D - Practice of contraception. The questionnaire was given to the literate women to fill, while same was used as interview schedule for the non-literate respondents. The data were collected between February and April 2008. Analysis was done using descriptive and inferential statistics (chi-square set at 0.05).

RESULTS

The socio-demographic characteristics of the respondents (Table 1) show that majority (30.8%, n=85) of the respondents were within 26-30 years while the least age group were between the ages of 16-20 years (n=32, 11.6%). The mean age was about 28 years. One and eighteen (66%) of the respondents were muslims and 94 (34%) christians; 42% Hausa, while 82 (29.7%) had primary education, 112 (43.8%) secondary education and 57 (20.7%) tertiary education, and 16 (5.8%) had no formal education. Among the 276 respondents, 123 (44.5%) were full housewives, 87 (31.5%) traders, 11(4%) were civil servants and the rest 55 (20%) were into one form of business or another.

Table 2 shows that almost all the respondents 260 (94.2%) were knowledgeable about contraception and a slightly lower number 249 (90.2%) were aware of family planning services in their area; 140 (50.7%) accepted contraception while 136 (49.3%) did not. However, only 96 (34.8%) had used or was using any form of contraception (Table 3). The tests of relationship between contraceptive use and socio-demographic variables show that the extremes of the age groups (16-20 and 36-40 years), the christians, and less educated appear to use contraceptives more; this correlates siginficantly for the level of education (X^2<0.05) as shown in Table 4.

Most respondents got their information on contraception from the hospital (91.2%), some from the media (52.3%), and others from friends (30.0%) (see Table 3). Among the 96 that used contraception, 29 (30.2%) of them used injectables, 23 (24%) used barrier methods, 20 (20.8%) pills, 14 (14.6%) intra-uterine contraceptive device (IUCD) while 20 (20.8%) said they have used a combination at different times. Among 96 users of contraceptives, the reasons given for use were child spacing (47.9%, n=46), to improve their own health (19.8%, n=19), to save lives of the other children (32.3%, n=31). Table 3 also shows some of the factors that hindered the use of contraceptive as stated by 180 respondents: cultural factors (32.7%, n=57), religious disapproval (44.4%, n=80), high cost (15.6%, n=28) and husbands' disaproval (8.3%, n=15).

DISCUSSION OF FINDINGS.

The age distribution of respondents shows that all the respondents were within child bearing age, with a mean age of 28 years. This constitutes a suitable target population. Similarly, all the respondents practice the two major religions and are from the major and minor tribes in Nigeria. The relatively high number of Hausas is probably because they are dominant dwellers of the study area. Age, religion and level of education of respondents have been found to relevant in contraceptive decisions (Isuigbo-Abanihe 1994), hence these are correlated the practice of contraceptive by married women.

Most all the respondents (94.2%, n=260) were knowledgeable about contraception, 249 (90.2%) were aware of family planning services in their various health centres in their area, majority of who got their information from the hospitals/health centres and the media. Despite the high level of knowledge and awareness,

only 140 (50.7%) of them accepted they would use and fewer (n=96, 34.8%) had actually used or was using contraceptives. Such wide gaps between knowledge and practice were reported by Lasee (1997) and Burgard (2004). The use was sigificantly related to the level of education of the married women (see Table 4).

The common methods used by the 96 respondents (injectables: 30.2%, n= 29; pills: n=20, 20.8%; IUCD: n=14, 14.6%; and barrier methods: n=23, 24%) were similar to those used elsewhere (UNFPA 1997). The possible reasons for these preferences are may. Many women prefer injectables compared to other types bacause of ease of compliance (2-3 monthly), Pills by some as emergency contraceptive (Haggai, 2003) while Barrier methods (e.g. condoms) have additional advantage of protection againts STIs and HIV/AIDS; none considered the sterilisation method. This may mean that the women may consider having more children in future. Women who used contraceptive tend to do so with some background reasons such as to improve health, and child spacing.

Among the several reasons for declining to use any form of contraception, religion appears to be the most significant factor (44.4%), and closely followed by culture (31.7%). These two are closely related as socio-cultural considerations appear to major determinants of contraceptive use in Zaria. Spouse disapproval and economic variables such as cost are still other factors. These are consistent factors as found in previous studies (Isuigbo-Abanihe 1994; Biddlecom 1997). No respondent mentioned any plot to use contraceptive to make women sterile or even infect them with disease, as many are said to believe in this part of the country.

CONCLUSION AND RECOMMENDATIONS

There are high knowledge and awareness levels about contraception among married women, but with a relatively low contraceptive use. The age of women, their religious affiliations and level of education were correlated with the contraceptive use. Many reasons were stated for the low practice of contraception: socio-cultural determinants such as religious and cultural beliefs and spouse disaproval are still the main obstacles to contraceptive use. Therefore, religious and community leaders should form the deliberate target of family planning enlightenment progrgammes and advocacy. A family-centred approach to family planning services involving husbands will further strenghten use of such services.

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Table 1: Respondents' Socio-demographic Characteristics

Variables	Samaru (%)	Sabon-Gari (%)	Hanwa (%)	Total (%)
Age (in years)*:				
16 - 20	4(3.7)	20(19.4)	8(13.1)	32(11.6)
21 - 25	20(17.8)	30(29.1)	18(29.1)	68(24.6)
26 - 30	42(37.5)	32(31.1)	11(18.0)	85(30.8)
31 - 35	20(17.9)	10(9.7)	12(19.7)	42(15.2)
36 - 40	26(23.2)	11(10.7)	12(19.7)	49(17.8)
Total	112(100)	103(100)	61(100)	276(100)
Religion:				
Islam	76(67.8)	60(58.3)	46(75.0)	182(66.0)
Christianity	36(32.1)	43(41.7)	15(25.0)	94(34.0)
Total	112(100)	103(100)	61(100)	276(100)
Tribe:				
Hausa	62(55.3)	23(22.3)	31(50.8)	116(42.0)
Yourba	14(12.5)	53(51.5)	15(24.6)	82(29.7)
Ibo	4(10.7)	25(24.3)	6(9.8)	35(12.7)
Others	32(28.5)	2(1.9)	9(14.8)	43(15.6)
Total	112(100)	103(100)	61(100)	276(100)
Occupation:				1
Civil servant	4(3.6)	4(3.9)	3(4.9)	1(4.0)
Trader	14(12.5)	66(64.1)	7(11.4)	87(31.5)
Housewife	72(64.3)	12(11.7)	36(59.0)	123(44.5)
Others	22(19.6)	21(20.3)	12(19.7)	55(12.0)
Total	112(100)	103(100)	61(100)	276(100)
Level of Education:				
No formal education	10(8.9)	3(3.9)	3(4.9)	16(5.8)
Primary	16(14.3)	40(39.0)	26(42.6)	82(29.7)
Secondary	62(55.4)	30(29.1)	29(47.5)	121(43.8)
Tertiary	24(21.4)	30(29.1)	3(4.9)	57(20.7)
Total	112(100)	103(100)	61(100)	276(100)

*Mean age = 28 years

Table 2: Respondents' Knowledge of Contraception

Variable	Samaru (%)	Sabon Gari (%)	Hanwa (%)	Total (%)
Knowledge of contraception				
Good	110(98.2)	92(89.3)	58(95)	260(94.2)
Poor	2(1.8)	11(10.4)	3(5)	16(5.8)
Total	112(100)	103(100)	61(100)	276(100)
Sources of Information*				
Hospital	138	56	43	237(91.2)
Media	74	44	18	136(52.3)
Friends	60	6	12	78(30.0)
Others	12	13	15	40(15.4)
Awareness of FP services in area				
Yes				
No	88(78.6)	103(100)	58(95.0)	249(90.2)
Total	24(21.4)	0	3(5.0)	27(9.8)
	112(100)	103(100)	61(100)	276(100)
Acceptance to contraception				
Accept	76(67.9)	43(41.7)	21(34.4)	140(50.7)
Don't accept	36(32.1)	60(58.3)	40(65.6)	136(49.3)
Total	112(100)	103(100)	276(100)	276(100)

**Multiple responses*

Table 3: Practice (use) of Contraception

Variables	Samaru (%)	Sabon Gari (%)	Hanwa (%)	Total (%)
Practice of contraception				
Yes	32(28.6)	43(41.7)	21(34.4)	96(34.8)
No	80(71.4)	60(58.3)	40(65.5)	180(65.2)
Total	112(100)	103(100)	61(100)	276(100)
Methods used				
Pills	6(18.7)	10(23.3)	4(19.1)	20(20.8)
Injectables	16(50.0)	3(6.9)	10(47.6)	29(30.2)
IUCD	2(6.3)	10(23.3)	2(9.5)	14(14.6)
Barrier	8(25.0)	10(23.3)	5(23.8)	23(24.1)
Others*	0	10(23.3)	0	10(10.4)
Total	32(100)	43(100)	21(100)	96(100)
Reasons for Practice				
Improved health	4(12.5)	8(18.6)	7(33.3)	19(19.8)
Save life	9(28.1)	6(14.9)	6(28.6)	31(32.3)
Birth control	19(59.4)	29(67.4)	8(38.1)	46(47.9)
Total	32(100)	43(100)	21(100)	96(100)
Reasons for not using contraceptive				
Culture	25(31.2)	15(25.0)	17(42.5)	57(31.7)
Religion	40(56.0)	33(55.0)	7(17.5)	80(44.4)
Economy (cost)	10(12.5)	12(20.0)	6(15.0)	28(15.6)
Husband disapproval	5(6.2)	0	10(25.0)	15(8.3)
Total	80(100)	60(100)	40(100)	180(100)

*withdrawal, safe periods,etc

Table 4: Respondents' Use of Contraceptive by their Socio-demographic Data

Variable	Yes	No	Total
Age(in years):			
16-20	14(43.8%)	18(56.2%)	32(11.6)
21-25	10(15.0%)	58(85.0%)	68(24.6)
26-30	23(26.9%)	62(73.1%)	85(30.8)
31-35	16(39.0%)	25(61.0%)	42(15.2)
36-40	37(64.9%)	20(35.1%)	49(17.8)
Total	96(34.8%)	180(65.2%)	276(100)
Religion:			
Islam	39(21.4%)	143(78.6%)	182(66.0)
Christianity	57(60.6%)	37(39.4%)	94(34.0)
Total	96(34.8%)	136(65.2%)	276(100)
Level of Education:			
No formal education	12(75.0%)	4(25.0%)	16(100%)
Primary	17(20.7%)	65(79.3%)	82(100%)
Secondary	45(37.2%)	76(62.8%)	121(100%)
Tertiary	22(38.6%)	35(61.4%)	57(100%)
Total	96(34.8%)	180(65.2%)	276(100%)

Level of Education: $X^2 = 18.99$, df=3, sig.level=0.05, cv = 7.8147 ($X^2 < 0.05$: significant)

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