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RESEARCH ARTICLE

AN INVESTIGATION OF SOCIO-CULTURAL FACTORS INFLUENCING THE USE OF FAMILY PLANNING SERVICES AMONG WOMEN (15-49) YEARS OF AGE IN PORT HARCOURT, NIGERIA

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ABSTRACT

Aim: The study was designed to investigate socio-cultural factors influencing the use of family planning services among women (15-49) years of age in a primary health centre typical of those in Port Harcourt, Nigeria

Methods: Data was collected from 100 women who were between the ages of 15-49 and attending antenatal health care at the Model Primary Health Centre Port Harcourt Nigeria. Self-administered questionnaires were used to gather information on the influence of socio-cultural factors on the uptake of family planning.

Findings: Bivariate analysis showed a significant relationship between education and women's uptake of family planning, religion and contraception use. The majority of respondents (64%) indicated they do not access family planning services due to their spouse's disapproval.

Research limitations/implications: This was a study limited to 100 women from a specific region in Nigeria – further research is necessary to ascertain the general is ability of the study to a wider population.

Practical implications: Husband decision making regarding contraceptive use was a strong determinant of family planning use among the population studied. Encouragement of male involvement in family planning should be encouraged alongside the establishment of strategies that empower women to make decisions about their reproductive health.

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INTRODUCTION

The development and introduction of modern contraceptives have led to increased contraceptive use throughout the World, (Palamuleni, 2013). This has also led to tremendous improvements in existing contraceptive methods while recent, effective and acceptable methods are being developed (Obi and Ozumba, 2009). This is particularly true in the developing countries where the prevalence of contraceptive use increased from 9% in 1960 to 60% in 2010, (Adebayo *et al*., 2013).Also, it has helped to reduce the total fertility rate of many developing countries from 6.0% in 1960 to 3.1% in 2010 (ibid, 2013).Available evidence shows that contraceptive use among Nigerian women increased from 3% to 8% between 2000 and 2010 (Chigbu *et al*., 2010). Olaitan (2011) argues that low rate of contraceptive use, particularly in the northern and rural areas of Nigeria was a key cause of high fertility rates. There is a high infant, neonatal and maternal mortality in Nigeria which has been attributed to the low use of contraceptive methods of birth control (Obi and Ozumba, 2009). In addition to this the increasing incidence of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) and other sexually transmitted diseases are on the increase courtesy of poor contraceptive use (ibid, 2009).Recent findings indicate that contraceptive use in the northern region of Nigeria is almost zero as only 9% of women in this region were reported to have used one in 2010 (Adebayo *et al*., 2013). The geopolitical statistical representation of contraceptive use in Nigeria shows that only 3% of women in the North-East and North-West use modern methods (Iwuagwu, 2009). In contrast, 23% of women in the South-West reported using a modern method of family planning (Adebayo *et al*., 2013).This corroborates the fact earlier reported by the N.D.H.S. (2010) which shows the overall country's fertility percentage rates to be a) North-East, 7.0; b) North-West, 6.7 and c) South-West, 4.1. However, the implication of this is that Nigeria still has large unmet needs for contraception.

Contraceptive Knowledge, Attitudes and Practices in Nigeria

Knowledge of available contraceptive devices and family planning services can go a long way in determining their

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access and use (Oye-Adeniran *et al*., 2005). On the other hand, attitude controls the acceptability of family planning methods (Obi and Ozumba, 2009). Studies exploring knowledge and awareness of contraception among people across the six geopolitical zones of Nigeria show that there is good knowledge of family planning and contraceptive use (Iwuagwu, 2009; Oye-Adeniran *et al*., 2005; Bradley and Casterline, 2009). However, the level of knowledge differs regarding different forms of contraceptives. Adebayo *et al*. (2013) revealed that the majority have an awareness of barrier and oral contraception methods, whilst a significant number of couples were not aware of other forms of contraception. Abiodun and Balogun (2009) assessed contraceptive knowledge of women in Ilorin in North-Central Nigeria and found that knowledge levels varied in relation to the availability of contraceptive methods. Findings from this study indicate that condoms are the most popular method with 69.0% awareness, oral contraceptive pill (38.8%), intrauterine contraceptive device (29%) and periodic abstinence (32%). Unfortunately, some of the respondents could not name one contraceptive method (ibid, 2009). Across the study, there was good knowledge among the various populations investigated.

However, poor prevalence of contraceptive use was still reported (Iwuagwu, 2009). In addition, high sexual activity was reported in all the studies reviewed. Findings from previous studies indicate an early age of first sexual intercourse which ranges from 12 to 20 years with a mean average age of first sexual intercourse at 16 years (Bradley and Casterline, 2009). Olaitan (2011) states that the implications of early and high sexual activities among the populationare an increased rate of unwanted pregnancies, induced abortions and unplanned livebirths. Previous research has shown that there is low contraceptive use with resultant induced abortion within Nigeria (Akani *et al*., 2008). Several points have been reported as reasons for people's inability to use contraceptives; partners refusal, conflict with religious beliefs, objection from family members, and unplanned sexual debuts, which are often attributable to rape (Obi and Ozumba, 2009).

Contextual Backdrop to the Study

This study was undertaken at Model Primary Healthcare Centre Port Harcourt River State, Nigeria. Port Harcourt is the capital of River State in Nigeria, and it is one of the largest cities in Southern Nigeria (Ordinioha, 2013). Port Harcourt has a population representative of diverse socio-cultural groups. The study population was constructed entirely of Nigerian women (15-49) years of age, selected as being representative of reproductive age parameters in Nigeria (Ronsmans *et al*., 2006). The female reproductive years are a universal public health concern globally (U.N., 2007). It is vital that women in this age group are aware of safe access, affordable, acceptable and effective methods of family planning to enable them to achieve a safe and satisfying sex life while being capable of conceiving and delivering healthy neonates as often as they wish (Cleland *et al*., 2012).

Research Design and Methodology

Research Design

The study incorporated a cross-sectional quantitative method which facilitated the use of numerical data in making comparisons of various categories of data collected (Creswell, 2013) and indicated prevalence of an outcome of interest in a given population or sub group in a specific time frame. The process ensured that undue influence was not imposed on respondents by the researcher unlike qualitative approaches. The participant's age, educational level, religious beliefs along with their knowledge and family planning use were the variables tested in this study, since the association between risk factors and outcome of interest could be accessibly tested through the cross-sectional design. In this study, the relationship or association between women's age, educational level, religion, cultural influences and their access to family planning services were tested, allowing cause-effect relationships to be demonstrated (Burns and Groove, 2003).

Sampling Strategy

A purposive sampling technique resulted in a population sample size of one hundred participants profiling females between 15-49 years of age attending antenatal health care services at the Model Primary Health Centre in Port Harcourt. Inclusion criteria targeted all women within the age range of 15-49 who consented to take part in the survey. Exclusion criteria determined that women below or above the age range of 15-49 were not eligible to take part in the study. Since the focus of the study was women, men were also excluded as participants.

Data Collection

Data was collected using self-administered structured questionnaires, with questions based on the extant literature in contraceptive use. A previously validated questionnaire (adapted from Olaitan, 2011) which measured similar concepts related to this study was utilised to allow active comparison with other previously published evidence. The questionnaire consisted of 25 questions covering the women's demographic data, socio-cultural, reproductive and sexual history and included questions on their current knowledge and use of contraception. Questionnaires were administered to 100 women, following informed consent and guaranteed anonymity and confidentiality. The questionnaire had 100% response rate.

Reliability and Validity

Various measures were incorporated in reducing errors and increasing the credibility of the research project. Reliability entails reproducibility and consistency of the participant's test performance. It is essential for measuring test quality (Liddy *et al*., 2011). If test results show inconsistency or poor reliability, it is ethically not acceptable to continue the research. Reliability can be calculated by various methods (Creswell, 2013).To measure consistency of assessment over time and ensure the reliability of the questionnaire, a process of test –re-test was implemented; this involved administering the same questionnaire twice in one week to ensure that there were no changes in the construct and quality being measured (Steffen and Seney, 2008). The responses collected showed 100% correlation when compared. However, to ensure a reliability of the study, participants who took part in the test re-test exercise were not included in the final collection of data in order to guarantee consistency of the study. The advantage of using this measure of reliability meant it could be conducted on a single occasion utilising a single form (Markon *et al*., 2011). This method of ensuring test quality estimated the

correlation of one set of items to another on the test form (John and Benet-Martínez, 2012). Markon *et al*. (2011) asserted that it is used to ascertain the relationship in a participant's response from a single survey. The researcher asked 13 questions on knowledge and attitude regarding the use of family planning methods to ensure internal consistency. Respondents were asked questions such as, "Are you aware of family planning methods", "Tell us about your use of family planning and/or reasons for not using it". To these questions, the subject's responses show consistency and were highly correlated. For example, none of the respondents who said, "No" in response to a question surrounding their awareness of contraception question, indicated they had been using contraception. Parallel-forms of reliability aided the researcher in the evaluation of different sets of questions that aimed to assessing the same construct (Picardi and Masick, 2013). Prior to the main collection of data, the researcher developed different questions on contraception and split them into two distinct halves. Each of these questions was administered to half of the participants, who were randomly selected. The test questions that provided the most consistent response were then used for the final study. Construct validity checks were also undertaken to ensure sufficient test validity alongside the overall representativeness of the data.

Data Analysis

The Statistical Package for Social Sciences version 22.0 (SPSS) was used for data analysis in the study. Raw data was coded from the raw data of questionnaires into numerical data. Results were then presented in tables, graphs, figures and percentages.

Research Ethics

Ethical approval for this study was granted by the University of Sunderland Ethics Committee, the Health Research Ethics Committee of the River State Health Management Board and the River State Primary Healthcare Management Board. P Participants were assured of anonymity, confidentiality and privacy throughout the study and the questionnaire was administered with the informed consent of all women involved.

RESULTS, DATA PRESENTATION AND ANALYSIS

Socio-Demographic Context

A total of 100 participants were enrolled in the study and were categorised into five age groups; Group A: 15-24 years 22 (22%), Group B: 25-34 years, 71 (71%), Group C: 35-44 years, 7 (7%) and Group D: 45-49 years, 0 (0%). The majority of the respondents were noted to be within the age of 25-34 years, 71 (71%). The majority of the respondents 71 (71%) utilising health care services were within the ages of 25-34 years.

Socio-cultural characteristics

Marital status

The majority of the participants 91 (91%) were married, 6 (6%) of respondents were single and 3 (3%) were cohabiting.

Level of education

51 (51%) of respondents had attained tertiary level of education, (43%) had attained secondary level of education with 6 (6%) attaining only primary level education.

Religious affiliations

49 (49%) of respondents were Pentecostal Christians, with 23 (23%) Roman Catholic, 18 (18%) Protestant/Anglican Christians, 5 (5%) Muslims and 5 (5%) describing themselves as being of Other Faiths/No Faith

Respondents' occupation

Of the respondents studied, 37 (37%) were self-employed, 25 (25%) were unemployed, 24 (24%) were students, 12 (12%) were employees and 2 (2%) were farmers.

Spouse refusal or acceptance of family planning

64 (64%) of the respondents indicated that their husband's rejected the opportunity to adopt any form of contraception, whereas 36 (36%) of respondents were encouraged to use contraception as a mechanism of family planning by their spouses.

Sexual and reproductive health characteristics

Age and age of first sexual encounter

It was established from the study that 61 (61%) of respondents had their first sexual encounter at the age of 20 years and above; the remainder 39 (39%) of respondents had their first sexual encounter at before the age of 20 years.

Age at first pregnancy

65 (65%) of the respondents first conceived at age 20 years or over whilst 35 (35%) had their first pregnancies below the age of 20 years.

Number of pregnancies

56 (56%) of the respondents gave birth to between 2-4 number of children, that is 2 to 4 pregnancies. 21 (21%) had one pregnancy, 6 (6%) had 5-7 number of pregnancies while 17 (17%) had over 7 pregnancies. However, the category of respondents who had over 7 pregnancies are considered to be at high risk of obstetric complications

Analysis of relationships between socio-cultural variables and use of family planning services (test of hypothesis)

Relationship between level of education and age at first pregnancy

The findings (Table 1: Correlation analysis between level of education and age at first pregnancy) of the study indicate the relationship between level of education and women's age at first pregnancy. The table reveals that there is no relationship ($p > 0.05$) between (95% CI; 0.05) levels of education and age at which respondents had their first pregnancies. This implies that educational level had no impact on the age at which respondents got married.

Table 1. Correlation analysis between level of education and age at first pregnancy

		Level of Education	Age at first pregnancy
Level of Education	Pearson Correlation	1	.226*
	Sig. (2-tailed)		.024
	N	100	100
Age at first pregnancy	Pearson Correlation	.226*	1
	Sig. (2-tailed)	.024	
	N	100	100

*. Correlation is significant at the 0.05 level (2-tailed).

Relationship between level of Education and Number of pregnancy

The table below reveals the association between level of education and number of pregnancies. Meanwhile, the result indicates that there is a significant relationship between level of education and number of pregnancies among the respondents in this study. This is because at 95% CI; 0.05 the significant value was -0.073 which is less than 0.05 which entails a strong association between levels of education and number of pregnancies.

Table 2. Correlation analysis between level of education and number of pregnancies

		Level of Education	Number of pregnancy
Level of Education	Pearson Correlation	1	-.073
	Sig. (2-tailed)		.470
	N	100	100
Number of pregnancy	Pearson Correlation	-.073	1
	Sig. (2-tailed)	.470	
	N	100	100

Relationship between level of education and contraceptive use

Table 3 (Correlation analysis between level of education and contraceptive use) below shows the association between level of education and contraceptive use. From the result there is a significant relationship between level of education and contraceptive use (at 95% CI; 0.05 the significant value was -0.106 which is less than 0.05 which entails a strong association between levels of education and contraceptive use.

Table 3.Correlation analysis between level of education and contraceptive use

		Level of Education	Ever of used
Level of Education	Pearson Correlation	1	-.106
	Sig. (2-tailed)		.295
	N	100	100
Use of family planning	Pearson Correlation	-.106	1
	Sig. (2-tailed)	.295	
	N	100	100

Relationship between level of education and awareness of family planning services

Table 4 (Correlation analysis between level of education and awareness of family planning services) below reveals the association between level of education and awareness of family planning services. From the result there is a significant relationship between level of education and contraceptive use. This is because at 95% CI; 0.05 the significant value was -0.014 which is less than 0.05 which entails a strong association between levels of education and awareness of contraceptive use.

Table 4. Correlation analysis between level of education and awareness of family planning services

		Level of family	Awareness of family planning
Level of Education	Pearson Correlation	1	-.014
	Sig. (2-tailed)		.889
	N	100	100
Awareness of family planning services	Pearson Correlation	-.014	1
	Sig. (2-tailed)	.889	
	N	100	100

Relationship between Religion and Contraceptive use

Table 5 (Correlation analysis between religion and contraceptive use) reveals the association between religion and contraceptive use. From the result, there is a significant relationship between religion and contraceptive use. This is because at 95% CI; 0.05 the significant value was -0.119 which is less than 0.05 which entails a strong association between religion and contraceptive use

Table 5. Correlation analysis between religion and contraceptive use

		Religion	Ever used
Religion	Pearson Correlation	1	-.119
	Sig. (2-tailed)		.237
	N	100	100
Use of family planning	Pearson Correlation	-.119	1
	Sig. (2-tailed)	.237	
	N	100	100

Table 6. Correlation analysis between culture and contraceptive use

		Reason for not using family planning	Culture prohibi ts it
Reason for not using family planning	Pearson Correlation	1	-.133
	Sig. (2-tailed)		.186
	N	100	100
Culture prohibits it	Pearson Correlation	-.133	1
	Sig. (2-tailed)	.186	
	N	100	100

Relationship between culture and Contraceptive

Table 6 (Correlation analysis between culture and contraceptive use) below reveals the association between culture and contraceptive use. From the result there is a significant relationship between level of education and contraceptive use. This is because at 95% CI; 0.05 the significant value was -0.133 which is less than 0.05 which entails a strong association between contraceptive use and culture

RESULTS AND DISCUSSION

A total of 100 participants were enrolled in this study and were categorised into four age groups as previously outlined; Group A: 15-24 years 22 (22%), Group B: 25-34 years, 71 (71%),

Group C: 35-44 years, 7 (7%) and Group D: 45-49 years, 0 (0%). The majority of the respondents were noted to be within the ages of 25-34 years, 71 (71%). All the respondents (100) were women and the majority of the respondents 71 (71%) who utilise health care services are between 25-34 years. The respondents' marital status showed that 91 (91%) of them were married while a very few 6 (6%) were single mothers, and only 3 (3%) were cohabiting with their partners, but not married. Respondents' educational levels indicated that the majority of them 51 (51%) attained tertiary level while 43 (43%), 6 (6%) respectively, attained secondary and primary levels of education. Regarding their religious affiliations, the majority of the participants (41%) were of the Pentecostal denomination; Catholic, 23 (23%); Anglican, 18 (18%); Muslim, 5 (5%) and others, 5 (5%). The respondents' occupations as presented in chapter 6 indicated that majority of them 37 (37%) were self-employed; 25 (25%) were unemployed; 24 (24%) students; 12 (12%) employees and only 2 (2%) were farmers. Also, those whose husbands did not approve of family planning as presented in Table 6 were higher 64 (64%) than those whose husbands approved of it 36 (36%). Findings from the analysis of age, education, religion, occupation and husband's approval of family planning revealed the important socio-cultural variables when explaining the use of family planning services among the population studied. On analysis, the results indicated that use of family planning services was higher among the married population within the age group of 25-34 years while it decreased among younger and older age groups. The low use of contraceptives among younger age groups may be attributed to the fact that they were newly married and marriage is traditionally seen as an institution where children are produced. However, other problems such as awareness and availability may influence young mothers' ability to seek family planning services. Furthermore, reduced use of family planning among older mothers may be because coital frequencies reduce with age. Meanwhile, it is possible that some of them may be using other traditional methods that they may not want to share with the researcher. However, a good percentage of the older women may no longer be sexually active or may have attained their desired number of children. Bivariate analysis indicated that educational level is a significant factor that influences women's use of family planning services. As previously presented in the results, there is an important relationship between levels of education and women's age at first pregnancy. Nonetheless, this study's findings reveal that at 95% CI (p=0.05), there was a significant association between level of education and the period or age at which respondents had their first pregnancies. This implies that the higher the educational level of women, the more informed on the relevance of contraceptive use and vice versa. The implication of this could be that increasing the educational level of women is an effective approach that can promote the use of contraceptives or family planning services. These findings are consistent with other studies conducted in other parts of Nigeria as well as in other countries. The findings of Azuh *et al*. (2015) conducted in Western Nigeria, Yeshiwondim *et al*. (2009) conducted in Ethiopia and Saleem and Boback (2005) conducted in Pakistan, indicated that a higher level of education, good communication, including the husband's approval increase the use of contraceptives. Therefore, these findings confirm that it is important to empower women to enable them to make good health choices. Meanwhile, the most important predictor of use of family planning services in this study is the respondents 'partner approval. The majority, 64 (64%) of the respondents were refused the use of contraception by their husbands. This may imply that men, (husbands) are dominant in terms of decision-making regarding reproductive issues in the families of those studied. This suggests that the higher the partners favourable attitude and involvement in family planning; the higher the likelihood of their use. There is a higher likelihood that the respondents whose husbands approved of contraceptive use will be positive in their attitude towards using family planning services. This is consistent with the findings of Azuh *et al*. (2010) and Tomlinson *et al*. (2013) conducted in Northern Nigeria and Malawi respectively which indicated that family planning services were utilized more by women who got support from their husbands. Therefore, these studies confirm the need for male involvement in family planning. Findings recorded in this study as presented in the results reveals an association between culture and contraceptive use. At 95% CI; 0.05 the significant value was -0.133 which is less than 0.05 showing a strong association between contraceptive use and culture. This agrees with the findings of previous studies conducted in Nigeria. Erinsho (2005) reported that culture can influence an individuals' health in several ways, for instance, health behaviour and people's actions towards illnesses are shaped by culture. Azuh *et al*. (2015) found cultural factors that can influence women's health include gender norms, child marriage and early pregnancy, cultural practices that prohibit women from eating nutritious diets particularly during pregnancy and female genital mutilation. Also, Joseph *et al*. (2007) reported that the adverse consequence of these practices can result in damaging the health of women and young girls. In Nigeria, there is a high preference for many children, particularly for boys, which may have been the reason for the respondents' refusal to use contraceptives. A previous study by Azim and Lotfi (2011) reveal that women's reproductive choices in terms of a number of children and the spacing are shaped by these cultural factors. Besides, Erinsho (2005) and Lanre-Abass (2008) found that women are not allowed to exercise rights regarding their reproductive intentions as only their husbands are culturally empowered to make decisions about whether or not a particular treatment or contraception will be adopted. In Nigeria and some other developing countries, women often fear that their husbands may refuse them access to some treatment options that in most cases result in covert treatment, particularly in the use of birth control devices (Ekechi *et al*., 2012).This implies that women's right to their reproductive choices are limited by these cultural practices. In the opinions of Ezeonwu (2011), cultural practices and taboos restrict women from seeking proper health information as they cannot freely discuss their health needs and risks while those who do not associate with others may not readily obtain assistance towards resolving their health issues. Decisions about women's health and reproductive choices can only be taken by their husbands due to the cultural norms in their society that place men as superior beings (Azuh *et al*., 2015; Olaitan, 2011). The implication of this is that women's health decisions about when to seek medical attention are dependent on their husbands which can lead to unnecessary delays. Furthermore, the significant relationship between a husband's refusal and acceptance of family planning as presented in Tables 1 and 2 could be due to the fact that men are culturally empowered to make decisions alone, even when it involves women's reproductive health. On the other hand, the non-association between levels of education and age at which the respondents had their first pregnancies as presented in the results may be attributable to the fact that the level of

education attained at that particular time may not be enough to be transformed into power that can enable them face gender roles. This may equally limit their abilities to challenge cultural issues. Therefore, there is the need for better education for women to empower and enhance their rights and perceptions on the use of family planning services. The socio-cultural determinants in the use of family planning services in Nigeria as reported in this study have policy and programme implications. This includes potential generalis ability to other African countries that have similar socio-economic and cultural contexts (Tomlinson *et al*., 2013).This study highlights the need for the national health infrastructure of Nigeria to incorporate increased emphasis on the further development of programmes targeted at increasing accessibility of family planning services to women. Family planning programmes ought to incorporate the potential empowerment of women through education (Azuh *et al*., 2010). This is of particular relevance to remote villages, where cultural adjustments could be incorporated to accommodate local tradition and cultural perspectives. In some instances, women express a fear of the potential side effects of contraceptive use (Tomlinson *et al*., 2013).

This necessitates the need for continuous dialogue between service users and healthcare workers or service providers to allay this anxiety (Azuh *et al*., 2010). Most significantly in terms of enhancing family planning services, decision making ought to accommodate the contribution of the husband. Enhancing communication between couples in relation to contraception and family planning ought also to be a priority. This is because the cultural orientations of Nigeria and other countries empower men more than women in relation to their capacity for informed decision-making regarding reproductive health and family well-being. Research reveals that Nigerian society and culture are largely male-dominated, even with issues concerning women's reproductive health (Tomlinson *et al*, 2013; Azuh *et al*, 2009). This implies that men's involvement in family planning is a dominant force in marital relationships and those men are often solely responsible for making decisions about family planning in Nigeria and many other developing countries (Yeshiwondim *et al*., 2009; Saleem and Bobak, 2005). Similarly research by Olaitan (2011) revealed that in Nigeria, one of the factors hindering the effectiveness of family planning across Nigeria, is male dominance in decision-making, which can be attributed to male fertility preferences. The success and adoption of family planning services can be improved by the involvement of men in its programmes through the establishment of family planning clinics in their workplaces (ibid, 2011). Another crucial step that can improve the use of family planning services in Nigeria is theongoing iterative education of young girls and women, in relation to reproductive health. Azuh *et al*. (2009) noted that an increase in the level of education of girls and young women actively increases their engagement and access to family planning services, particularly in relation to oral contraception. As an adjunct to this, an increased level of education programmes for girls and women, was found to enhance female participation in the market economy as long as a decade ago (Saleem and Bobak, 2005). This suggests that family planning programmes should be designed to focus more on younger, less educated women and they should be provided with reproductive health information, including basic life skills that can enable them to make informed decisions about their sexual health and emotional maturity in relation to childbearing

Conclusion

The results of this study compound findings of the extant literature that a convergence of social and cultural factors strongly determine health outcome in Port Harcourt, Nigeria. The findings of this study conclusively revealed that while some socio-cultural variables influenced women's access to family planning services, many of the factors analysed did not significantly affect their contraceptive use or informed choice amongst this population sample. Socio-cultural factors such as occupation, marital status or preference for traditional methods did not significantly impact on uptake of contraceptive use and informed decision making. However, cultural norms, the level of education, age at first intercourse and pregnancy and number of births were factors that significantly affected respondents' use of family planning services. Spouse decision regarding the use and choice of contraception was a strong determinant of its use amongst the population of women studied. Furthermore, the use of modern methods of family planning among this populace, as observed from this study's findings, could potentially be increased by prioritising the reproductive health educational needs of teenagers of both genders. Targeting schools, youth associations, religious organisations and local communities would be one potential mechanism of ensuring that whole families are educated about the importance of family planning or contraceptive use. This can be intensified through mass media and awareness raising campaigns.

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