Personal and Socio-cultural Factors as Determinants of Family Planning Adoption Among Female Secondary School Teachers in Oyo Zone, Oyo State

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Chapter one

Introduction

1.1 Background to the Study

Family is the basic unit of any human community, and it is the primary agent of socialization. It is also a product of a very important institution known as marriage, and marriage is known to be one of the sacred social institutions through which man may have been able to perpetrate his presence on earth [3]. Planning is a systematic arrangement or organization of a programme. The essence of family planning is to protect women from any health risks that may occur before, during or after childbirth. These include high blood pressure, gestational diabetes, infections, miscarriage and stillbirth[4].

Overtime, family planning has contributed immensely to maternal health and ensured healthy and safe means of child bearing. However, with the widespread information and use in developed countries, this is not so most especially in developing countries, particularly in Oyo State, Nigeria. The use of family planning is termed exclusively to the elites as most women in the community of Oyo zone see family planning as a waste of time and a way of disrupting Gods plan[1].

Reports and complaint by medical practitioners and nurses who are prime preachers of adoption of family planning has it that, most women around Oyo zone do not see the positive or benefits of family planning, rather listen to complains and negative reports of the adverse effects of family planning reported or rumored by other women in the community. Secondly, some women who are ready to adopt one of the various types were not supported by their spouse or given money to go about the available choice of family planning. In some cases, some women are prevented from adopting a family planning type due to religion and norms that are associated by choice of preventing fertility. This norms or taboo is highly preached about which significantly reduced the adoption of family planning by some women in Oyo zone.

Oyo zone has a population of females than males and most of which are teachers due to the enormous schools in the zone. It is however a thing of surprise that even among the elites who are teachers, that are supposed to fully understand the benefits and value to which family adoption will do to them, most of those women are always seen having pregnancies that are not spaced and when asked why they have not yet adopted family planning, they complained of fear of health hazard, non-consent by spouse, request for desire of more children and also that their religion is not in support of family planning. This has put even teachers who are pregnant and their administrators to at times find such period unnecessary and most times these women are not fully permitted to stay off work and indirectly affects the way such teachers deliver instruction in classroom to students or pupils they are in charge of.

The benefits of family planning are enormous and adopting one's choice is of great benefits and value to the mother and child health. The choice of family planning is based on individual body composition and how their body can adapt to the choice been given. Teachers in Oyo zone are among the middle class citizens and their take home are not encouraging, taking into consideration of complains by some who says they cannot afford family planning because of funds. With the rate of inflation and rise in price of commodities in the country, it is hard to convince even an educated individual to do family planning when they know such can be prevented by other means of contraception which is readily available in chemist. Although several educated teachers agree such contraceptives fails, they risk their chance of having pregnancy due to the fact of fund, fear of disrupt in their reproductive health among many other reported post symptoms of family planning when stopped or removed from the body[1].

Developing countries are characterized by rapid population growth which is usually due to high fertility, high birth rates, and low contraceptive prevalence rate. The

rate of population growth is high compared to the rest of the world[1]. Consequently, the number of people in need of health and education and basic infrastructure, among other public benefits, is enormous. This in turn requires large amounts of resources and personnel, and it may be an impediment toward the realization of the Millennium Development Goals[2].

The International Conference on Population and Development in 1994 affirmed the importance of providing family planning within a right-based framework and as part of a comprehensive set of services to meet individual reproductive health needs that would also address broader development concerns [3]. Family planning is described as having the freedom and responsibility by couples and individuals to decide the number of children they desire and having the knowledge, education and tools for this purpose. In other words, family planning is a preventive service that allows married couples achieve their desired number of children and deciding the spacing of pregnancies according to their economic opportunities and personal wishes, and to ensure that the births are at appropriate intervals for the mother and child health.

Family is the basic unit of any human community, and it is the primary agent of socialization. It is also a product of a very important institution known as marriage, and marriage is known to be one of the sacred social institutions through which man may have been able to perpetrate his presence on earth [3]. Planning is a systematic arrangement or organization of a programme. The essence of family planning is to protect women from any health risks that may occur before, during or after childbirth. These include high blood pressure, gestational diabetes, infections, miscarriage and stillbirth[4].

Family planning refers to the use of various methods of fertility control that will help individuals (men and women) or couples to have the number of children they desire and when they want them in order to ensure the wellbeing of children and the parents[4].

Promotion of family planning in countries with high birth rates has the potential of reducing poverty and hunger, while at the same time averting 32% of all maternal deaths and nearly 10% of child mortality. Unintended pregnancy poses a major challenge to reproductive health [5]. Each year, 210 million women around the world become pregnant, among which 36% are unplanned and/or unwanted [6]. Nigeria currently has a high rate of maternal mortality, and 40% of these maternal deaths are due to complications of unsafe abortions as a response to unwanted pregnancy[7],[8].

Family planning implies the ability of individual and couples to anticipate and attains their desired number of children by spacing and timing their births. It is achieved through the use of contraceptive methods and the treatment of involuntary infertility. It safeguards individual health and rights, and improves the quality of life of couples and their children [5]. It is also an important strategy in promoting maternal and child health. It improves health through adequate spacing of births and avoiding pregnancy at high risk. It was demonstrated that even if there is no reduction in the family size of individual couples, delaying child bearing will bring about a decline in fertility and population growth rate [6].

. The fertility rate in Nigeria is 5.7% children per woman. Contraceptive prevalence rate has been found to be low at 13% in 2008 and with a minimal increase of 3% in 2013[9]. Everybody has the option to choose the number and timing of kids without segregation, viciousness and persecution, to have the vital data and offices for it, to get to sexual and regenerative wellbeing administrations at the best quality[10]. Inadequate or erroneous family planning techniques, wrong perspectives and practices toward the strategies and resulting impromptu pregnancies, expanded maternal and baby death rates are the primary medical issues in many nations. People learning modern family planning

strategies and having inspirational disposition for these techniques may expand the utilization of these strategies and contribute to the development of solid networks.

Over 22 million unsafe premature births that happen each year cause about 47,000 maternal deaths in the short or long term, mostly in developing countries. It is estimated that up to one-third of maternal deaths can be prevented by using contraception in women who are seeking to postpone or delay postpartum [2]. Across the world, it is estimated that 222 million women have unmet need for family planning. This unmet need is prevalent in particular populations, especially those who are sexually active, those with low socioeconomic status, those living in rural communities and those coping with conflicts and disasters. If the need for uncontrolled birth is met, it is estimated that maternal mortality still occurring in these countries can be avoided by more than 30% [5].

In a society, appropriate conditions for fertility and bringing the child to the world, pregnancy, how birth will be, what the prenatal and postnatal care standards are, the 'birth culture' that is peculiar to the collective and tries to preserve the basic approaches, perhaps changing a little from generation to generation and taught to other generations. Economic conditions of the society (distribution of income, employment opportunities, etc.), family structure (which is common among the core/extended family models, relationships among family members, sharing of responsibilities, etc.), gender roles, beliefs of society, marriage models (polygamy, same place, same family marriage, relatives marriage, etc.), sexual behaviors (premarital, out-of-marriage relationships, marriage prohibitions, etc.), using or not using contraceptive methods vary from community to community [21].

Properties of family, economic circumstance of community, the ban of some contraceptive methods in that society, opinion about abortions', concerns about using

several contraceptive methods, population policies, gravidity, religion, the idea of sin, traditional practices, etc.; are all among the most important factors determining health status. Some are not direct health care determinants but may be preparatory, adjuvant or preventative [22]. Having a strong religious identity affects willingness of women to discuss contraception with their partners/families/communities and an unwillingness to consider accessing it and eventually using it. Similarly, the institutionalized religious doctrines intersect with cultural beliefs in a society which bestows man as the overall head of the house and, such beliefs are inherently subsumed in a patriarchal structure, where women have been relegated as a weaker gender and could only measure their freedom of choice within the acceptable framework.

Different determinants of family planning are mentioned by different scholars in their studies. Among these are lack of adequate information and ignorance. Some of the key determinants factors are fear of health hazard related to childbearing, desire for more children, religious belief, spousal disposition, media influence, tradition, norms and customs of family planning adoption in Nigeria. Many potential informational barriers exist to contraceptive use, women must be aware of the methods available, must know where supplies of these methods can be obtained and they must know how to use the method they choose [6]. Each year, an estimated 500,000 women die of complications in African due to pregnancy, child bearing or unsafe abortion [8].

Research on family planning determinants during the last four decades has focused on economic and sociocultural determinants that affect the attitude of individual or couples towards family size[7]. The policies and programmes intended to bring about a change from large to small family norms cannot succeed without a thorough understanding of these factors in various socio-economic contexts; hence the need for this

study cannot be overemphasized. In a developing country like Nigeria, family planning gets priority and many programmes have been implemented by the Nigerian government to increase a contraceptive practice. This was publicized through the use of media; both electronic and print, public sensitization, women health talk in maternity centers and the creation of awareness through non-governmental organizations public rally.

The problem of high fertility rate and low contraceptive practices are still present. Researchers asserted that personal and socio-cultural factors are one of the major determinants of family planning in developing countries like Nigeria [10]. As a result, in this study, personal and socio-cultural determinants of family planning adoption will be considered in the discussion of the researcher in conducting research on family planning adoption among female teachers in secondary schools.

Spousal disposition is one of the personal factors affecting family planning in Nigeria. The importance of spousal communication is often emphasized in family planning programmes and research[8]. In some analysts' view, it is the first step in a rational fertility decision-making process. Numerous studies show that the amount of communication that occurs between partners is positively associated with contraceptive use and Spousal communication concerning contraception, especially in developing countries, remains rare[9]. Thus, communication interventions have been developed and implemented to encourage couples to talk about the number of children to have, birth spacing and contraceptive use. Since relatively little is known about reproductive decision-making, studies on the process and its outcomes are important for both programmatic and theoretical reasons.[10]

The association of spousal communication with family planning use is widely recognized, the sequence of the relationship whether spousal communication precedes or follows adoption of contraception is unclear. A common assumption is that

communication leads to family planning use, but the reverse could also be true. For example, one study suggests that use of natural family planning methods leads to greater communication, because couples need to talk about the reproductive cycle [11]. If communication follows the adoption of a method, then it would be unnecessary for programs to focus on facilitating communication; they could, instead, invest in other strategies for enhancing clients' acceptance and use of family planning services[12].

Part of the difficulty in drawing inferences about the direction of the relationship is that most research on spousal communication is based on cross-sectional data. Researchers who have studied spousal views about and attitudes toward contraception and communication in various settings have acknowledged this limitation of their work. Thus, the use of panel data would be necessary to clarify this relationship[13].Another personal factor for family planning is personal preferences. Personal preferences play a critical role in the selection of family planning method. The decision-making dynamic is at least influenced if not fully determined by the partner's or spouse's position on the subject. Men, who generally act as head of their households, hold full decision-making power, including power over family planning issues that are socio-cultural perceived as "women's matters"[14.] Men report that they feel entitled to dominate women, a clear expression of unequal power relations, ensuring that women are unable to control the timing of sex, the use of condom and either their wives should use[15]. In rural areas, women rarely make a decision to use contraception without consulting their husbands first. Women who receive support from their partner for family planning or reproductive health care, on the other hand, are more likely to have access to and use these services[16].

Desire for more children is also another personal factor. Couples are having fewer children in recent times, and this may have led to a decrease in population growth in most

high-income countries. They are able to achieve their fertility desires and pregnancy spacing by using modern contraceptives[17]. However, contraceptive use and other family planning strategies are considered to be low in Nigeria, and this has increased mistimed and unwanted pregnancies, as well as high youth dependency[18,19,20.]

As indicated above, this reveals that desire for more children is of great concern for women in their reproductive ages in Nigeria. Deeply rooted in strong societal and personal factors, desire for children is pivotal to family formation process in several communities of the world. Desire for more children is greatly driven by preference for large families, desire for sons, and the union's stability[24.] A Demographic and Health Survey (DHS) based study observed that women in their reproductive ages in about sixty countries desired more children, however, these women had an average of six children[25.] While, in today's society, cost and availability issue spousal disposition, media influences, religious belief seems not to be such a priority, contraceptive "acceptance" is still a problem among female teachers.

The researchers argue that contraceptive acceptance is still a fundamental issue that requires policy attention. This, they stressed, will involve delicate social custom which may "involve such sensitive community factors as the relative value of fertility within specific societies, local customs about sexual activity at early ages, community pressures on teenagers to bear children, social norms about genital manipulation, and religious prescriptions against the use of particular contraceptive"[21]. Using contraception has two main benefits of preventing unplanned pregnancy and the potential secondary benefits of protection against sexually transmitted infections (STIs).

1.2 Statement of the Problem

Adoption of family planning (FP) guarantees women of reproductive ages health and rights. It improves families' quality of life and by implication, the larger society. Despite the many benefits of FP, it was observed that female teacher in Oyo zone women level of family adoption was very low judging by the way at which they procreate and the gap between births. The trend was also visible among the female teachers in the same zone. This was in particular worrisome because these teachers are expected to be knowledgeable about the benefit of family planning and the element of change in the community by show_ casing these benefits through practice. Personal interactions with some of the female teachers revealed that though many of them have heard about FP, yet they have not adopted any particular method.

The rate at which female teachers in Oyo procreate and subsequently request for maternity leave and take absence from duty due to health consequences experienced by them during pregnancy affect teaching and learning processes in school. This consistent request for permission from head teachers and administrators in schools pose treat to teaching and instructions in classroom. Female teachers in school who are pregnant gives attitude to students in schools due to mood swing and they do not teach effectively in classrooms due to health consequences that comes with pregnancy.

If teachers who are expected to be knowledgeable about family planning adoption do not see its benefits to their reproductive health, then the subsequent challenges faced with Oyo Female teachers as regards unnecessary permission request from their supervisors and also not giving their full attention to the task of delivering instructions to students in classroom will continue to persist and further affect teaching and learning as well as their reproductive health due to constant labor and child bearing.

Therefore, this research investigates the personal and socio-cultural factors as determinants of family planning adoption among female secondary school teachers in Oyo Zone, Oyo State.

1.3 Aim and Objectives of the Study

The aim of this study was to investigate the personal and socio-cultural factors that determines the adoption of family planning among female teachers in Oyo Zone, Oyo State.

The objectives of this study are: to

i. determine is the level of family planning adoption among female secondary school teachers in Oyo Zone?

ii. determine the joint determinant of personal factor (fear of health hazard related to child bearing and desire for more children.)

iii. examine the joint determinant of socio factor (religion, spousal disposition and media influence) on family planning adoption

iv. determine the joint determinant of cultural factor (tradition, norms and customs) on family planning adoption among female secondary school teachers in Oyo zone

1.4 Research Question

The following research question were raised and answered in the study;

1. Do female secondary school teachers adopt family planning in Oyo Zone?

1.5 Hypotheses

The following hypotheses were tested at 0.05 level of significance:

Ho1. There is no significant joint influenced contribution of Personal factors (fear of health hazard related to child bearing and desire for more children) to adoption of family planning among female secondary school teachers in Oyo Zone.

Ho2. There is no significant relative influenced contribution of Fear of health hazard related to child bearing and desire for more children to adoption of family planning among female secondary school teachers in Oyo Zone.

Ho3. There is no significant joint influenced contribution of Social factors (religion, spousal disposition and media influence) to adoption of family planning among female secondary school teachers in Oyo Zone.

Ho4. There is no significant relative influenced contribution of Religion, spousal disposition and media influence to adoption of family planning among female secondary school teachers in Oyo Zone.

Ho5. There is no significant joint influenced contribution of Cultural factors (tradition, norm and customs) to adoption of family planning among female secondary school teachers in Oyo Zone.

Ho6. There is no significant relative influenced contribution of Tradition, norm and customs to adoption of family planning among female secondary school teachers in Oyo Zone.

Ho7. There is no significant difference in the level of family planning adoption among female secondary school teachers across the four local government areas in Oyo Zone.

1.6 Significance of the Study

It is anticipated that this study would be of use to the female teachers, as well as the researchers in the field of health education, mental health expert, health policy decision makers and Non-governmental organization. This will assist the female teachers

in all registered schools in Oyo zone to adopt family planning and enhance child bearing according to their financial ability. It will be of great benefit to population planners as it will reflect the values associated with population control to Nigeria and its citizens. It will be useful for every family as it will assist all couples in planning for their family by adopting the best family planning methods and improve child spacing and also health of the mother and child.

The study will also contribute to the advancement of knowledge particularly in the area of family planning and its management. It will also enable us to know how to protect and nurture the historical brand of various forms and nature of ideal family planning. The findings and recommendation of this study will helps in order to meet their dream to be highly productive as well as to be a happy family.

It is hoped that the study will provide information for government teachers, parents, educators, school administrators and policy makers to reflect upon facilities, materials that will make teaching and use of family planning effective among females in schools, market and the community at large in Oyo zone.

1.7 Scope of the Study

This research focused on study of personal and socio-cultural factors as determinants of family planning adoption among female secondary teachers in Oyo Zone, Oyo State. The participants of the study were made up of female teachers in all registered secondary schools in Oyo Zone, Oyo State.

1.8 Limitation of the study

Getting teachers to attend to the questionnaire was a bit stressful due to the job schedule of the teachers in their schools. Also some felt reluctant and it took time to convince them

of the confidentiality of their responses. Despite these area of limitations, the findings of this study are adjudged to be valid

1.9 Operational Definition of Terms

1. **Contraceptive:** This is any method or a device use to prevent pregnancy.
2. **Family Planning**: This is the provision of birth prevention information services and appliances to women of reproductive ages.
3. **Birth Control**: This is a strategy adopted by a family to manage the birthrate, so as to achieve the aim of giving birth to only children they can cater for.
4. **Religion**: This is the pursuit or interest followed with great devotion.
5. **Family Planning Technique**: These are the procedure which women uses in an effort to control birth.
6. **Spousal Disposition**: This refers to the husband and wife's attitude to the adoption of family planning.
7. **Teachers**: These are classroom and subject teaching staff in public secondary school in Oyo zone.
8. **Media Influence:** The actual force exerted by a media message over family adoption that brings about changer or reinforcement in audience or individual beliefs.
9. **Fear of Health Hazard:** Is worrying excessively that someone may become seriously ill due to adopting family planning.
10. **Desire for More Children:** The cravenness or process of carrying and giving birth to children
11. **Tradition:** This is a belief or behavior passed down by female teachers or women in the society towards family planning adoption with origin in the past.

12. **Norms:** Are rules or expectations that are socially enforced towards adoption of family planning.

13. **Customs:** A traditional and widely accepted way of behaving or doing something that is specific to a particular society, place or time.

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Chapter Two

Literature Review

This chapter presents the review of related literature. The conceptual framework, theoretical and review of related literature is discussed in this chapter under the following sub-headings:

2.1 **Conceptual Review**

2.1.1 Concept of Family Planning

2.1.2 Personal Factors Determining Contraceptive Adoption

2.1. 3 Socio-Cultural Factors Determining Contraceptive Adoption

2.1.4 Overview of Family Planning Adoption in Nigeria Among Teachers

2.1.5 Concept of Family Planning

2.1.6 Concept of Contraception

2.1.7 Types of Contraception

2.1.8 Attitudes Affecting Family Planning

2.1.9 Other Factors Affecting Family Planning

2.1.10 Benefit of Family Planning

2.2 **Theoretical Review**

2.2.1 Health Belief Model

2.3 **Review of Empirical Studies**

2.3.1 Fear of Health Hazard and Desire for More Children

2.3.2 Religion, Spousal Disposition and Media Influence

2.3.3 Tradition, Norms and Customs

2.3.4 Family Planning Among Teachers

2.4 **Conceptual Framework (Model)**

2.5 **Summary of the Reviewed literature**

Endnotes

2.1 Conceptual Review

2.1.1 Personal Factors

Fear of Health Hazard Related to Child Bearing

Health hazard of family planning methods, either experienced or anticipated, have been identified as a common reason that women either choose not to start or discontinue contraceptives. This includes menstrual changes (heavier bleeding, amenorrhea or oligo menorrhea), changes in weight, headaches, dizziness, nausea, and cardiovascular impacts. In addition, women may harbor fears of long-term effects of contraceptive use, such as infertility and childbirth complications [1]. A 2014 systematic review found a significant proportion of women attributed their unmet need for family planning to a fear of side effects: 28% in Africa, 23% in Asia, and 35% in Latin America and the Caribbean. A fear of health hazard may occur when a woman or someone she knows has experienced side effects with a method, or when rumors or overestimations or rare complications are considered factual [2].

Common side effects were irregular bleeding no period, headaches, nausea/dizziness and weight gain/loss. These side effects occurred mainly among pill and injection users. The occurrence of side effects had a negative impact on continuation rates. Forty-seven per cent of the women stated that they had received counselling regarding side effects [3].

Desire for More Children

During the last half-century, many industrialized countries have seen vast changes in family dynamics and of the idea of what constitutes a family. Knowledge about how family dynamics have changed over time but know less about how intentions,

negotiations and decisions are shaping family patterns among today's generation of adults are considered among couples. Women's and men's roles have changed, primarily as many women have become economically independent through labour force participation and men are increasingly involved in caring for their children. We are, in this study, interested in whether this increased gender equality has led to a gender equal influence over decisions within the family. Also, focus on what is perhaps the most crucial and life-altering decision for a couple: whether to have a child or not has become what many couple discussed a lot[3].

The reason behind this decision on child bearing varies based on what each couple is battling with and the nature of the society they live. Some couple desire to have more children, some do not see reason to have children, some believe that having children will deter their office assignment, as a result, they give preference to office work than having more children. The reasons why most of Nigerian couple desire for more children include wanting a large numbers of children to populate the earth, help with farm work, and to provide old-age support, honour and prestige [4]. The authors further add that religion is another reason for the desire. Women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child. The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behavior [5].

2.1.2 Social Factors

Religious Influence

Religion is one of the factors which affect the pattern of contraceptive use as method of family planning. Islamic women for example tend to let men decide on the number of children required; such women are unlikely to use contraceptives. Also, the

Roman Catholic Church is opposed to many birth control methods and are very rigid in their views of family planning. Thus, the strong religious desire for more children prevented married women from using family planning. In addition, children come from God and therefore, there is no need for planning or controlling fertility[6]. In Nigeria, religion has been identified as one of the determinant factors that affect family planning practices[7]. However, based on religion kicking against family planning among married couples, it has shown that religion is a strong setback of family planning in Nigeria.

In a religiously pluralistic Nigerian setting, decision-making processes in different areas of and groups within the country are largely influenced by religious beliefs and practices. Consequently, religion is firmly intertwined with the day-to-day life of an average Nigerian. Considering the importance of religion to a majority of the population as well as the influential positions occupied by religious leaders in Nigeria. Religion plays a prominent role in how many children families have in Nigeria. About 50% of Nigerians identify themselves as Muslims, while 48.1% identify as Christians. Islam promotes large families and encourages early marriage and a polygamous family system. Christianity prohibits the most effective forms of contraception and does not support abortion[4].

The findings of a study, established that the concept of religiosity connotes a strong adherence to religious beliefs and doctrinal teachings. It also revealed that the family planning decisions made by the majority of women were influenced by religion. This demonstrates the importance of addressing religion in order to increase contraceptive use in Nigeria[8]. The key role religion plays in shaping the decision to use contraceptive methods. It was also affirmed that engaged religious leaders in promoting family planning had substantial coverage, as a large proportion of women were exposed to religious leaders' messages on family planning in the past year. Of the women who had this exposure, about one-third were currently using modern contraceptive methods. Moreover,

results from multivariable analysis established a significant association between exposure to family planning messages from religious leaders and modern contraceptive uptake. The importance of exposure to religious leaders' family planning messages was further supported in the adjusted model that included background characteristics and exposure to other interventions. The fact that exposure to religious leaders' messages became insignificant in the model that included the ideational variables is not surprising and suggests that the effect of exposure to communication operates through its effect on ideation. These results have important policy implications.

Considering the importance of religion in Nigeria's sociocultural fabric and the position of influence, authority, and respect occupied by various religious leaders (i.e., bishops, pastors, evangelists, imams, and sheiks as well as eminent trado-religious leaders, like emirs and sultans), one way of achieving a rapid increase in Nigeria's modern contraceptive prevalence rates may be to continuously engage religious leaders at all levels in advocacy efforts. Generally, Nigerians are very religious and seem to accord their religious leaders greater honor and veneration than what they confer on political leaders. As a result, religious leaders wield great influence over their large congregations. Their body language and messages can inhibit or facilitate effective health care-seeking behaviors. For example, religious belief, a key determinant of child immunization completeness, has previously been cited as an underlying factor for calling for a boycott of childhood immunization by trado-religious leaders in some parts of northern Nigeria. By engaging religious leaders in using appropriate family planning messaging, the modern contraceptive prevalence rates in Nigeria will likely increase [8].

In addendum, the looking into the relationship between effective contraception and maternal and child health, religious leaders have the power to promote family health and well-being and contribute to the discourse and strategies on maternal and newborn

morbidity and mortality reduction through congregational advocacy messages on the health benefits of family planning. Religious prohibition of contraceptive adoption still persists in Nigeria, partly because of the spread of myths and misconceptions about family planning. Because of this, the strategy of working with religious leaders to increase their knowledge of family planning and its benefits and, ultimately, engage them as change agents, may be crucial to increasing family planning adoption and promoting family health in Nigeria [8].

Moreover, higher contraceptive uptake among somewhat religious women than their strongly religious counterparts suggests that strong adherence to religious doctrines and practices, combined with religious leaders who do not incorporate appropriate family planning messages into their communications, likely contributes to low contraceptive uptake. Religion has been established as one of the most important determinants of behaviors, including health seeking. As religious beliefs continue to hinder contraceptive uptake in Nigeria, engaging religious leaders as potential change agents is crucial for creating positive change. The findings from this study, therefore, underscore the importance of enlisting religious leaders in efforts to increase contraceptive uptake in Nigeria[8].

Spousal Disposition

This studies in many developing countries of the world have shown that men often dominate in taking important decisions in the family, including reproduction, family size and contraceptive use[9]. The inter-spousal communication in Nigeria is also a factor in the adoption and sustained use of family planning[10]. The unawareness of husbands towards family planning methods, modern contraceptive and lack of spousal consent on family planning could impede the acceptability and utilization of modern family planning. This implies that male involvement is important in the awareness of family planning, as well

as, its adoption, usage and continuation. However, this argument does not justify in every human society and it depends on the cultural setting of the communities. For instance, a matriarchically society does not recognize the approval or consent of the men[11].

Media Influence

Mass media is a key strategy for increasing demand for use in health services. It is a process that helps communities to identify their own needs and to respond to and address these needs. Gaining the participation of community members can help providers raise awareness both of health issues at the community level and of social and cultural issues that may promote or inhibit use of information and services, as well as improve masses understanding of the methods or services being offered. Specific barriers to service access and use can be addressed and service utilization increased [12].

Effects of mass media, involve the feelings and emotions of individual members of society. As images of violence routinely appear in the media, for example, people may become desensitized to scenes of violence encountered in reality. They may experience different levels of fear, anxiety, hostility, frustration and related emotions as events are processed through media channels. Ultimately, the behavioral effects of mass media, according to the dependency theory, are described in terms of individuals doing something that they otherwise might not do if it were not for the influence of the media on which they are dependent. Media field is widely appreciated to promote Family Planning Programs in various areas [13].

Television is a powerful medium for appealing to mass audience. It reaches people regardless of age, sex, income, or educational level. In addition, television offers sight and sound, and it makes dramatic and lifelike representations of people and products. Studies revealed that women exposed to television regarding messages about Family

Planning used the methods more (2.44 times) than those who are not exposed to television in India [14].

Radio is the oldest form of electronic media than television, and is far better adapted to abstract thought and also reaches mass and diverse audiences. The specialization of radio stations by listener age, taste, and even gender permits more selectivity in reaching audience segments. Since placement and production costs are less for radio than for TV, radio is able to convey public health messages in greater detail. Thus, radio is sometimes considered to be more efficient. Radio health message campaigns have been effective in developing countries, especially when combined with posters and other mass media [14].

Unlike radios and TV, posters and newspapers are a direct way of communicating with people. They are used to spread a message, to promote an event and to support a great cause. Choosing the location of posters is very important. The message and the place should be changed occasionally. If posters are left in one place too long, they become part of the environment and no one looks at them, they should be easy to read and have an attractive image. Newspapers are read daily in 70 percent of U.S. households, and in as many as 90 percent of high-income households. Newspapers permit a higher level of detail in health reporting what is not feasible with other broadcast media. Whereas, one can miss a television broadcast about breast cancer, and thus, lose its entire message, one can read the same (and more detailed) message in a newspaper at one's choice of time and venue. Although newspapers permit consumers flexibility concerning what is read and when, they do have a brief shelf life. In many households, newspapers seldom survive more than one or two days. Newspapers are available in daily and weekly formats, and local, regional, and national publications exist. In addition, there are numerous special audience for newspapers (e.g. various ethnic groups, women and feminist related, gay and

lesbian, geography-specific, neighborhood). Consequently, health messages contained in newspapers can reach many people and diverse groups. Reading newspapers about Family Planning Program can influence positively the adherence to this program. Stories have power to shape personalities, to change beliefs, behaviors, and lives[14].

2.1.3 Cultural Factors

Tradition

The level of affiliation of an individual to his/her cultural beliefs influence childbearing behavior, and thus also contraceptive usage and/ or non-usage. In many Nigeria cultures, husbands pay bride prize in the form of money, or a particular kind of gift to the bride's family. Men because of this payment, they regard their wives as possessions that they have bought. Women end up not being able to decide on the number of children desired nor about use of contraceptives. In some circumstances the men can claim back his pride price if a wife fails to bear children[7]. In polygamous marriages, the wife with most children is likely to be the husband's favorite wife. Women in this kind of a marriage are not likely to use contraceptives, if they are competing to be the husband's favorite with the largest number of children,[16]. In this instance, even adolescents might not be willing to use contraceptives since they know the values, culture and beliefs about children in their societies. It implies that culture poses a barrier to the use of contraceptives.

Norms

Social norms are understood broadly as widely shared beliefs and common practices within a particular group[17]. Interrelated social norms concerning gender, tradition/modernity, religion, social status, age, education and employment status, and so on are important factors influencing family planning and contraception use. Modern contraceptives are condoms and hormonal birth control, as opposed to traditional methods. Social norm interventions focus at the interpersonal and community levels[18]. Social norm approaches at a basic level look at 'how particular social groups' shared expectations may be modified to shift behavior towards socially desired outcomes'[18]. More ambitious social norm approaches can 'aim to change power relations, economic inequalities and deeply rooted ideologies and cultural values'[17]. Both of these levels can influence contraception and family planning.

Customs

A custom is defined as a cultural idea that describes a regular, patterned behavior that is considered characteristic of life in a social system. Shaking hands, bowing, and kissing all customs are methods of greeting people. The method most commonly used in a given society helps distinguish one culture from another[19]. Before the introduction of modern methods of family planning, Africans had methods of fertility regulation. Nigerian custom includes many myths, rituals, and the use of herbs in attempts to regulate women's fertility. Although many of these traditional methods of family planning have no harmful effects on a woman's health, some however, do have dangerous or counterproductive effects. In addition, the complete effectiveness of many of the traditional methods remains doubtful[20].

The traditional methods of contraception include the lactation amenorrhea method, coitus interrupts (withdrawal method), calendar method or rhythm method, cervical mucus method and abstinence. Other form of traditional contraceptive methods (TCMs)

can be customs or beliefs which include some rituals and use of traditional medicine and herbs[20].

2.1. 4 Socio Cultural Factors

In every cultural group events such as coitus, pregnancy and birth show differences. In a society, appropriate conditions for fertility and bringing the child to the world, pregnancy, how birth will be, what the prenatal and postnatal care standards are, the 'birth culture' that is peculiar to the collective and tries to preserve the basic approaches, perhaps changing a little from generation to generation and taught to other generations. Economic conditions of the society (distribution of income, employment opportunities, etc.), family structure (which is common among the core/extended family models, relationships among family members, sharing of responsibilities, etc.), gender roles, beliefs of society, marriage models (polygamy, same place, same family marriage, relatives marriage, etc.), sexual behaviors (premarital, out-of-marriage relationships, marriage prohibitions, etc.), using or not using contraceptive methods vary from community to community [21].

Properties of family, economic circumstance of community, the ban of some contraceptive methods in that society, opinion about aborts', concerns about using several contraceptive methods, population policies, gravidity, religion, the idea of sin, traditional practices, etc.; all of which are among the most important factors determining health status. Some are not direct health care determinants but may be preparatory, adjuvant or preventative [22]. Having a strong religious identity affects willingness of women to discuss contraception with their partners/families/communities and an unwillingness to consider accessing it and eventually using it. Similarly, the institutionalized religious doctrines intersect with cultural beliefs in a society which bestows man as the overall head of the

house and, such beliefs are inherently subsumed in a patriarchal structure, where women have been relegated as a weaker gender and could only measure their freedom of choice within the acceptable framework.

Location

There are large differences by region. Contraceptives are used by almost all of the world's married or majority members. In 2015, 64% of married or in-union women between 15 and 49 years of age in the world were using any form of contraception. However, the use of contraceptives was much lower in less developed countries (40%), and was especially low in Africa (33%). Among other large geographical regions, the use of contraceptives increased significantly in 2015 from 59% in Oceania to 75% in North America [23]. Furthermore, place of residence has an impact on the use of contraceptive, and is higher in urban areas than in rural areas [24] The factors revealing these differences are better availability of social services such as education, access to health services, information and family planning services [25].

The results of a study support that social factors such as place of residence, affect the contraceptive utilization patterns. In this study, urban women were found more likely to use contraceptives compared to rural women [26]. Another study showed that utilization of family planning methods was found more in women of age group 30 or more, parity four and more, educational level up to high school and above and those of higher socioeconomic status whereas their residential area (urban or rural) was not found an influencing factor on practice of family planning by them. This study showed that all the women, both in urban and rural area, were willing to adopt a family planning method in future. All the women interviewed were in favor of practicing family planning.

However, only 55.9% women were found to have used some form of family planning. When comparing modern and traditional methods, the difference between the preferences of future family planning methods between urban and rural areas is statistically significant. Conservative use of the condom in rural areas (44.6%) and modern methods in urban areas (32.3%) seem to be at the highest level of future use preferences. The study also revealed a good knowledge and favorable attitude toward future use of family planning methods [27].

Age

The age of women plays an important role in the process of deciding when women will start and finish the process of giving birth and how long to wait after the birth of the next child. Also the use of family planning method varies according to the age of the woman. As women get older, their need for contraception and the rate of contraception decreases [28]. In a study, it was demonstrated that younger women, often have a stronger fertility desire than older women. In this study, 26% of the women aged 15–24 wanted another child within 2 years compared to 16% among women aged 25–34 [29]. The use of pills and condoms are preferred more when the average age is lower. When the contraceptive use of married and fertile women is examined according to their age, it is observed that middle-aged women tend to use the family planning method more than younger and older ones [30] Another study, demonstrated that use of contraception was maximum (84.8%) in 30 years and more and minimum (2.2%) in 20 years' age [31]. Similarly, NFHS-III, India reported more use of contraceptive by women of higher age group and parity [32]. Maternal age at first birth is an important determinant of the quality of life of the woman and the baby, maternal and child health and general fertility level.

Education

Women's education has a great influence on many health indicators and is one of the most commonly studied determinants of the use of contraception and unmet need. Women's attitudes toward family planning are influenced by experiences such as education and pregnancy. It was found that women who had a primary school graduate or higher education, had 1–3 pregnancies and did not want more children in the future got higher scores on the family planning attitude scale. As the level of education increases, the number of children required decreases [33]. The reason for this can be explained by the opportunity to learn about family planning and to raise awareness about the issue.

Similarly, as women's education levels increase, awareness increases. Sociocultural characteristics play an important role in this issue [34]. Education contributes significantly to the quality of women's lives. Improving women's access to education and encouraging continuous and constant exposure would significantly increase use of family planning and reduce unmet need. In societies with high levels of education and socioeconomic status, marriage, pregnancy and childbearing age occur at a later stage and therefore the need for contraceptive methods increases.

Using contraceptive methods prevent advanced pregnancies and high fertility. As the interval between births increases, the number of high-risk pregnancies decreases and maternal mortality declines. It was identified that the use of effective modern methods, intrauterine devices and oral contraceptives, increased as the education level and socioeconomic status of the women improved. Failure rate of contraceptive methods is reduced by informing pairs. Visual and audiovisual media play an important role in information provision and in creating awareness. Education and counseling services are most accessible and suitable for prenatal and postnatal periods[35].

Gender

Reproduction is a dual commitment, but in most of the world it is often seen as the responsibility of women entirely, and many family planning programs have focused mainly on women. Men are often described as forgotten reproductive health clients in family planning services. The role of men in family planning population planners have received more interest in recent years as they begin to notice the importance of male influence on reproductive decisions around the world. Up to this point, many activities are in the effort to determine or develop the knowledge and attitudes of men about family planning. While men play a direct and major role in deciding contraceptives, they play an indirect role as a dominant factor in women's economic, social and family needs. The role of men in decision-making on women's fertility and birth is always dominant.

The United State Agency for International Development has addressed women's participation in many aspects of family planning, such as condom promotion through social marketing or community-based distributors, training and promotion of vasectomy and Information and Education Campaigns to increase awareness and knowledge and to influence behavior change. The prevalence of contraceptive method use in married men was found to be approximately 15.0%, about 6.0% in their wives and 16.0% in couples. The mean age of participants was 38.3 ± 9.0 and the respondents' spouses were 32.7 ± 8.4. The percentage of married men who do not know how to read and write is 52.0 and 77.5% of their spouses are illiterate. Most married men were now using condoms and their wives were now using oral pills. Most married men (97.0%) were aware of common contraceptive methods. The research findings showed that married men who are illiterate and younger do not exchange ideas or allow their spouses to do family planning and that they do not even discuss family planning with their wives [36].

In another study, among married men about their contraceptive use and fertility preference reported interesting findings concerning male involvement in family planning decisions. The report also revealed that majority of the men have supportive attitude toward contraception use and recommended to strengthen efforts to convert the positive attitudes to positive behaviors to achieve greater success in family planning programs [37]. The reasons for inclusion of men in reproductive health issues are multifaceted. Above all, men have their own reproductive health concerns and their involvement should not be seen as a tool for better female reproductive health. Also, men's sexual health and reproductive health welfare and behavior directly affect their partners. Besides decisions about reproductive health occur in relationships between men and women [38].

Male methods of contraception, such as coitus interrupts' and condoms, although they have historically played a far greater role than women's methods, are denigrated as being unreliable or associated with extramarital sex, respectively. Birth control pills have been put in place of birth control, but responsibility should be shared by partners regardless of pregnancy, no matters which of them desires. The prominence of behavioral factors is due to the fact that most of the contraceptive failures originate from human error [39].

In the private arena, men can directly influence women's economic and social progress. In many societies men still say the last words about family planning and reproductive health, the use of family resources, including spouses and girls' participation in the labor market, and medical and educational spending. In developed countries, men have limited participation in child care and domestic affairs; this situation places a great burden on women's education and professional life. The role of men in developing countries is even more important in patriarchal structures that supervise the health

decisions of women of their husbands or other family members. Women's reproductive health is influenced by men's policy makers, male health care providers and men's services [39].

Men also affect women's reproductive health as partners and ancestors. Accordingly, understanding the behaviors and beliefs of the man about fertility and family planning is very important for the design of successful reproductive health policies. Poor knowledge of reproductive health issues among males may pose barriers for women to seek care for these problems [40]. Men as the heads of government and ministers of state, design and implement policies as leaders of religious and faith-based institutions, judges, chiefs of armies and other power organs. But they do not support women's priorities and needs. As public authorities, they also exercise control over a wide range of resources, such as health, education, transport or finance. This situation continues gender inequality in many parts of the world [41]. Presently, decision-makers are looking for ways and programs to involve men in reproductive health decisions, including family planning and support for safe motherhood. Previous programs have established that a supportive partner facilitates women's reproductive health and contraceptive usage.

Women have been the main target of family planning campaigns at the expense of their male counterparts for a long time. Despite this, a greater percentage of women using contraception use a male contraceptive method or a contraceptive method that requires male cooperation [42]. The cause why men have a varied attitude than women and men exposed to family planning counseling at different levels and in the process of decision making, men have different experiences [43]. The authoritarian and patriarchal structure of family relationships also necessitates the approval of the man in using the family planning

method. While most of the men in developing countries agree that responsibility is shared by couples, they believe that women should use family planning methods [44].

One of the biggest obstacles to men's participation in reproductive health is the inadequacy of information. Only male information about the contraception is not important, but also how it is used and its effectiveness is important. Various studies have examined how cultural and social organizations influence contraceptive patterns. Studies in Ghana and Nigeria show that women are at high level influence of male's population to contraceptive decisions; however, the converse may not be true. In addition, men are effective at the first decade of reproductive marriage and up to the first four children. Males want more children in families with fewer members and it is seen how important the number of surviving children is for women [45].

The importance of men's involvement in policy designs and research on reproductive health is also emphasized by other researchers. This claim that contraceptive unmet need data in Sub-Saharan Africa derives from data collected only for women [46]. Men's positive approach makes it easier for women to access and use family planning services, and as a result, availability and continuity in services is ensured [47]. Participation of men in family planning involves using more male-oriented methods and supporting their partners in using the family planning method. It is very important for men to decide which method to use in family planning and to act together with women during the selection use and follow-up of methods [48].

Men should be able to lead and support his wife or use one of these methods himself. As a wife and a husband, they may be more aware of the needs of their spouse and family members and may make better plans for their children's future. Positive attitudes of men in family planning can enable their spouses to use their methods and go

to the health institution regularly. They can also play an important role in the prevention of sexually transmitted diseases through the use of condoms regularly. Zen's attitudes will be used in women's reproductive health decisions family planning methods. Many factors affect women's use of the family planning method, such as the educational status of women and their spouses, the number of children they have, the family structure, the point of view of men toward family planning and the disapproval of spouse or family elders.

Dissatisfaction against existing methods in developed countries leads to new methods of searching for men. In Zimbabwe, despite men report having "the final says" in contraceptive use, women are the ones responsible for obtaining contraceptives. These and other studies show that couples in contraceptive use are incompatible. The primary conclusion in past research is that men are on the contraception for the purpose of spacing for restricting family size. Men want more children; this suggests that reproductive health programs or policies in developing countries should occur in both genders. Note that most of the conclusions are derived from surveys where individuals prefer their own preferences and preferences. For this reason, it is necessary to work more accurately to measure the "unmet needs" of women, the difference between fertility preferences and the use of contraception [49].

One of the problems generated by unmet need for family planning is the occurrence of unwanted pregnancies that have impact on abortion. Given that one of the four pregnancies in the world is intentionally terminated, there is also evidence of male opinion about abortion, an important element in contraception. Abortion is perhaps the best example of a direct relationship between laws and policies and inadequate reproductive health outcomes, and in many countries it is men who write, confirm, and

enforce abortion. For example, married women in Turkey need permission from their spouse to have an abortion. This situation is about Islamic law. In addition, men can directly influence women's decisions about abortion. For example, in an amniocentesis and abortion inquiry in New York, Rapp found that spouses' beliefs were largely influential on the rejection of prenatal tests such as contraceptive use or amniocentesis. According to her results, women who felt that her partners would love and help increase a handicapped child were less likely to undergo such test, relying heavily on her partner's beliefs about the attraction of a handicapped child in their decisions about.

The study by Browner for Colombia demonstrated the strong influence that spouse have on women's abortion decisions. When it is expressed directly or when it perceives that it will be abandoned, the abortion rate increases [50]. Getting men involved in the family planning program will lead to increase the usage of contraceptives methods as a result will improve the continuous use of male method. Identifying individuals' attitudes and behaviors toward the family planning, completing missing information and correcting false information are important to be able to provide an effective family planning service and for planning the training and consultancy services to be given to the women.

Health workers should be guided to choose the right method and use it correctly. This helps couples enhance the quality of their sexual lives. In order to potent scale up reproductive health service provision to meet the present-day and future needs, a sufficient number of educated health care professionals should be available. However, the inadequacy of health workers prevents the provision of family planning services, especially in rural areas. Experiences from some developing countries show that community-based family planning services have been used successfully to deliver family

planning methods including distribution of pills as well as injectable contraceptives [51]. Even though literature on uptake as well as methods used for family planning at community level in developing countries is available, literature on perceptions and attitudes of women toward the use of family planning services offered by community health workers is scarce [52].

Adults need more information about how family planning is useful in the severity and severity of known contraceptive side effects. A new literature survey of modern contraceptive use from qualitative research mentions about obstacles similar to contraceptive use for women, such as lack of knowledge, access and fear of side effects. In addition to school-based programs, media campaigns can help remove the myths surrounding the perceived health effects of contraceptive use. In addition, more researches are needed among younger couples to develop communication and counseling about the family planning. This can be achieved by encouraging more male participation in contraceptive communication and decision-making processes, which may lead to increased use of family planning, better management of side effects and improved health relationships.

As young women communicate with their peers and supportive family members, programs that encourage, build and support social networks will provide safe spaces for young adults to talk about the family planning and where they can access services [53]. As a result, more researches are needed in regards to knowledge and attitudes toward contraception use. The knowledge level in many countries of the world is high among both men and women, but the use of contraception is still low. In the future, qualitative research is needed for the reasons behind non-use contraception. Determination of

attitudes and fears affecting contraception use could be a huge driver for increasing the prevalence.

2.1.5 Concepts of Family Planning

Family planning has been conceptualized in different ways in scholarly literatures, but essentially it implies enabling individuals and couples to attain the desired number, spacing and timing of their children, through the use of modern or traditional (also called natural) contraceptive methods. The term birth control is sometimes used as a synonym, but its connotation is more on preventing pregnancies and limiting the family size than on planning families.

At the forefront of interventions aimed at improving sexual and reproductive health wellbeing in developing countries is the efforts to increase the use of modern contraceptives. This is justified in terms of evidence showing its association with fewer unintended pregnancies, decrease in the incidence of sexually transmitted infections including HIV and reduction in maternal and neonatal morbidity and mortality. Post-2015, the Sustainable Development Goals (SDG) have also identified demand for family planning (FP) satisfied by modern contraceptive uptake as a measurable indicator of universal access to sexual and reproductive health care. The uptake of FP is one of the critical developmental goals for improving maternal and child survival in low and middle-income countries [54].

In another view, family planning is defined as having the freedom and responsibility of all the couples and the individuals to decide the number of children they desire and having the knowledge, education and tools for this purpose. In other words, family planning is a preventive service that allows married couples achieving their desired number of children and deciding the spacing of pregnancies according to their

economic opportunities and personal wishes, and to ensure that the births are at appropriate intervals for the mother and child health [55].

The goal of family planning services is to improve pregnancy planning and spacing, and prevent unintended pregnancy. It allows individuals to achieve desired birth spacing and family size, and contributes to improved health outcomes for children, women, and families. Family planning services include contraceptive services for clients who want to prevent pregnancy and space births, pregnancy testing and counseling, assistance to achieve pregnancy, STD services (including HIV/AIDS), and other preconception health services[56].

Unintended pregnancies occur among women of all incomes, educational levels, and ages. Negative outcomes associated with unintended pregnancy include delays in initiating prenatal care, reduced likelihood of breastfeeding and increased risk of maternal depression and parenting stress [57]. Children from unintended pregnancies are more likely to experience poor mental and physical health during childhood, lower educational attainment, and more behavioral issues in their teen years [58]. To avoid the complications related to unintended pregnancy, contraceptive services must continue to be provided. Access to family planning is a human right; it saves lives and promotes healthier populations. Much progress has been made in the last 25 years to make family planning methods available to the needy population.

As of March 2020, there were an estimated 450 million women using modern contraceptives across 114 low- and middle-income countries. Ending unmet need for family planning by 2030 is one of the three goals set by the UNFPA for Sustainable development [25]. COVID-19 pandemic is already hampering in meeting the family planning needs. Women are refraining from visiting health facilities due to fears about COVID-19 exposure or due to movement restrictions. Disruptions to global

manufacturing and supply chains may reduce the availability of contraceptive commodities. It is anticipated that many contraceptive methods are expected to become out of stock in the next 6 months in some of the lowest income countries [59].

For every 3 months the lockdown continues, up to 2 million additional women may be unable to use modern contraceptives [60]. Family planning does not mean limiting the number of people in a family. The goal of family planning is preventing pregnancy-related health risks in women and reducing the need for unsafe abortion and infant mortality. Maternal health, risk of pregnancy and even maternal death significantly increase when births made at intervals of less than 2 years [61]. In addition, babies born at frequent intervals are not fully developed (babies with low birth weight), disability rate increases, care becomes difficult and infant mortality increases in the mother's womb [62].

2.1.6 Concept of Contraception

Contraception is the intentional prevention of conception through the use of various devices, sexual practices, chemicals, drugs, or surgical procedures. Thus, any device or act whose purpose is to prevent a woman from becoming pregnant can be considered as a contraceptive. In any social context effective contraception allows a couple to enjoy a physical relationship without fear of an unwanted pregnancy and ensures enough freedom to have children when desired. The aim is to achieve this with maximum comfort and privacy, at the same time minimum cost and side effects. Some barrier methods, like male and female condoms, also provide twin advantage of protection from sexually transmitted diseases (STDs) [63].

A growing number of women and men of reproductive age wish to regulate their fertility and have fewer children. Between the ages of 20 and 44, a fertile, sexually-active woman is potentially capable of giving birth about 12 times, even if she breastfeeds each

baby for 1 year. To avoid the need for an abortion, she has to successfully practice birth control for 16–20 of her roughly 25 childbearing years [64]. Among the reasons why couples go for contraception is to solve the conflict goals of achieving satisfying sex life and keeping a small family, failure to do so results in unwanted pregnancy and abortions. When abortion seeking is risky, late or in the hands of unsafe providers or unhygienic conditions, it can lead to both reproductive morbidity and maternal mortality. World over, if contraception is accessible and used consistently and correctly by women wanting to avoid pregnancy, maternal deaths would decline by an estimated 25–35% [65].

The contraceptive effect can be obtained through temporary or permanent means. Temporary methods include: periodic abstinence during the fertile period; coitus interrupts' (withdrawal); the naturally occurring periods of infertility (e.g., during breast-feeding and postpartum amenorrhea); use of reproductive hormones (e.g., oral pills and long-acting injections and implants); placement of a device in the uterus (e.g., copper-bearing and hormone-releasing intrauterine devices); interposing a barrier that prevents the ascension of the sperm into the upper female genital tract (e.g., condoms, diaphragms, and spermicidal). Permanent methods of contraception are male and female sterilization (vasectomy and tubectomy, respectively) [66].

The United Nations Population Division provides periodic updates on contraceptive prevalence for all countries of the world where data are available, using the definition noted above. Some noteworthy variants to the standard definition followed by some researchers are: using the age group 15-44 years instead of 15-49 years for the reproductive age span; and using the denominator of "exposed" women, that is, those who are sexually active and are not in the period of postpartum non-susceptibility [67]. Applying the denominator of "all" women of reproductive age rather than only those who are married or in consensual unions; and [68] restricting the definition of contraception to

only "modern" methods rather than "any" contraceptive method. These exceptions are however few and do not seriously hamper the comparison of contraceptive prevalence across most countries and regions [69].

2.1.7 Types of Contraception

There are different types of contraception. The common ones include Long-acting reversible contraception:

Long-acting reversible contraception (LARC) is a contraceptive that lasts for a long time. There are two types of LARC:[70]

1. the intra uterine device (IUD) that lasts for three, five or ten years
2. the implant that lasts for five years. They are sometimes called “fit and forget” contraception because once it is put in, you don’t need to remember it every day or every month. LARCs are the most effective types of contraception. They are more than 99% effective at preventing pregnancy.

Hormonal Contraceptives: These are contraceptives that use hormones to prevent pregnancy.

Hormonal contraceptives include the pill and the Depo Provera injection. There are two types of pill:

1. Combined Oral Contraceptive Pill
2. Progestogen-only Contraceptive Pill

You take one pill each day. The pill is more than 99% effective at preventing pregnancy if you take it correctly. However, in typical use it is about 92% effective.

The Depo Provera injection_is another type of hormonal contraception. You get an injection every three months. If you get your injections on time, Depo Provera is more than 99% effective but typically it is 97% effective.

Barrier Methods: Barrier methods stop sperm from entering the vagina. The two barrier methods are: Condoms, internal condoms.

Condoms protect against sexually transmissible infections (STIs) as well as unintended pregnancy. You can buy internal condoms from our website, on other online shops and from some pharmacies. You can get a prescription for condoms from Family Planning or your doctor, or you can buy them from our website, other online shops, pharmacies, supermarkets and other shops.

Emergency Contraception: There are two options for emergency contraception: the emergency contraceptive pill (ECP) or a copper IUD. The ECP is approved to be taken up to three days after unprotected sex. If you are an average weight, the ECP is 98% effective. If you weigh more than 70kg, the ECP is less effective and a copper IUD is recommended. If you weigh more than 70kg and you choose to take ECP, you should ask if taking a double dose is the right option for you. The copper IUD can be inserted up to five days after unprotected sex, and is more than 99% effective at preventing pregnancy. Emergency contraception can be used to prevent pregnancy if:

1. You haven't used protection
2. Your normal contraception fails e.g. condom splits
3. You have missed more than one contraceptive pill
4. You have been vomiting or had diarrhea while on the pill

5. You have missed your injection

6. You have been forced to have sex without contraception.

The ECP as your regular method of contraception is less effective than if you were using a LARC or hormonal method.

Permanent Contraception: Permanent contraception, sometimes called sterilization, prevents all future pregnancies. It is very difficult or impossible to reverse. Permanent contraception is either a vasectomy or a tubal ligation.

2.1.8 Attitudes Affecting Family Planning

Attitude refers to the positive or negative feelings or tendencies of an individual about an idea, an object or a symbol. According to Buhner, the attitude is anything that a person actually possesses and that he realizes later. According to Arcana attitude, generally attributed to many academicians, is a tendency which is attributed to a person and which creates his feelings and behaviors related to a psychological object in an orderly way. Attitudes naturally affect beliefs as well. Faith includes true or false information, opinions and beliefs based on personal experimentation or external sources. All variables affecting family planning cause behavior to occur [71].

Behaviors and attitudes play an important role among the choice of using family planning methods and so it effects the change of fertility status and population rate indirectly. In order to promote the usage of an effective method, attitudes and behaviors play an important role on preference of choosing a family planning method. The identification of attitudes that affect the use of the family planning method by individuals is an important factor contributing to the scheduling of family planning services [72]. The

basis of most attitudes depends on childhood and is generally acquired through direct experience, reinforcement, imitation and social learning.

The most important feature is that once they have developed, they are very resistant to change [73]. Studies conducted in different countries have found that most women know the methods of family planning but have a lack of practice. This is due to the fact that individuals are in a negative and prejudiced attitude toward modern methods. It is known that positive or negative attitude affects the use of family planning method. It is considered important to examine the current attitudes and determinants in order to spread the choice of effective method [74]. Individuals obtain information about family planning methods, emotionally empower them with information and ultimately turn their attitudes toward information into positive or negative behavior. Individuals also respond to the reactions they have through the process of transformation into behavior [75].

Individuals' attitudes for family planning methods are influenced by some characteristics, such as economic factors, socio-cultural factors, environmental factors, location, age, educational, traditional beliefs, religion, family type and level of knowledge. It is known that these factors have effects on turning the attitudes into behaviors. Attitude is a notional concept and although it cannot be observed directly, the effects on behavior are well known [76].

Individuals get the knowledge of family planning methods, then they transcribe it emotionally by themselves. After all they combine them with their attitudes and positive or negative behavior is ready for decision of which method is suitable for them [77]. Many anthropologists have insisted that reproductive behavior or decisions made in relation to family planning is not only decided by economic factors, but also affected by socio-cultural factors such as fertility preferences or values related to having children. Further, political issues such as national population policy or reproductive health programs, are

also influential maters. Subsequently, anthropologists emphasize that it is very important to understand what social, cultural or structural factors may shape people's thoughts and behaviors [78].

In early 1970s, two factors were found to affect the fertility behavior of women. Surveys on sex preferences have used deductions from attitude and behavior charts due to inadequate direct scales. In this regard it is possible to distinguish three groups of countries: countries where it is reasonable to choose male siblings; male siblings are preferred due to certain criteria; and countries with no sexual preference systematically. There is a period during which the transition from high fertility to low fertility requires couples to decrease the number of family members but yet not practitioners of contraception. Those who do not use any contraception methods, among those at any age, who want to limit their family size are far more numerous than those in developed societies compared to the developing societies. When education is considered as one of the variables of modernization, it is understood that inconsistent behavior tends to decrease with education [79]. By 1980s, comparable data for a large number of developing countries participating in the World Fertility Survey (WFS) have become available. Cross-national studies based on WFS data confirmed that education generally exerts a negative influence on fertility. But even at low levels of socioeconomic development, where education had a negligible, a negative association emerged after a critical level of schooling, was reached [80].

A pronounced preference of parents to have male children has been noted in a number of countries, although a desire of a balanced number of sons and daughters is also common [81]. In recent years, the idea that it is significant to understand the sociocultural contexts in demographic studies has gradually expanded [81]. Some studies have mentioned the importance of the role of men in reproductive health and their influence on decision-

making and behavior related to reproduction [82]. As mentioned above, many family planning programs have focused mainly on women. Even though men are increasingly being "involved" in reproductive health programs, the view of men still seem to be that they are peripheral and problematic [83].

2.1.9 Other Factors Affecting Family Planning

Socio-economic Factors

Gender indicates the characteristics, positions and roles of man and woman in all social relationships. But in most studies on family planning, women are usually on the front line of factors that affect socioeconomic outcomes. For age, a commitment to supporting gender equality in economic outcomes has underlined women's empowerment. However, despite important advances toward equality, differences in the socioeconomic outcomes of men and women still persist. If the population is increasing by forcing natural resources and economic opportunity, the necessity of implementing effective and adequate family planning in the society is emerging. With industrialization, families have better economic opportunities and social security. Thus, aggravating living conditions and taking more roles in women's work life reduces the desire to have many children.

It is accepted by some scientists upon that human rights are an integral part of the economic process, and that it is impossible to support the process without women. Consequently, it is necessary to expand the aims of existing societies to include the interests of women. Everywhere in the world, men have an important role in the socioeconomic progress of women. When designing social sex-based policies, ignoring women increases both their effectiveness and inequality. The use of fertility and

contraception in developing countries are associated with socioeconomic status and other relevant factors [84].

The withdrawal method is the most commonly used birth control method in the world. There are not enough data on whether withdrawal method choice is influenced by variables such as socioeconomic status and education [85]. It was demonstrated that withdrawal use is quite common among young US females in different study. Because nearly one-third of females aged 15–24 years in study nationally representative sample indicated that they had recently used withdrawal.

2.1.10 Benefits of Family Planning

Different scholars have submitted different opinions on the benefits of family planning. It is submitted that family planning can result in higher levels of education, better employment opportunities, higher socioeconomic status and empowerment. Another aim of family planning services is to prevent unwanted pregnancies and related maternal and infant mortalities, to provide help and counseling to every family whenever they want and to have as many children as they want [86].

Family planning services improve the abilities of family members in decision-making and recognize the freedom to make free decision about having a child. Family planning services have an important role within the scope of "Primary Health Care", which must be presented to the public [37]. In studies on family planning in the world, differentiation in attitudes, behaviors and the use of contraceptive methods largely lead to change in fertility [87]. Biological, psychosocial and cultural factors determining fertility and factors affecting choice and use with birth control instrument are evaluated together in the regulation of fertility [88].

In order to maximize the benefits of family planning, it is essential to educate individuals and families about reproductive health, to raise the level of maternal and child health by teaching modern and medical ways of protecting the parents from pregnancy and explain to women that many and frequent births have negative effects on mother and child health, teach couples that family planning prevent maternal deaths and protect their health, guide couples that family planning ensure that babies are born and live well, to prevent high-risk and unintended pregnancies, providing medical assistance to those who want to have children and educating individuals about family planning methods [88]

Benefits of Family Planning on Different Levels

Individual level benefits

• Empowering women - enabling them to plan the size and timing of their families

• Saving women's lives – enabling them to avoid unwanted pregnancies; and, avoid unsafe abortions

• Improving infant and child health - spacing between births, limiting births to heathier years

Household level benefits

• Increasing household savings.

• Increasing investment in individual children - children in smaller families are better educated.

• Increasing work productivity, in particular female work participation.

Community/country level benefits

• Increasing the size of the labor force (demographic dividend), and domestic savings

• Reducing poverty, and accelerating the demographic transition

Global level benefits

• Slowing down population growth and reducing pressure on the environment and natural resources

• Making progress towards a sustainable human population

Family Planning and Contraceptive Trends in Nigeria

In developing countries like Nigeria, children are highly valued as they do not only represent the virility of men, but also act as a source of income in places where agriculture is the main source of livelihood, acting as extra hands for work. In addition to this, parents and extended relatives depend on their children for maintenance as they get old and are thus hesitant to restrict births [89]. In 1992, due to the rapid population growth that was seen in Nigeria, the then Nigerian president suggested that each family should have only four children. In response to this, the mass media started awareness campaigns on the disadvantages of having too many children. During this period, family planning clinics were also established in government owned hospitals, mostly in urban centers [89]. However, this did not achieve the desired results mostly due to the cultural and religious preferences of the various ethnic groups that make up Nigeria. Some reports in Nigeria have showed that in general, Nigerian women would want to have fewer children than they actually have; in other words, Nigerian women are more receptive of family planning than their male counterparts mostly because they bear the burden of childbearing as well as attending to household chores and sometimes understand the probable break down in their health as a result of child-bearing [90,91]. Between 1990 and 2015 in Nigeria,

the maternal mortality ratio (MMR) declined by almost 30%, falling from 1,110 deaths per 100,000 live births to 814 deaths per 100,000 live births [92]. In spite of the reported decline in maternal deaths, many women in Nigeria still die from pregnancy-related causes and more recent trends in MMR suggests that there has been a stagnation in the decline. In 2013 for example, the WHO reported that approximately 40,000 women died due to maternal causes [93]. This figure accounts for 14% of the global maternal death burden, which is disproportionate when Nigeria constitutes only 3% of the world population. Data from the Nigeria Demographic and Health Surveys (NDHS) show that the percentage of currently married women with an unmet need for contraceptive increased between 1990, 2003 and 2008 while a decline in unmet needs was observed between 2008 and 2013 [94]. Contraceptive choices and behaviors in all the regions in Nigeria. Their study revealed that intrauterine contraceptive devices (IUCD) were the most popular choice and accounted for 77.9% of the Nigerian women users and it was followed by injectable (12.6%), oral contraceptive pills (4.1%) and progestin implants (2.3%). The less popular were condoms, spermicides and female sterilization (1.5%, 0.1% and 0.1% respectively) [95]. This may reflect the relative availability of each method and cost variations. The invasive nature of Bilateral Tubal Ligation (BTL), religious beliefs and cost consideration may contribute to making it less acceptable compared to the other methods available [96]. Most studies on contraceptives in Nigeria converge and found that the majority of women use IUCDs. IUCDs are the most widely used reversible contraceptives in the world, and it has been estimated that over 130 million women of reproductive age uses it for birth control. Regional differences in choices have also been observed by many studies [95]. Progestogen-only injectable use of 12.6% is found in Ife (South-western) Nigeria which is lower than the 71.8% found in Aba (South-eastern Nigeria) but comparable to 14.2% reported from Jos (North-central Nigeria) [97].

2.1.11 Trends in Family Planning, Education Programmes and Policies in Nigeria

In every country, understanding the size of unmet need and the characteristics of women with unmet need can help planners strengthen programmes and inform policy. Survey data on unmet need can provide overall direction by helping to pinpoint the obstacles in society and weaknesses in services that need to be overcome. Family planning programmes clearly have a role to play in helping people get the information and services they need to make informed choices. In this section, we present the trends in family planning programmes and policies as well as the trends in education programmes in Nigeria.

2.1.12 Family Planning Policy in Nigeria

The Nigerian government initially did not perceive the rapid population growth as constituting a significant barrier to economic growth. The 1975-1980 third development plan in Nigeria revealed an insight into the official thinking of government about its population before 1980. The Government's thought about creating a policy to curb population growth because they felt that economic progress was seriously impeded by demographic factors. However, they came to a conclusion that rather than instituting a course of actions that would control the population by consciously reducing family size, the plan emphasized accelerating the growth of the economy which, in turn, would bring down the birth rate in the long run. There was, however, a plan to continue with integrating various family planning schemes into an overall health and social welfare for the country[98].

In 1988, in response to the rapid rate of population growth and its adverse implications for development, the federal government of Nigeria approved the National Policy on Population for development, unity and self-reliance [98]. At the beginning of the national policy in 1988, the TFR was 7 births per woman, the infant mortality rate (IMR)

was 87 deaths per 1000 live births and the maternal mortality rate (MMR) was one of the highest in Africa at the time. The policy highlighted the need to reduce the proportion of women who marry before the age of 18 years by 80% in the year 2000, reduce under 18 pregnancies and over 25 pregnancies by 80% in 2000, reduce TFR to 4 by the year 2000 and the growth rate from 3.3% to 2% and to extend the coverage of FP services to 80% in 2000 [99]. This policy remained one of the only major family planning policies in Nigeria until emerging issues like HIV/AIDS, gender inequality and poverty, made it necessary for a review.

After the review, the Nigerian government launched the National Policy on Population for Sustainable Development in 2004 [100]. The new policy recognized that population factors, social and economic development, and environmental issues are interconnected and critical to the achievement of sustainable development in Nigeria.

The overall goal of the policy was to improve the quality of life and standard of living for the Nigerian population, by achieving a number of specific goals that included an improvement in the reproductive health of every Nigerian at every stage of the life cycle [101]. With the ongoing population growth and in recognition of the important link between reproductive health and the quality of life of its citizens, the Nigerian government launched a national reproductive health policy and strategy in 2001 [101]. Even before the creation of this policy, the Nigerian society (government, individual and nongovernmental organizations) either independently or in collaboration with international agencies and organizations exhausted a lot of resources on providing reproductive health education and reproductive health services to Nigerians [101]. However, statistics showed that the reproductive health situation in Nigeria at the time was still extremely poor.

The Multiple Indicators Cluster Survey (MICS), conducted by the Federal Office of Statistics in collaboration with UNICEF at the time, showed that the maternal mortality ratio was 704 deaths per 100,000 live births, with a wide geographical disparity ranging from 166 per 100,000 live births in the southwest to 1,549 per 100,000 live births in the northeast. The figures were believed to be an underestimation of the situation because the WHO and other UN statistical sources, estimated it to be around 1,000 maternal deaths per 100,000 live births [102]. An estimated 40 percent of pregnant women experience pregnancy-related health problems during or after pregnancy and childbirth [103].

The Nigerian Bureau of Statistics (NBS) suggested that low level of access to, and utilization of quality reproductive health played significant parts in the high maternal mortality in Nigeria. For example, the 1999 NDHS revealed that only 31% of deliveries took place within health facilities. Study of the 1999 NDHS also revealed that the level of utilization of modern contraceptive in Nigeria was still low, although it had increased over the last decade from 3.5 to 8.6%. The level of contraception among sexually active adolescents was particularly low, and was contributing to the high level of teenage pregnancy, unsafe abortions and maternal mortality. On the whole, the total demand for FP was also relatively low as only 29 percent of women demanded for family planning [103].

Reproductive health remained on the concurrent legislative list (concurrent list implies the list that bears the matters over which both the federal and state authorities can exercise legislative authority in Nigeria), with each state having the advantage to determine its activities, guided by the national reproductive health policy and guidelines and based on the availability of local resources. To facilitate the implementation of the policy, a National Strategic Framework and Plan for Reproductive Health (2002-2006) was developed with the objectives to increase the CPR, reduce gender-based violence and practices, reduce the prevalence of sexually transmitted infections (STIs), reproductive

cancer and infertility as well as reduce the MMR. The National Strategic Framework and Plan for Reproductive Health called for the decentralization of services to the states, LGAs and communities.

It recognized the need for the promotion of community participation and encouraged private sector support to ensure effective implementation of the strategies and activities in the plan [104]. Another relevant family planning policy was the National Adolescent Health Policy in 1995, which was designed to create a climate for laws necessary to meet adolescent health needs and to promote and support the dissemination of reproductive knowledge and information to adolescents [104].

The policy, which was developed by the Federal Ministry of Health (FMOH) was revised in 2006, in collaboration with other ministries, government agencies and NGOs. The revised framework encompasses a broad range of issues addressing adolescents, including sexual behavior, nutrition, drug abuse, education, career and employment, and parental responsibilities and social adjustment techniques. This strategic framework was designed to facilitate implementation of the National Adolescent Health Policy by translating the policy into actionable plans to promote adolescent sexual and reproductive health in Nigeria [105].

2.1.13 Family Planning Programmes in Nigeria

Family planning programmes give women access to contraceptives and contraceptive information. Many developing countries like Nigeria have implemented such programmes to reduce high birth rates, lower maternal and child mortality as well as support women's right to decide when and how many children they want to have. The primary justification for voluntary family planning programmes is substantial unmet need for contraception. This unmet need results in 9.2 million unplanned pregnancies in

Nigeria each year, about half of which end in abortion [106]. Family planning programmes vary widely in the coverage and quality of their services. In Nigeria, there have been approximately 11 major family planning programmes that have been implemented since the late 1980s when family planning programmes where initially introduced. Many of these programmes focused on improving service delivery through service provision, counselling and mass media campaigns.

From the 11 major programmes identified only two have been implemented nationwide and the rest in various states in Nigeria. While some family planning programmes have reported increases in contraceptive use after implementation, contraceptive use in Nigeria remains relatively low [107]. Some of the programmes have revealed that communities are not usually involved in the planning and pre-implementation phases of programmes, which could have encouraged their full participation and help to unravel the barriers to uptake of services[108]. It was concluded that understanding the main factors influencing contraceptive use among women is the key to the development of effective family planning programmes. Some of the reports from some of the programmes reveal that there have been increases in modern contraceptive use in the areas that the programme occurs [108].

The ACCESS/MCHIP USAID Nigeria programme reported that at baseline use of FP services was approximately 5% in 2006 across the three states and that by end-line, use of FP services had increased to 13.5% in 2012. It also reported that maternal deaths had reduced from approximately 3.7% at the baseline to 0.7% in these areas. Another programme, the Community Participation for Action in the Social Sector Project also reported increases in the use of modern contraceptive use in some of the states post programme. Post-programme figures showed that the use of modern family planning methods in the intervention states had increased from 18% and 5% to approximately 25%

and up to 11% in Kano and Bauchi respectively. The Community-Based Access to Injectable Contraceptive (CBA2I) programme also reported that in the 11 months that the programme lasted for, it was able to provide injectable to 1,662 women and that uptake of the injectable increased from 20% in 2011 at baseline to 38% after the project ended in the facilities where the programme occurred.

2.1.14 Education Programme and Policies in Nigeria

Both within and across SSA countries, differential and changes in contraceptive use have been explained largely by socio-economic and sometimes sociocultural differences among groups. Particularly, a large body of research has emphasized the importance of women's education in contributing to the increase in the use of modern contraceptive methods both directly at the individual level through women autonomy, financial and cultural access to reproductive health services, and indirectly through social interaction [109]. It was suggested that education is an event of human life that carries out a significant role in determining social status but that education may also contribute to increases in women's knowledge and exposure to mass media. Mass media can influence fertility attitudes and behavior by publicizing non-traditional lifestyles, including small families and by creating a climate conducive to behavioral change[110]. They concluded that education considerably enhances women's knowledge about their bodies and reproductive physiology [110]. The gap between girl and boy in SSA has been seen to grow as they progress through their primary education: it has been reported that girls are much less likely to complete primary school [111,112.]

However, tackling gender equality within schools is only part of the issue. Many of these concerns and constraints have their roots in deep-seated inequalities in the wider

community, which impact on girls' ability to access schooling and to stay there [112]. Changing these mindsets and behaviors is one of the biggest challenges facing girls' education and also one of the most complex to address. The burden of caring and of household domestic labor falls on girls and women in traditional gendered roles [113]. As such many of the education policies and programmes implemented in the SSA region not only focus on improving the quality of education as well as access to education, but many focus on empowering, most especially girls.

In this regard, we have identified key education programmes in Nigeria most of which have a focus on reducing the gaps between girls and boys as well as programmes with some family planning focus component. One of the first major education programmes in Nigeria was the Universal Primary Education (UPE), which was implemented by the Nigerian government in 1955 and provided free primary level education to all Nigerian children. The programme featured prominently up till 1966 but was scrapped, following the military take-over of government in that year as well as corruption in the government at the same time. The scheme however left an indelible imprint in education in Nigeria. Following this programme, there has been a total of seven major education programmes[114].

In 1999, following the reinstatement of the civilian regime in Nigeria, the Universal Basic Education (UBE) programme was implemented by the Obasanjo administration [114]. The implementation process of the programme started in 1999, but progress was hampered by the inability to execute certain aspects of the programme. However, in 2004, the programme was re-implemented and made provision for basic education comprising of Early Childhood Care and Education (ECCE) and Primary and Junior Secondary Education [114]. The programme is one of the longest running and most successful education programmes providing universal, free and compulsory education to

all Nigerians from birth till the junior secondary education level. The UK Department for International Development (DFID) is one of the few donors with a significant long-term commitment to improving basic education in Nigeria. DFID started work in education in Nigeria in 2003. DFID's education programme in Nigeria is targeted on interventions in some of the poorer states, with a focus on gender parity. It currently has two main education programmes: The Girls Education Programme (GEP) and the Education Sector Support Programme in Nigeria (ESSPIN).

The GEP is delivered by UNICEF and aims to improve girls' access to education and learning in four northern States (Sokoto, Niger, Katsina and Bauchi). It started in 2005 and it is now in its third phase (GEP3). Phase 1 (GEP1) ran from 2005 until 2008; Phase 2 (GEP2) ran from 2008 until 2012; and Phase 3 is due to run until 2019. DFID chose to work with UNICEF because of its well-established presence and network of contacts at federal and state levels in the country. As for the ESSPIN, it is delivered by a Cambridge Education-led consortium, which is working to strengthen governance and systems of basic education in six states (Lagos, Enugu, Kwara, Kaduna, Kano and Jigawa). It started in 2008 and finished in 2014 [115]. In 2011, Nigeria joined the Global Partnership for Education to implement an education programme in five northern states (Jigawa, Katsina, Kano, Kaduna, and Sokoto). Each state created an education sector plan to outline its priorities and objectives as to how the programme would work [116]. Among the other recent education programmes that have been implemented was the Cash Transfer for Girls Education that aimed to increase school attendance by girls led by UNICEF in 2014 in Sokoto State in the north-eastern part of Nigeria. This project aimed to provide girls with financial support to pay for textbooks and other school materials.

A sample of 23,000 girls benefited from the cash transfer programme and another 50,000 beneficiaries were added in 2015 [117]. This programme was closely followed by the

implementation of the National Action Plan on Child Labour Education Programme in the same year to address the growing concern about the high number of child labourers in Abuja. The programme was expected to run until the end of 2017, when the Government was expected to have eradicated child labour in Nigeria [118]. This did not happen however and child labour still remains an issue in Nigeria, the deadline to eradicate child labour has now been extended to 2025 [119]. Finally, the most recent programme in 2014 was the Promotion of Literacy Skills Programme implemented in Rivers state in Southern Nigeria. It aimed at promoting the use of books and encouraged reading among Nigerian girls in the region. The project that ended in 2015 had a great success with over 2500 participating students [120].

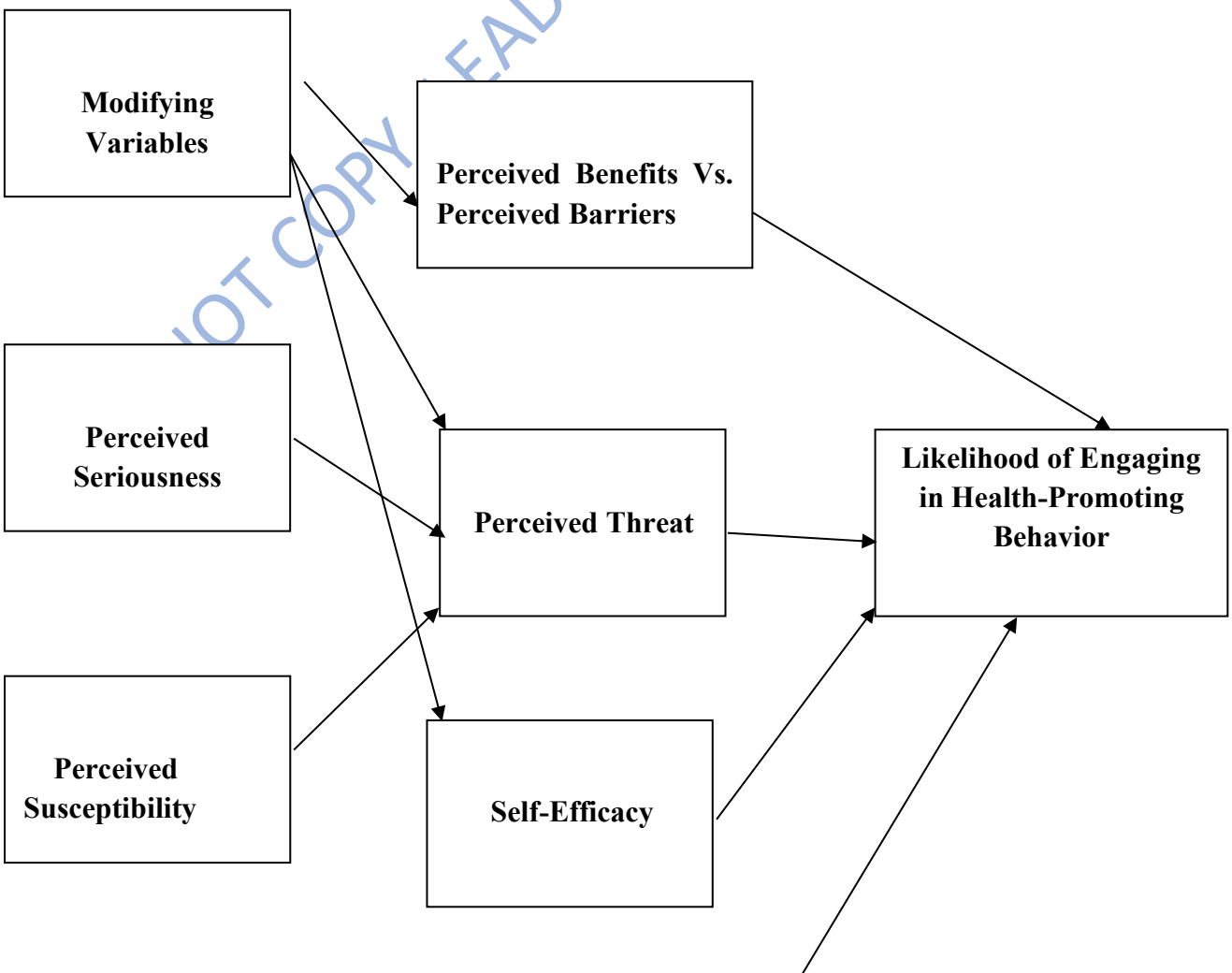
2.2 Theoretical Review

The theoretical framework that is used for the study is Health Belief Model (HBM). The focus of the Health Belief Model is upon the prevention of disease, rather than on its control after it has started. The model emphasizes motivation and the historical perspective of the individual based on his or her prior experiences. Thus, currents dynamics confronting the individual are emphasized as well as all the factors that motivate behaviour. As one of the most widely applied theories of health behavior, the Health Belief Model (HBM) posits that six constructs predict health behavior: risk susceptibility, risk severity, benefits to action, barriers to action, self-efficacy, and cues to action. Originally formulated to model the adoption of preventive health behaviors in the United States, the HBM has been successfully adapted to fit diverse cultural and topical contexts [121].

The HBM would seem to be ideal for communication research. Surprisingly, the HBM is utilized less frequently by communication scholars. Communication researchers

are primarily interested in explicating communication processes, an objective that favors explanatory frameworks. As an explanatory framework, the HBM has significant limitations. Notably, researchers have argued that the HBM fails to specify variable ordering. This limitation is significant for research hers interested in utilizing the HBM to understand communication processes, as numerous process-oriented questions are raised by the model that currently have no answer. For example, it is possible that all six variables serve as equivalent mediators, that some variables form sequential or serial chains, or that variables are hierarchically situated so that some moderate the mediational influence of others. Unfortunately, these different models are rarely examined or compared in the literature [122].

2.2.1 The Health Belief Model



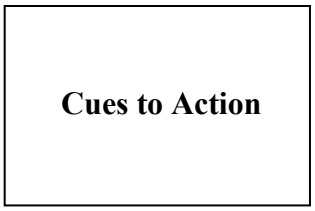


Fig 1: A Chart illustrating Health Belief Model [122].

The Health Belief Model (HBM) in Relation to Family Planning Adoption

A well-tested, comprehensive social cognitive framework used to predict and explain variations in contraceptive behavior among women, the HBM has seldom since been applied in family planning in health science research to predict and explain health behavior and provide foundations for behavioral interventions towards improved health outcomes[122].

The purpose of this model is to examine the suitability of the Health Belief Model (HBM) as a framework for explaining and predicting adoption of family planning among female teachers in Oyo zone. The HBM is a cognitive, interpersonal framework that views humans as rational beings who use a multidimensional approach to decision-making regarding whether to perform a health behavior. The model is suitable for complex preventive and sick-role health behaviors such as contraceptive behavior. Its constructs emphasize modifiable factors, rather than fixed variables, which enable feasible interventions to reduce public health problems in particular adoption of family planning by female teachers of Oyo zone[121].

Overall, the HBM's adaptability and holistic nature facilitate applications in diverse contexts like family planning and with complex behaviors like contraceptive behavior. Contraceptive behavior, one form of family planning refers to activities involved in the process of identifying and using a contraceptive method to prevent pregnancy and can include specific actions such as contraceptive initiation (to begin using a contraceptive method), continuation or discontinuation (to maintain or stop use of a contraceptive method), misuse (interrupted, omitted or mistimed use of a contraceptive method), nonuse, and more broadly compliance and adherence (general terms often used to denote any or all of the former contraceptive behavior terms).

Constructs of the Health Belief Model, as Applied to Contraceptive Behavior

Perceived Threat Perceived threat (susceptibility and seriousness) of an unwanted pregnancy and its sequelae (i.e. birth, abortion, parenthood) provides the incentive to use contraception. This construct considers personal feelings of the seriousness of becoming pregnant, based upon subjective assessment of medical and social consequences of pregnancy and childbearing. This construct may include factors like fear of body changes or pregnancy complications, or worry of quitting school or losing a job due to increased child-rearing responsibility, which can impact the likelihood of contraceptive use[122]. For example, an analysis of data from the National Longitudinal Study of Adolescent Health found that the 14% of teens with ambivalent attitudes about the risk and seriousness of becoming pregnant had reduced odds of using contraception consistently. In another similar study of 4869 high scholars, girls with pro-pregnancy versus anti-pregnancy attitudes (such as positive perceptions of consequences like social embarrassment, increased stress and parenthood responsibilities) were at increased risk for becoming pregnant within one year [121].

Cost-benefit Analysis

Perceived Barriers Perceived barriers are negative consequences of using contraception. This dimension includes factors such as perceived side effects of hormonal contraception (i.e. weight gain or mood swings), physiological risks of hormonal contraceptives (i.e. blood clots), inconvenience (i.e. having to remember to take a daily pill or apply a condom during intercourse), and limited access to methods (i.e. having to obtain a prescription for OC refills or requiring a medical procedure for intrauterine

device (IUD) insertion). All of these potential contraceptive disadvantages have been found to inhibit contraceptive use[121].

Perceived Benefits Perceived benefits relate to the perceived effectiveness, feasibility and other advantages of using a contraceptive method to prevent pregnancy vis-à-vis the perceived barriers. Through a cost-benefit analysis, the perceived ratio of a contraceptive's benefits to its barriers helps determine the preferred and specific contraceptive action and method. This construct may also include non-contraceptive, health promoting benefits of a method (i.e. protection against ovarian cancer, uterine cancer, and anemia, improvement of menstrual symptoms and acne) [122]. Indeed, increased knowledge of all benefits of a hormonal method like OCs have been shown to increase and improve use.

Cues to Action

Cues to action are internal and external stimuli that trigger a consciousness of the perceived pregnancy threat and facilitate consideration of using contraception to remedy the threat. This may include symptoms like missed menses after intercourse (internal stimuli) or contraceptive communication from the media, and worry from a sexual partner or counseling by a health care provider (external stimuli) [121].

Modifying and Enabling Factors

Modifying or enabling factors interact with an individual's perceptions of pregnancy and decision-making to influence contraceptive use. This dimension includes a broad range of well researched demographic, social, structural, psychological and reproductive factors predictive of contraceptive behavior. For instance, adolescents and women of racial/ethnic minority are more likely to experience an unintended pregnancy secondary to contraceptive non- or misuse than their older and non-minority counterparts. Women of rural residence, with low income levels, and who are uninsured are less likely to use a highly effective contraceptive method than are urban women, of higher socioeconomic status, with insurance[122].

2.3 Review of Empirical Studies

The awareness drive should be for both couples as they are the ones to jointly take the decision of accepting the need for family planning and what method(s) to adapt from available options. According to research, information given to clients refers to information imparted during provider-client interactions that enables clients make informed choice and derive satisfaction. Modern methods of contraception include pill, injection, implants, female sterilization, male sterilization, female condom, male condom, intrauterine device, diaphragm, foam/jelly, and emergency contraception. Choice of methods refers to both the number of contraceptive methods offered regularly and the extent to which methods offered meet the needs of significant subgroups [123].In a study reported that Knowledge of family planning methods was nearly universal with (98.1%) and that method-specific knowledge was highest for short-term methods (e.g. male condoms (98.3%), pills (97.9%) and injectable (97.6%) while Knowledge of long-term FP methods (implants (91.7%); intra-uterine devices (89.1) was equally high as was knowledge of permanent methods (female (79.3%); male sterilization (77.6%)). with knowledge of lactation amenorrhea and emergency contraceptives being the lowest at 71.9% and 40.1% respectively [124]. In a case study conducted in Ghana, it was reported that a little over 90% of both cases (93.8%) and controls (91.5%) knew at least a method of modern contraceptive of which Injectable was the most known modern method of family planning amongst both cases (93.1%) and controls (82.6%), followed by the pill (cases-86.9%; controls-65.9%) [125]. The diaphragm was the least known method amongst the cases (3.1%), while vasectomy or male sterilization was the least known amongst the controls (0.4%). Sources of information on family planning include television, radio, posters, hospitals, friend/relatives, communities, religious organizations, seminars, talk show, and even social Medias among others [125]. A study reported that overall - close to half of their respondents (45.7%) reported to have obtained FP information from their

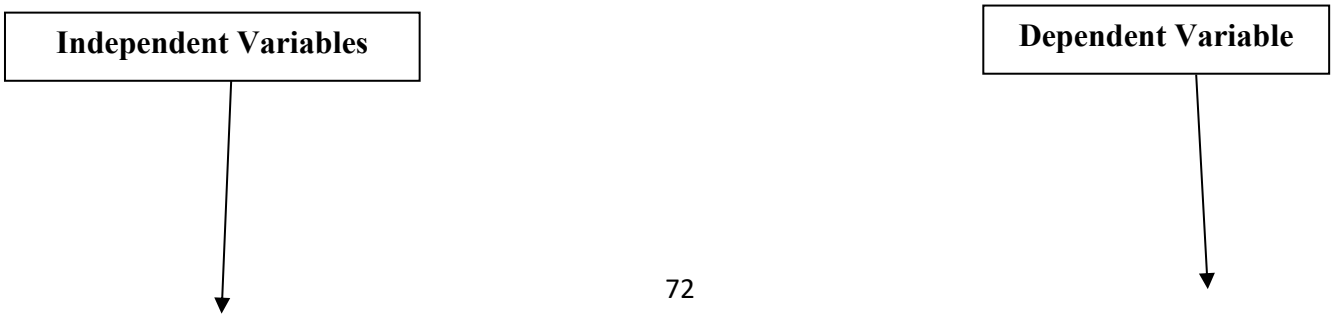
spouses [94]. The other half received such information through other sources including mass media (27.6%); health facilities where they attended for care seeking (18.1%); community health meetings (12.6%), and others from neighbors, friends, campaigns, and billboards. While on actual access by mediums, it was discovered that Majority of respondents were exposed to at least one type of mass media with 82.7% of them reported to have listened to radios at least once per week. One third (38.4%) of those that listened to radios also watched television while a slightly lower proportion (28.1 %) claimed to have received FP information by additionally reading newspapers. Out of those who listened to the radio, 78.1% confirmed to have heard FP messages as compared to more than half (65.7%) of respondents who got such messages by watching TVs [126]. Moreover, about half of respondents (48.4%) reported to have had access to newspapers through which they could get FP messages. For those reporting to have had seen or heard of FP messages through the mass media, they specified that the contents of the messages were related to such issues as child spacing, types of recommended FP methods, importance of using the methods, their safety and male involvement in FP services. However, the above study is for male and there is much likelihood that male tend to be more media friendly than women. According to findings, only 15 percent of Nigeria women are utilizing any form of family planning which is at variance with the 2012 London Summit targets [127]. National CPR figures mask the significant range in contraception use patterns across Nigeria. State-level modern contraceptive prevalence rates (mCPRs) range from child was too young; therefore, we wanted to have another child once our first child was grown enough; so we used condoms [128].” Method-wise, condoms were mostly preferred by men. Quoting another woman respondent from Punjab, “The idea of using a condom was my husband’s; he had asked the Doctor and decided.” [123]. Report revealed that in the overall, 62.2% of the women reported that they were currently using a family planning method;

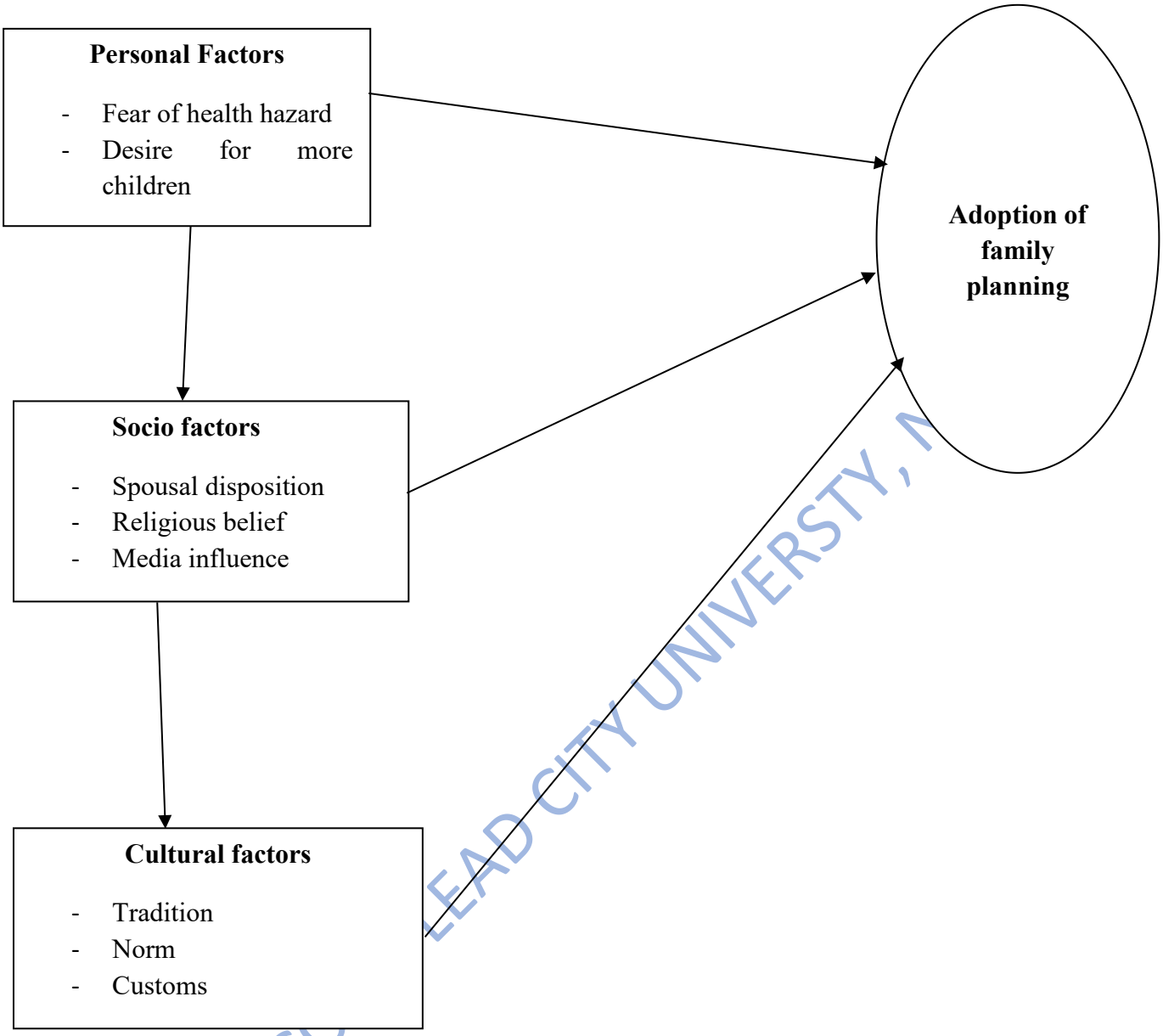
76.3% of these were using a modern method. This was highest for injectable (33%), lactation amenorrhea (16.7%), female sterilization (12.3%) and male condoms (11%). Current use of IUD (7.2%) was low just like pills (6.7%). Low demand for FP services and commodities remains a significant barrier to increasing CPR [92]. Many women are not aware of the various methods of contraception or the relative benefits and side effects of each of them. In addition to lack of awareness, common misconceptions about side effects and efficacy persist among many men and women. Furthermore, the overall health and economic benefits of birth "spacing" and "limiting" are not well understood among families or even providers. This seems to translate into a low motivation to use family planning and low usage patterns. To address this situation, all stakeholders and influential leaders should be encouraged to provide correct and appropriate information on birth spacing. There is a low knowledge of contraceptives, especially LARCs, across Nigeria [124]. The NDHS reported that 84.6 percent of married women of reproductive age have heard of at least one method. However, this average masks critical differences related to method type, age, wealth, and other factors. For example, only 25.9 percent of women have heard of implants in Nigeria a much lower rate of knowledge than in other countries. From a geographical perspective, knowledge is significantly lower in the North, as is contraceptive prevalence[129]. Reasons for not using family planning and modern contraception included incomplete family size, negative perceptions, in-laws' disapproval, religious concerns, side-effects, and lack of access to quality services [129].

Over the last quarter century, many developing countries, including Iran, have undergone a drastic fertility decline after wide adoption of family planning. The literature documenting this demographic shift has largely focused on investigating the determinants of contraceptive use and the role contraceptives have played in declining fertility rates. In contrast, there has been less research examining the impact of family planning use on

women's lives. The research that has been carried out in this area has concentrated on the role of contraceptive use in improving maternal health and welfare and child survival, and in preventing HIV infection. Beyond these well documented health benefits of family planning, little empirical knowledge is available regarding whether and to what extent contraceptive use is an essential ingredient for a more socially rewarding life for women in developing countries. In addition to its health benefits, the use of available effective contraceptive methods has the potential to enable a woman to be better poised to take on non-reproductive roles outside the home, including furthering her education[129].As noted by some researchers, a new research agenda is needed to investigate the impact of family planning programs on women in developing nations beyond their physical health and that of their children [129].

2.4 Conceptual Framework (Model)





Source: Researcher 2022

Fig 2: A model of personal and socio-cultural factors

2.5 Summary of the Reviewed Literature

The role Women and men have changed, primarily as many women have become economically independent through labor force participation and men are increasingly

involved in caring for their children. We are, in this study, interested in whether this increased gender equality has led to a gender equal influence over decisions within the family. Also, focus on what is perhaps the most crucial and life-altering decision for a couple: whether to have a child or not has become what many couple discussed a lot [3].

Health hazard of family planning methods, either experienced or anticipated, have been identified as a common reason that women either choose not to start or discontinue contraceptives. This includes menstrual changes (heavier bleeding, amenorrhea or oligo menorrhea), changes in weight, headaches, dizziness, nausea, and cardiovascular impacts. In addition, women may harbor fears of long-term effects of contraceptive use, such as infertility and childbirth complications [1].

In addendum, the looking into the relationship between effective contraception and maternal and child health, religious leaders have the power to promote family health and well-being and contribute to the discourse and strategies on maternal and newborn morbidity and mortality reduction through congregational advocacy messages on the health benefits of family planning. Religious prohibition of contraceptive adoption still persists in Nigeria, partly because of the spread of myths and misconceptions about family planning. Because of this, the strategy of working with religious leaders to increase their knowledge of family planning and its benefits and, ultimately, engage them as change agents, may be crucial to increasing family planning adoption and promoting family health in Nigeria [8].

Mass media is a key strategy for increasing demand for use in health services. It is a process that helps communities to identify their own needs and to respond to and address these needs. Gaining the participation of community members can help providers raise awareness both of health issues at the community level and of social and cultural issues that may promote or inhibit use of information and services, as well as improve

masses understanding of the methods or services being offered. Specific barriers to service access and use can be addressed and service utilization increased [12].

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Chapter Three

Methodology

This chapter presents the research methods and procedure that was used for the study. These are discussed under the following sub-headings:

3.1. Research Design

3.2. Population of the Study

3.3. Sample and Sampling Techniques

3.4. Description of the Research Instrument

3.5. Validity of the Instrument

3.6. Reliability of the Instrument

3.7. Data Collection

3.8. Data Analysis

3.1 Research Design

The research design that was adopted is the descriptive survey method. Descriptive survey research design is a scientific method which involve observing and describing the behavior of a subject without influencing it in any way. The aim of the survey is to accurately and systematically describe a population, situation or phenomenon. Therefore, information will be collected on personal and socio-cultural factors as determinants of family planning adoption among female secondary school teachers of Oyo Zone, Oyo State.

3.2 Population of the Study

The population of the study was made up of all female teachers which is 1,227 in the 47 registered secondary schools in Oyo Zone, Oyo State.

3.3 Sample and Sampling Techniques

The researcher adopted simple random sampling technique to select the respondents from selected secondary schools in Oyo Zone, Oyo State. Female teachers in four (4) local government area and 30% of the secondary schools in each local government were sampled from the total population of the proposed respondents due to the availability of respondents and accessibility of those schools to major roads. Also, fifty percent (50%) female teachers were randomly sampled from the fifteen schools as a result of their readiness and population size in those schools. This make the total number of sampled female teachers to be two hundred (210). Schools were randomly selected in each of the local governments visited in phases as indicated in table 3.1. The population table showing the total numbers of female teachers is shown in appendix 10

Table 3.1: Sample Size

S/N	Schools	Population	Sample (50%)
	Oyo East		
1	Abiodun Atiba Memorial school, Oyo	49	25
2	Olivet Baptist Junior High School, Oyo	44	22
3	St Bernadine Senior Girls Grammar School, Oyo	37	19
	Oyo West		
4	Ladigbolu Grammar School 1,Oyo	43	22
5	Ladigbolu Grammar School 2, Oyo	47	24
6	Fasola Grammar School, Fasola ,Oyo	11	06
	Atiba		
7	Alaafin High School 2,Oyo Atiba	17	09
8	Oranyan Grammar School 2,Atiba	28	14
9	Isale Oyo Com Commercial Secondary School 2, Oyo	18	09
10	Bode Thomas Memorial Grammar School, Oyo	13	07
	Afijio		
11	Awe High School, Oyo	24	12

12	Akinmorin Grammar School, Iware Road, Akinmorin	21	11
13	Fiditi Grammar School, Fiditi	15	08
14	Ilora Baptist Grammar School 2, Ilora	40	20
15	Imini Grammar School,Imini	03	02
	Total	**410**	**210**

Source: Oyo State Teaching Service Post Primary Commission Office

3.4 Research Instrument

The instrument for this research work was structured questionnaire. The researcher developed the questionnaire based on the research questions of this study with the intention of eliciting information on personal and socio-cultural factors as determinants of family planning adoption among female secondary school teachers of Oyo Zone, Oyo State.

The questionnaire was divided into two parts. Section A contained question on demographic information of the respondents, while section B was made up of questions drawn from the research questions and hypotheses. Four likert scale format was adopted with the following options: Strongly Agree (SA), Agree (A), Disagree (D) and Strongly Disagree (SD). The questionnaire contained thirty-six items.

3.5 Validity of Instrument

Validity of the instrument is the ability of the instrument to measure what it purports to measure. In the light of this, the two instruments were shown to the experts in education and the supervisor and the women who have experience of family planning. Based on their comments, modification was made and final drafts were produced.

3.6 Reliability of the Instrument

The data collected were subjected to Cronbach Alpha to determine the reliability coefficient. Personal Factors Scale (PFS) had 0.71, Social Factors Scale (SFS) had 0.78, Cultural Factors Scale (CFS) had 0.65, while the value for Family Planning Adoption Scale (FPAS) was 0.95. Also, the internal consistency of the entire questionnaire was 0.85.

3.7 Data Collection

Copies of the questionnaire were administered to the selected female teachers for a period of two weeks to the selected population. There were letters collected from the department to the principals of each secondary schools. This was done by the researcher with the help of four research assistants in each of the selected secondary schools in Oyo Zone, Oyo after getting consent from the Principals of each school and briefing the respondents on the research purpose. During the data collection process in the school, female teachers were served with copies of the questionnaire to complete and the researcher subsequently retrieved the questionnaire after their responses have been duly indicated for analysis. The researcher uses 14 days for administered of the questionnaire.

3.8 Data Analysis

Data collected from the respondents with the aid of questionnaire was analyzed with the use of Statistical Package for the Social Sciences (SPSS). Answers to the research questions were presented in a descriptive form using simple percentages, mean, standard deviation, while research hypotheses were tested using inferential statistics such as regression analysis to test the statistical level of significance. The research hypotheses were tested at 0.05 level of significance.

Chapter four

Results and Discussion of Findings

This chapter presents results of the analyses and discussion of findings. The results and discussion of findings are presented based on demographic characteristics of the respondents, research question and hypotheses as follow:

Results

4.1 Demographic Data Analysis

The below are the socio-demographic characteristics of the respondents.

Table 4.1: Distribution of the Respondents by Age

Age	Frequency	Percent
20-29 years	73	36.5
30-39 years	70	35.0
40-49 years	39	19.5
50 years and above	18	9.0
Total	200	100.0

Source: Field Survey, 2022

Table 4.1 reveals that 73 (36.5%) of the respondents were in the age range of 20-29 years, 70 (35.0%) were between 30-39 years, 39 (19.5%) were in the age range of 40-49 years, while 18 (9.0%) were 50 years and above. This means that, most of the respondents were between 20-29 years, while the respondents who were over 50 years were the least.

Table 4.2: Distribution of the Respondents by Religion

Religion	Frequency	Percent
Christianity	115	57.5
Islam	84	42.0
Traditional	1	0.5
Total	200	100.0

Source: Field Survey, 2022

Table 4.2 reveals that, 115 (57.5%) of the respondents were Christians, 84 (42.0%) were Muslims, while 1 (0.5%) respondents practiced traditional religion. This means that, most of the respondents were Christians, while a respondent was practicing traditional religion.

Table 4.3: Distribution of the Respondents by Marital Status

Marital Status	Frequency	Percent
Single	34	17.0
Married	157	78.5
Divorced	5	2.5
Widow	4	2.0
Total	200	100.0

Source: Field Survey, 2022

Table 4.3 reveals that, 34 (17.0%) of the respondents were single, 157 (78.5%) were married, 5 (2.5%) were divorced, while 4 (2.0%) were widows. This means that, most of the respondents were married, few were widows.

Table 4.4: Distribution of the Respondents by Educational Qualification

Educational Qualification	Frequency	Percent
NCE	55	27.5
First Degree	116	58.0
PGDE	24	12.0
Master Degree	5	2.5
Total	200	100.0

Source: Field Survey, 2022

Table 4.4 reveals that, 55 (27.5%) of the respondents obtained NCE, 116 (58.0%) possessed First Degree, 24 (12.0%) had PGDE, while 5 (2.5%) possessed Master Degree. This means that, most of the respondents had First Degree, while few possessed Master Degree.

Table 4.5: Distribution of the Respondents by Local Government Area

Local Government Area	Frequency	Percent
Afijio	59	29.5
Atiba	35	17.5
Oyo East	71	35.5
Oyo West	35	17.5
Total	200	100.0

Source: Field Survey, 2022

Table 4.5 reveals that, 59 (29.5%) of the respondents were teaching in Afijio, 35 (17.5%) were from Atiba, 71 (35.5%) were from Oyo East, while 35 (17.5%) were teaching in

Oyo West Local Government Area. This means that, most of the respondents were teaching in Oyo East Local Government Area, while Atiba and Oyo West Local Government Area had the least number of respondents.

Research Question

The research question below was answered:

Research Question 1**:** What is the level of family planning adoption among female secondary school teachers in Oyo Zone?

Table 4.6: Summary of Result on the Level of Family Planning Adoption

S/n	Statement	Regularly	Sometimes	Never
1.	I accept to be engaged in any family planning based on the associated benefits	106 (53.0%)	44 (22.0%)	50 (25.0%)
2.	Introduction of different family planning devices at the health facilities motivate me to adopt family planning	85 (42.5%)	41 (20.5%)	74 (37.0%)
3.	I engage in family planning programme without considering the cost implications	45 (22.5%)	116 (58.0%)	39 (19.5%)
4.	The sources of information about family planning devices / methods contribute to the manner at which I embrace family planning	113 (56.5%)	16 (8.0%)	71 (35.5%)
5.	I will go for any appropriate family method when the need arises	108 (54.0%)	41 (20.5%)	51 (25.5%)
6.	I do encourage individuals to go for family planning at the available health facilities, based on my worthwhile experience	73 (36.5%)	71 (35.5%)	56 (28.0%)

Total	530/6 88 (44.2%)	329/6 54.8=55 (27.4%)	341/6 57 (28.4%)

Source: Field Survey, 2022

Table 4.6 reveals that 106 (53.0%) respondents that they regularly accept to be engaged in any family planning based on the associated benefits, 44 (22.0%) sometimes involved in it, while 50 (25.0%) never engage in it. In addition, 85 (42.5%) respondents that they involved in introduction of different family planning devices at the health facilities motivate me to adopt family planning, 41 (20.5%) sometimes involved in it, while 74 (37.0%) never engage in it. Moreover, 45 (22.5%) respondents that they engage in family planning programme without considering the cost implications, 116 (58.0%) sometimes involved in it, while 39 (19.5%) never engage in it. Furthermore, 113 (56.5%) respondents that the sources of information about family planning devices / methods contribute to the manner at which they embraced family planning, 16 (8.0%) sometimes involved in it, while 71 (35.5%) never engage in it.

Besides, 108 (54.0%) respondents that they would go for any appropriate family method when the need arises, 41 (20.5%) sometimes involved in it, while 51 (25.5%) never engage in it. Also, 73 (36.5%) respondents that they do encourage individuals to go for family planning at the available health facilities, based on my worthwhile experience, 71 (35.5%) sometimes involved in it, while 56 (28.0%) never engage in it. The table 4.6 further reveals that most of the respondents (44.2%) regularly engaged in family planning adoption, 27.4% sometimes, while 28.4% never engaged in it.

4.2 Hypotheses

The following hypotheses were tested in the study.

Hypothesis 1: Personal factors (fear of health hazard and desire for more children) will not jointly and significantly determine adoption of family planning among female secondary school teachers in Oyo Zone.

Table 4.7: Regression Analysis of Joint Contribution of Personal Factors to Adoption of Family Planning

R=.901

R^2=.811

Adj. R^2=.809

Std. Error=1.73716

Model	Sum of Squares	Df	Mean Square	F	Sig. (*p* value)	Remark
Regression	2550.787	2	1275.393	422.633	.000	Significant

Residual	594.493	197	3.018
Total	3145.280	199	

Source: Field Survey, 2022

As shown in table 4.7, it was found that the linear combination of personal factors (fear of health hazard and desire for more children) was tested significant on adoption of family planning among female secondary school teachers in Oyo Zone ($F_{(2,197)}$=422.633, p<0.05). The result yielded a coefficient of multiple regression of R=0.901 and multiple R-square of 0.811. The result also reveals that adjusted R^2=0.809; indicating that about 80.9% of variance was accounted for by the independent variables. This means that, personal factors of fear of health hazard and desire for more children jointly and significantly determined adoption of family planning among female secondary school teachers in Oyo Zone. The null hypothesis was therefore rejected.

Hypothesis 2: Fear of health hazard and desire for more children will not relatively and significantly determine adoption of family planning among female secondary school teachers in Oyo Zone.

Table 4.8: Regression Analysis of Relative Contributions of Personal Factors to Adoption of Family Planning

	Unstandardized Coefficients		Standardized Coefficients			
Variables	B	Std. Error	Beta	T	Sig.	Remark
(Constant)	1.468	.369		3.981	.000	
Fear of health hazard	.362	.058	.379	6.272	.000	Sig.
Desire for more children	.545	.059	.554	9.181	.000	Sig.

Source: Field Survey, 2022

Table 4.8 reveals fear of health hazard and desire for more children, the unstandardized regression weight (ß), the standardized error of estimate (SEß), the standardized coefficient, the t-ratio and the level at which the t-ratio was significant. As indicated in table 4.8, fear of health hazard (ß=0.379, t=6.272, p<0.05) and desire for more children (ß=0.554, t=9.181, p<0.05) were independently tested significant on adoption of family planning among female secondary school teachers in Oyo Zone. However, desire for more children had a higher contribution to adoption of family planning than fear of health hazard. This means that fear of health hazard and desire for more children relatively and significantly determined adoption of family planning among female secondary school teachers in Oyo Zone. The null hypothesis was therefore rejected.

Hypothesis 3: Social factors (religion, spousal disposition and media influence) will not jointly and significantly determine the adoption of family planning among female secondary school teachers in Oyo Zone.

Table 4.9: Regression Analysis of Joint Contribution of Social Factors to Adoption of Family Planning

R=.940

R^2=.883

Adj. R^2=.881

Std. Error=1.36999

Model	Sum of Squares	Df	Mean Square	F	Sig. (*p* value)	Remark
Regression	2777.414	3	925.805	493.272	.000	Significant
Residual	367.866	196	1.877			
Total	3145.280	199				

Source: Field Survey, 2022

As indicated in table 4.9, it was found that the linear combination of social factors (religion, spousal disposition and media influence) was tested significant on adoption of family planning among female secondary school teachers in Oyo Zone ($F_{(3,196)}$=493.272, p<0.05). The result yielded a coefficient of multiple regression of R=0.940 and multiple R-square of 0.883. The result also reveals that adjusted R^2=0.881; indicating that about 88.1% of variance was accounted for by the independent variables. This means that, social factors of religion, spousal disposition and media influence jointly and significantly

determined adoption of family planning among female secondary school teachers in Oyo Zone. The null hypothesis was therefore rejected.

Hypothesis 4: Religion, spousal disposition and media influence will not relatively and significantly determine the adoption of family planning among female secondary school teachers in Oyo Zone.

Table 4.10: Regression Analysis of Relative Contributions of Social Factors to Adoption of Family Planning

Variables	Unstandardized Coefficients		Standardized Coefficients	T	Sig.	Remark
	B	Std. Error	Beta			
(Constant)	1.643	.393		4.177	.000	
Religion	-.015	.015	-.024	-.965	.336	Not Sig.
Spousal disposition	.637	.051	.687	12.477	.000	Sig.
Media influence	.201	.041	.272	4.930	.000	Sig.

Table 4.10 reveals religion, spousal disposition and media, the unstandardized regression weight (ß), the standardized error of estimate (SEß), the standardized coefficient, the t-ratio and the level at which the t-ratio was significant. As indicated in table 4.10, spousal disposition (ß=0.687, t=12.477, $p<0.05$) and media (ß=0.272, t=4.930, $p<0.05$) were independently tested significant on adoption of family planning among female secondary school teachers in Oyo Zone; while religion (ß=-0.024, t=-0.965, $p>0.05$) did not. However, spousal disposition had a higher contribution to adoption of family planning than media. This means that spousal disposition and media influence

relatively and significantly determined adoption of family planning among female secondary school teachers in Oyo Zone. The null hypothesis which stated that spousal disposition and media influence would not relatively and significantly determine the adoption of family planning among female secondary school teachers in Oyo Zone was therefore rejected.

Hypothesis 5: Cultural factors (tradition, norm and customs) will not jointly and significantly determine the adoption of family planning among female secondary school teachers in Oyo Zone.

Table 4.11: Regression Analysis of Joint Contribution of Cultural Factors to Adoption of Family Planning

R=.630

R^2=.397

Adj. R^2=.388

Std. Error=3.11004

Model	Sum of Squares	Df	Mean Square	F	Sig. (*p* value)	Remark
Regression	1249.501	3	416.500	43.061	.000	Significant
Residual	1895.779	196	9.672			
Total	3145.280	199				

Source: Field Survey, 2022

As indicated in table 4.11, it was found that the linear combination of cultural factors **(**tradition, norm and customs) was tested significant on adoption of family planning among female secondary school teachers in Oyo Zone ($F_{(3,196)}$=43.061, p<0.05). The result yielded a coefficient of multiple regression of R=0.630 and multiple R-square of 0.397. The result also reveals that adjusted R^2=0.388; indicating that about 38.8% of variance was accounted for by the independent variables. This means that, cultural factors of tradition, norm and customs jointly and significantly determined adoption of family planning among female secondary school teachers in Oyo Zone. The null hypothesis was therefore rejected.

Hypothesis 6: Tradition, norm and customs will not relatively and significantly determine the adoption of family planning among female secondary school teachers in Oyo Zone.

Table 4.12: Regression Analysis of Relative Contribution of Cultural Factors to Adoption of Family Planning

Variable	Unstandardized Coefficients		Standardized Coefficients	T	Sig.	Remark
	B	Std. Error	Beta			
(Constant)	3.256	.971		3.354	.001	
Tradition	1.882	.166	.780	11.337	.000	Significant
Norm	-.130	.133	-.104	-.976	.330	Not Sig.
Customs	-.424	.139	.333	3.055	.003	Significant

Table 4.12 reveals tradition, norm and customs, the unstandardized regression weight (ß), the standardized error of estimate (SEß), the standardized coefficient, the t-

ratio and the level at which the t-ratio was significant. As indicated in table 4.12, tradition (ß=0.780, t=11.337, p<0.05) and customs (ß=0.333, t=3.055, p<0.05) were independently tested significant on adoption of family planning among female secondary school teachers in Oyo Zone; while norm (ß=-0.104, t=-0.976, p>0.05) did not. However, tradition had a higher contribution to adoption of family planning than customs. This means that tradition and customs relatively and significantly determined adoption of family planning among female secondary school teachers in Oyo Zone. The null hypothesis which stated that tradition and customs would not relatively and significantly determine the adoption of family planning among female secondary school teachers in Oyo Zone was therefore rejected.

Hypothesis 7: There is no significant difference in family planning adoption among female secondary school teachers in the Local Government Areas in Oyo Zone.

Table 4.13.1: Analysis of Variance on difference in family planning adoption among female secondary school teachers in Oyo Zone

Source	**Sum of square**	**Df**	**Mean square**	**F**	**Sig. (p value)**	**Remark**
Between Groups	17.875	3	5.958	1.396	.245	Not Sig.
Within groups	836.520	196	4.268			
Total	854.395	199				

Table 4.13.1 reveals that, there was no significant difference in family planning adoption among female secondary school teachers in the Local Government Areas in Oyo Zone ($F_{(3,196)}$=1.396; p>0.05). Hence, the null hypothesis was accepted. This implied that Local Government Area had no significant difference in family planning adoption among female secondary school teachers in Oyo Zone.

Table 4.13.2: Post-hoc analysis showing descriptive difference in family planning adoption among female secondary school teachers in Oyo Zone

S/n	Local Government Area	Frequency	Mean	Standard deviation	Rank
1.	Afijio	59	13.07	2.34	2nd
2.	Atiba	35	12.34	2.73	4th
3.	Oyo East	71	13.18	1.63	1st
4.	Oyo West	35	12.86	1.52	3rd

Table 4.13.2 reveals that the respondents in Oyo East Local Government Area had the highest mean of 13.18 followed by those in Afijio with a mean score of 13.07 and Oyo West Local Government Area (12.86) respectively, while respondents in Atiba Local Government Area had the least mean score of 12.34. It means that teachers from Oyo East Local Government Area had the highest tendency to engage in adoption of family planning than their counterparts in other Local Government Areas in Oyo Zone, while the teachers in Local Government Area were the least.

4.3 Discussion of Findings

The findings of this study on socio-demographic characteristics revealed that, most of the respondents were in the age range of 20-29 years. Similarly, it was established that majority of the respondents were Christians, of which a considerable number of them were married; while most of such respondents had First Degree. Also, most of the respondents were teaching in Oyo East Local Government Area. In addition, the findings of this study on adoption of family planning revealed that the level of family

planning adoption among female secondary school teachers in Oyo Zone was moderate. This was established through the responses of the respondents in which most of them regularly adopted family planning adoption, while some of them sometimes engaged in it.

In the same vein, the findings of this study revealed that the linear combination of personal factors (fear of health hazard and desire for more children) was tested significant on adoption of family planning among female secondary school teachers in Oyo Zone. This means that, personal factors of fear of health hazard and desire for more children jointly and significantly determined adoption of family planning among female secondary school teachers in Oyo Zone. The outcome of this study on joint contribution of personal factors was in line with a previous finding which revealed that a fear of health hazard had effect on the method that can be used for the adoption of family planning[1]. In addition, the outcome of this study was in congruence with the outcome of a study which established that desire for more children was associated with adoption of family planning[2]

Moreover, the findings of this study revealed that fear of health hazard and desire for more children were independently tested significant on adoption of family planning among female secondary school teachers in Oyo Zone. This means that fear of health hazard and desire for more children relatively and significantly determined adoption of family planning among female secondary school teachers in Oyo Zone. The outcome of this study on relative contribution of personal factors had similarity with a previous study which found that women who had a primary school graduate or higher education, had 1–3 pregnancies and did not want more children in the future got higher scores on the family planning attitude scale[3]. It was further established that as the level of education increases, the number of children required decreases[3]. Additionally, the findings of this study on desire for more children was in agreement with a previous study which established that desire for more children had significant influence on family planning adoption[4].

It was further established that, the linear combination of social factors (religion, spousal disposition and media influence) was tested significant on adoption of family planning among female secondary school teachers in Oyo Zone. This means that, social factors of religion, spousal disposition and media influence jointly and significantly determined adoption of family planning among female secondary school teachers in Oyo Zone. The outcome of this study on joint contribution of social factors to adoption of family planning was in line with the finding of a previous study which stated that having a strong religious identity affects willingness of women to discuss contraception with their partners/families/communities and an unwillingness to consider accessing it and eventually using it[5].

Moreover, the findings of this study affirmed that spousal disposition and media were independently tested significant on adoption of family planning among female secondary school teachers in Oyo Zone; while religion did not. This means that spousal disposition and media influence relatively and significantly determined adoption of family planning among female secondary school teachers in Oyo Zone. The outcome of this study on relative contribution of social factors was in congruent with the finding of a previous study which established that men's positive approach makes it easier for women to access and use family planning services, and as a result, availability and continuity in services is ensured[6]. The outcome of this study on relative contribution of social factors was in contrast to the finding of previous studies which stated that religion was a strong determinant of family planning practices in Nigeria[4,7]. Likewise, the outcome on influence of media was in agreement with a study which revealed that media was associated with family planning programme[8].

In addition, it was found that the linear combination of cultural factors (tradition, norm and customs) were tested significant on adoption of family planning among female

secondary school teachers in Oyo Zone. This means that, cultural factors of tradition, norm and customs jointly and significantly determined adoption of family planning among female secondary school teachers in Oyo Zone. The outcome of this study on joint contribution of cultural factors was in line with a previous finding which established that beliefs of society has strong influence on use of contraceptive methods or otherwise among women in various communities[1]. Furthermore, the findings of this study on norm was in congruence with a previous outcome which established that more ambitious social norm approaches had influence on contraception and family planning[9].

Additionally, the findings of this study revealed that tradition and customs independently tested significant on adoption of family planning among female secondary school teachers in Oyo Zone; while norm did not. This means that tradition and customs relatively and significantly determined adoption of family planning among female secondary school teachers in Oyo Zone. The outcome of this study on relative contribution of cultural factors was also in line with a previous finding which established that beliefs of society has strong influence on use of contraceptive methods or otherwise among women in various communities[1]. The finding of this study was also in agreement with a previous outcome which established that culture had strongly influence on[10].

The finding of this study also revealed that, there was no significant difference in family planning adoption among female secondary school teachers in the Local Government Areas in Oyo Zone. This implied that Local Government Area had no significant difference in family planning adoption among female secondary school teachers in Oyo Zone. However, it was revealed that the respondents in Oyo East Local Government Area had the highest mean; followed by those in Afijio and Oyo West Local Government Area respectively, while respondents in Atiba Local Government Area had the least mean score. It means that teachers from Oyo East Local Government Area had

the highest tendency to engage in adoption of family planning than their counterparts in other Local Government Areas in Oyo Zone, while the teachers in Local Government Area were the least.

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Chapter Five

Conclusion

This chapter presents the summary, conclusion and recommendation of the study.

5.1 Summary of Findings

This study focused on personal and social-cultural factors as determinants of family planning adoption among female secondary school teachers in Oyo Zone, Oyo State. Consequently, independent variables were tested in relation to dependent variables. The tested independent variables were personal and social-cultural factors, while family planning adoption among female secondary school teachers in Oyo Zone was examined as the dependent variable. A research question was raised and answered, while six hypotheses were formulated and tested.

The review of relevant literature was carried out under different sub-headings. The review of related literature covered the conceptual studies, theoretical model and review of empirical studies, conceptual model and summary of the review literature. The conceptual studies in this study covered personal factors, socio cultural factors, concept of family planning, concept of contraception, types of contraception, attitudes affecting family planning, other factors affecting family planning as well as benefit of family planning. For the theoretical framework, health belief model was adapted in the study. The empirical studies review covered personal and social-cultural factors as determinants of family planning adoption. Then, summary of the reviewed literature was carried out to appraise the reviewed conceptual studies, theoretical model, empirical studies and conceptual model.

Population for this study consisted female secondary school teachers in Oyo Zone, Oyo State. Random sampling technique was used to select a total of 200 respondents for the study. The descriptive statistics of frequency counts and percentages were used to

analyze demographic information of the respondents and research questions. Also, inferential statistics of regression was used to test hypotheses at 0.05 alpha level.

The findings of this study on socio-demographic characteristics revealed that, most of the respondents were in the age range of 20-29 years. Similarly, it was established that majority of the respondents were Christians, of which a considerable number of them were married; while most of such respondents had First Degree. In addition, the findings of the study on adoption of family planning revealed that the level of family planning adoption among female secondary school teachers in Oyo Zone was moderate.

In the same vein, the findings of this study revealed that personal factors of fear of health hazard and desire for more children jointly and significantly determined adoption of family planning among female secondary school teachers in Oyo Zone. Moreover, the findings of this study revealed that fear of health hazard and desire for more children relatively and significantly determined adoption of family planning among female secondary school teachers in Oyo Zone.

Also, social factors of religion, spousal disposition and media influence jointly and significantly determined adoption of family planning among female secondary school teachers in Oyo Zone. Moreover, the findings of this study affirmed that spousal disposition and media influence relatively and significantly determined adoption of family planning among female secondary school teachers in Oyo Zone, while religion did not. In addition, cultural factors of tradition, norm and customs jointly and significantly determined adoption of family planning among female secondary school teachers in Oyo Zone. Additionally, the findings of this study revealed that tradition and customs relatively and significantly determined adoption of family planning among female secondary school teachers in Oyo Zone, while norm did not.

5.2 Conclusion

It was concluded in the study that the level of adoption of family planning among female secondary school teachers in Oyo Zone was moderate. Conclusion was also made that personal factors of fear of health hazard and desire for more children jointly determined the adoption of family planning among female secondary school teachers in Oyo Zone. It was also affirmed that fear of health hazard and desire for more children relatively determined adoption of family planning among the respondents. Conclusion was further made that social factors of religion, spousal disposition and media influence jointly determined adoption of family planning among female secondary school teachers in Oyo Zone.

Moreover, the findings of this study affirmed that spousal disposition and media influence relatively determined adoption of family planning among the respondents, while religion did not. It was further established that cultural factors of tradition, norm and customs jointly determined adoption of family planning among female secondary school teachers in Oyo Zone. Also, tradition and customs relatively determined adoption of family planning among the respondents, while norm did not. It was also concluded that, there was no significant difference in family planning adoption among female secondary school teachers in the Local Government Areas in Oyo Zone. This means that Local Government Area had no significant difference in family planning adoption among the respondents in Oyo Zone.

5.3 Recommendations

Based on the findings of this study, the following recommendations were made:

1. The state Ministries of Health and Education should jointly organize periodic sensitization programme on adoption of family planning specifically among female

secondary school teachers across the five Local Government Areas in Oyo Zone of Oyo State. This is important so as to create more awareness on adoption of family planning among female secondary school teachers in Oyo Zone, with the aim of improving the level of adoption of family planning among the respondents from moderate to a satisfactory level.

2. The government, non-governmental organizations and other relevant agencies should organize an effective health education programme on specific socio-cultural factors (health hazard, desire for more children, tradition and customs) affecting adoption of family planning among female secondary school teachers in Oyo Zone. This is necessary so that the affected teachers in the Oyo zone would improve on the aforementioned factors.

5.4 Contributions to Knowledge

This study contributed to knowledge in the following ways:

1. It was established that the level of adoption of family planning among female secondary school teachers in Oyo Zone was moderate.
2. This study confirmed that personal factors of fear of health hazard and desire for more children jointly determined the adoption of family planning among female secondary school teachers in Oyo Zone.
3. This study established that social factors of religion, spousal disposition and media influence jointly determined adoption of family planning among female secondary school teachers in Oyo Zone.
4. It was established that spousal disposition and media influence relatively determined adoption of family planning among the respondents, while religion did not.

5. It was further established that cultural factors of tradition, norm and customs jointly determined adoption of family planning among female secondary school teachers in Oyo Zone.
6. Also, this study affirmed that tradition and customs relatively determined adoption of family planning among the respondents, while norm did not.
7. It was established that there was no significant difference in family planning adoption among female secondary school teachers in the Local Government Areas in Oyo Zone.

5.5 Suggested Area of Further Research

The following suggestions were made for further research based on the findings of the study.

1. The study of this nature can be replicated among female secondary school teachers in other political zones in Oyo State.
2. Also, the study of this nature can be carried out among male secondary school teachers in Oyo zone and perhaps in other political zones in Oyo State.
3. Some other personal and social-cultural factors that were not examined in this study can be worked on by other researchers in the subsequent studies.

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Appendix I

Department of Kinesiology, Sports Science and Health Education

Faculty of Arts and Education

Lead City University, Ibadan, Oyo State

Questionnaire

Dear respondent,

This questionnaire is designed to gather relevant information on personal and socio-cultural factors as determinant of family planning adoption among female secondary school teachers in Oyo Zone, Oyo State.

The information required is for the purpose of educational research. Hence, feel free to answer as it appears to you.

Thank you.

Desola Dorcas AKPAN

(The researcher)

Section A: Socio-demographic Information

Age: <19 years () 20-29 years () 30-39 years () 40-49 years () 50 years and above ()

Religion: Christianity () Islam () Traditional () Others ()

Marital Status: Single () Married () Divorced () Widow ()

Educational Qualification: NCE () Bachelor Degree () PGDE () Master Degree ()

Local Government Areas in Oyo Zone: Afijio () Atiba () Oyo East () Oyo West ()

Section B: Personal Factors Scale (PFS)

Instruction: Please tick (✓) in the appropriate column to indicate the extent to which you agree or disagree with the statements below:

Strongly agree (SA): Agree (A): Disagree (D) and Strongly Disagree (SD)

S/n	Statement	SA	A	D	SD
	Fear of Health Hazard				
1.	Fear of side effects is the main reason why I did not engage in the use of contraceptive devices				
2.	Contraceptive usage can cause changes to sexual experience, so it not advisable to involve in it.				
3.	I have the perception that consistent use of contraception can lead to menstrual bleeding, hence I desist from it.				
4.	I have a perception that the use of contraception can result to abdominal pain and weakness, so I don't involve in it.				
	Desire for More Children				
5.	I have no desire for more children, so I have to engage in contraceptive usage				
6.	My consistent usage of contraceptive pills is associated with low desire for additional children				
7.	I involve in barrier method of contraception (such as female condom and diaphragm) regularly due to my decision for not having more children.				
8.	**The adoption of intrauterine method (such as** hormonal IUD and copper IUD) by my family is				

	connected to lack of desire to **have more children.**				

Section C: Social Factors Scale (SFS)

Instruction: Please tick (✓) in the appropriate column to indicate the extent to which you agree or disagree with the statements below:

Strongly agree (SA): Agree (A): Disagree (D) and Strongly Disagree (SD)

S/n	Statement	SA	A	D	SD
	Religious Influence				
1.	My religion don't support family planning system				
2.	The clerics in my place of worship dictate the type of family planning system to adopt				
3.	Family planning is more scientific oriented than religion				
4.	Civilization has rendered religious opinion on adoption of family planning archaic				
	Spousal Disposition				
5.	There is a favourable spousal communication disposition to family planning adoption in my household				
6.	High contraceptive knowledge of my spouse contributes positively to family planning adoption				
7.	My spouse's inclination towards family size determination had positive influence on family planning adoption				
8.	The joint involvement in family planning decision				

	making between my spouse and I sometimes influence its adoption				
	Media Influence				
9.	I believe there is a strong influence between mass media and adoption of family planning in my household				
10.	My level of listening to radio is very high and that influences adoption of family planning				
11.	Frequent watching of family related issues on TV have strong influence on family planning adoption				
12.	Reading of newspapers, posters and so on contributes a lot to adoption of family planning in my household				
13.	My activeness in social media had strong influence in adoption of family planning.				

Section D: Cultural Factors Scale (CFS)

Instruction: Please tick (✓) in the appropriate column to indicate the extent to which you agree or disagree with the statements below:

Strongly agree (SA): Agree (A): Disagree (D) and Strongly Disagree (SD)

S/n	Statement	SA	A	D	SD
	Tradition				
1.	The type of family planning programme I engage in is passed to me from the previous generation				
2.	I involve in some family planning programmes based on information that is passed to me by some persons				
3.	The type of planning devices being involved in by me				

	are commonly used in my extended family				
	Norms				
4.	I involved in some family planning programmes based on what I regarded as normal				
5.	The use of barriers such as female condom is considered to be a common norm, so I involve in it as a normal rule that is socially enforced				
6.	I involved in some family planning programmes based on my personal expectations which I consider as normal				
	Customs				
7.	I adopt family planning based on common social practices				
8.	I use certain contraceptive methods based on common social practices being followed by most people in the society				
9.	I involved in some family planning programmes / contraception based on expectations that are socially enforced				

Section E: Family Planning Adoption Scale (FPAS)

Instruction: Please tick (✓) in the appropriate column that suits your response in the following statements. Regularly (RE), Sometimes (SM) and Never (NE)

S/n	Statement	RE	SM	NE
1.	I accept to be engaged in any family planning based on the			

	associated benefits			
2.	Introduction of different family planning devices at the health facilities motivate me to adopt family planning			
3.	I engage in family planning programme without considering the cost implications			
4.	The sources of information about family planning devices / methods contribute to the manner at which I embrace family planning			
5.	I will go for any appropriate family method when the need arises			
6.	I do encourage individuals to go for family planning at the available health facilities, based on my worthwhile experience			

Appendix ii

Sample Size

S/N	Schools	Population	Sample (50%)
	Oyo East		
1	Abiodun Atiba Memorial school, Oyo	49	25
2	Olivet Baptist Junior High School, Oyo	44	22
3	St Bernadine Senior Girls Grammar School, Oyo	37	19
	Oyo West		
4	Ladigbolu Grammar School 1,Oyo	43	22
5	Ladigbolu Grammar School 2, Oyo	47	24
6	Fasola Grammar School, Fasola ,Oyo	11	06
	Atiba		
7	Alaafin High School 2,Oyo Atiba	17	09
8	Oranyan Grammar School 2,Atiba	28	14
9	Isale Oyo Com Commercial Secondary School 2, Oyo	18	09
10	Bode Thomas Memorial Grammar School, Oyo	13	07

	Afijio		
11	Awe High School, Oyo	24	12
12	Akinmorin Grammar School, Iware Road, Akinmorin	21	11
13	Fiditi Grammar School, Fiditi	15	08
14	Ilora Baptist Grammar School 2, Ilora	40	20
15	Imini Grammar School,Imini	03	02
	Total	**410**	**210**

Appendix iii

Table 4.1: Distribution of the Respondents by Age

Age	Frequency	Percent
20-29 years	73	36.5
30-39 years	70	35.0
40-49 years	39	19.5
50 years and above	18	9.0
Total	200	100.0

Source: Field Survey, 2022

Table 4.2: Distribution of the Respondents by Religion

Religion	Frequency	Percent
Christianity	115	57.5
Islam	84	42.0
Traditional	1	0.5
Total	200	100.0

Source: Field Survey, 2022

Table 4.3: Distribution of the Respondents by Marital Status

Marital Status	Frequency	Percent
Single	34	17.0
Married	157	78.5
Divorced	5	2.5
Widow	4	2.0
Total	200	100.0

Source: Field Survey, 2022

Table 4.4: Distribution of the Respondents by Educational Qualification

Educational Qualification	Frequency	Percent
NCE	55	27.5
First Degree	116	58.0
PGDE	24	12.0
Master Degree	5	2.5

Total	200	100.0

Source: Field Survey, 2022

Table 4.5: Distribution of the Respondents by Local Government Area

Local Government Area	Frequency	Percent
Afijio	59	29.5
Atiba	35	17.5
Oyo East	71	35.5
Oyo West	35	17.5
Total	200	100.0

Source: Field Survey, 2022

Table 4.6: Summary of Result on the Level of Family Planning Adoption

S/n	Statement	Regularly	Sometimes	Never
1.	I accept to be engaged in any family planning based on the associated benefits	106 (53.0%)	44 (22.0%)	50 (25.0%)
2.	Introduction of different family planning devices at the health facilities motivate me to adopt family planning	85 (42.5%)	41 (20.5%)	74 (37.0%)
3.	I engage in family planning programme without considering the cost implications	45 (22.5%)	116 (58.0%)	39 (19.5%)
4.	The sources of information about family planning devices / methods contribute to the manner at which I embrace family planning	113 (56.5%)	16 (8.0%)	71 (35.5%)
5.	I will go for any appropriate family method when the need arises	108 (54.0%)	41 (20.5%)	51 (25.5%)
6.	I do encourage individuals to go for family planning at the available health facilities, based on my worthwhile experience	73 (36.5%)	71 (35.5%)	56 (28.0%)
Total		530 (44.2%)	329 (27.4%)	341 (28.4%)

Source: Field Survey, 2022

Table 4.7: Regression Analysis of Joint Contribution of Personal Factors to Adoption of Family Planning

R=.901
R^2=.811
Adj. R^2=.809
Std. Error=1.73716

Model	Sum of Squares	Df	Mean Square	F	Sig. (*p* value)	Remark
Regression	2550.787	2	1275.393	422.633	.000	Significant
Residual	594.493	197	3.018			
Total	3145.280	199				

Source: Field Survey, 2022

Table 4.8: Regression Analysis of Relative Contributions of Personal Factors to Adoption of Family Planning

	Unstandardized Coefficients		Standardized Coefficients			
Variables	B	Std. Error	Beta	T	Sig.	Remark
(Constant)	1.468	.369		3.981	.000	
Fear of health hazard	.362	.058	.379	6.272	.000	Sig.
Desire for more children	.545	.059	.554	9.181	.000	Sig.

Source: Field Survey, 2022

Table 4.9: Regression Analysis of Joint Contribution of Social Factors to Adoption of Family Planning

R=.940
R^2=.883
Adj. R^2=.881
Std. Error=1.36999

Model	Sum of Squares	Df	Mean Square	F	Sig. (*p* value)	Remark
Regression	2777.414	3	925.805	493.272	.000	Significant
Residual	367.866	196	1.877			
Total	3145.280	199				

Source: Field Survey, 2022

Table 4.10: Regression Analysis of Relative Contributions of Social Factors to Adoption of Family Planning

	Unstandardized Coefficients		Standardized Coefficients			
Variables	B	Std. Error	Beta	T	Sig.	Remark
(Constant)	1.643	.393		4.177	.000	
Religion	-.015	.015	-.024	-.965	.336	Not Sig.
Spousal disposition	.637	.051	.687	12.477	.000	Sig.

Media influence	.201	.041	.272	4.930	.000	Sig.

Table 4.11: Regression Analysis of Joint Contribution of Cultural Factors to Adoption of Family Planning

R=.630
R^2=.397
Adj. R^2=.388
Std. Error=3.11004

Model	Sum of Squares	Df	Mean Square	F	Sig. (*p* value)	Remark
Regression	1249.501	3	416.500	43.061	.000	Significant
Residual	1895.779	196	9.672			
Total	3145.280	199				

Source: Field Survey, 2022

Table 4.12: Regression Analysis of Relative Contribution of Cultural Factors to Adoption of Family Planning

Variable	Unstandardized Coefficients		Standardized Coefficients	T	Sig.	Remark
	B	Std. Error	Beta			
(Constant)	3.256	.971		3.354	.001	
Tradition	1.882	.166	.780	11.337	.000	Significant
Norm	-.130	.133	-.104	-.976	.330	Not Sig.
Customs	-.424	.139	.333	3.055	.003	Significant

Table 4.13.1: Analysis of Variance on difference in family planning adoption among female secondary school teachers in Oyo Zone

Source	**Sum of square**	**Df**	**Mean square**	**F**	**Sig. (*p* value)**	**Remark**

Between Groups	17.875	3	5.958	1.396	.245	Not Sig.
Within groups	836.520	196	4.268			
Total	854.395	199				

Table 4.13.2: Post-hoc analysis showing descriptive difference in family planning adoption among female secondary school teachers in Oyo Zone

S/n	Local Government Area	Frequency	Mean	S.D	Rank
1.	Afijio	59	13.07	2.34	2nd
2.	Atiba	35	12.34	2.73	4th
3.	Oyo East	71	13.18	1.63	1st
4.	Oyo West	35	12.86	1.52	3rd

Appendix iv

Reliability

Personal Factors Scale

Case Processing Summary

		N	%
Cases	Valid	20	100.0
	Excluded[a]	0	.0
	Total	20	100.0

Reliability Statistics

Cronbach's Alpha	N of Items
.708	8

Item Statistics

	Mean	Std. Deviation	N
VAR00001	1.3500	.58714	20
VAR00002	1.5500	.82558	20
VAR00003	1.2000	.41039	20
VAR00004	1.3000	.73270	20
VAR00005	1.2000	.41039	20
VAR00006	1.1500	.48936	20
VAR00007	1.9000	1.25237	20

VAR00008	1.7500	1.01955	20

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
VAR00001	10.0500	10.682	.374	.686
VAR00002	9.8500	11.503	.050	.754
VAR00003	10.2000	11.011	.472	.681
VAR00004	10.1000	9.568	.520	.653
VAR00005	10.2000	10.589	.638	.662
VAR00006	10.2500	10.618	.503	.671
VAR00007	9.5000	7.526	.490	.674
VAR00008	9.6500	8.029	.588	.628

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
11.4000	12.463	3.53032	8

SOCIAL FACTORS SCALE

Case Processing Summary

		N	%
Cases	Valid	20	100.0
	Excluded[a]	0	.0
	Total	20	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.779	13

Item Statistics

	Mean	Std. Deviation	N
VAR00009	1.3500	.74516	20
VAR00010	1.1000	.30779	20
VAR00011	1.9000	.96791	20

VAR00012	1.2000	.52315	20
VAR00013	1.0500	.22361	20
VAR00014	1.1000	.30779	20
VAR00015	1.0500	.22361	20
VAR00016	1.2000	.69585	20
VAR00017	1.1500	.36635	20
VAR00018	1.1500	.36635	20
VAR00019	1.1500	.36635	20
VAR00020	1.2500	.55012	20
VAR00021	1.4000	.82078	20

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
VAR00009	14.7000	12.326	.203	.793
VAR00010	14.9500	11.945	.896	.742
VAR00011	14.1500	12.661	.050	.834
VAR00012	14.8500	11.292	.677	.739
VAR00013	15.0000	12.842	.657	.762
VAR00014	14.9500	12.997	.384	.770
VAR00015	15.0000	12.842	.657	.762
VAR00016	14.8500	10.450	.669	.732
VAR00017	14.9000	11.884	.763	.744
VAR00018	14.9000	12.095	.673	.750
VAR00019	14.9000	12.095	.673	.750
VAR00020	14.8000	11.221	.657	.739
VAR00021	14.6500	12.661	.105	.811

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
16.0500	13.945	3.73427	13

CULTURAL FACTORS SCALE

Case Processing Summary

		N	%
Cases	Valid	20	100.0
	Excluded[a]	0	.0
	Total	20	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.651	9

Item Statistics

	Mean	Std. Deviation	N
VAR00022	1.5500	.99868	20
VAR00023	1.0500	.22361	20
VAR00024	1.1000	.30779	20
VAR00025	1.1000	.30779	20
VAR00026	1.0500	.22361	20
VAR00027	1.1500	.36635	20
VAR00028	1.1500	.36635	20
VAR00029	1.1000	.30779	20
VAR00030	1.4000	.59824	20

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
VAR00022	9.1000	4.200	-.105	.868
VAR00023	9.6000	4.042	.749	.589
VAR00024	9.5500	3.945	.594	.589
VAR00025	9.5500	4.050	.501	.603
VAR00026	9.6000	4.042	.749	.589
VAR00027	9.5000	3.842	.550	.586
VAR00028	9.5000	3.737	.632	.570
VAR00029	9.5500	3.839	.689	.573
VAR00030	9.2500	3.671	.321	.629

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
10.6500	4.766	2.18307	9

FAMILY PLANNING ADOPTION SCALE

Case Processing Summary

	N	%

Cases	Valid	20	100.0
	Excluded[a]	0	.0
	Total	20	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.953	6

Item Statistics

	Mean	Std. Deviation	N
VAR00031	1.5500	.99868	20
VAR00032	1.5000	.82717	20
VAR00033	1.6000	1.09545	20
VAR00034	1.4000	.94032	20
VAR00035	1.5500	1.09904	20
VAR00036	1.3000	.73270	20

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
VAR00031	7.3500	17.818	.938	.933
VAR00032	7.4000	19.305	.927	.937
VAR00033	7.3000	17.695	.850	.945
VAR00034	7.5000	18.368	.927	.935
VAR00035	7.3500	18.661	.722	.962
VAR00036	7.6000	20.568	.846	.948

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
8.9000	26.726	5.16975	6

Scale: ALL VARIABLES

Case Processing Summary

		N	%
Cases	Valid	20	100.0
	Excluded[a]	0	.0
	Total	20	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.852	36

Item Statistics

	Mean	Std. Deviation	N
VAR00001	1.3500	.58714	20
VAR00002	1.5500	.82558	20
VAR00003	1.2000	.41039	20
VAR00004	1.3000	.73270	20
VAR00005	1.2000	.41039	20
VAR00006	1.1500	.48936	20
VAR00007	1.9000	1.25237	20
VAR00008	1.7500	1.01955	20
VAR00009	1.3500	.74516	20
VAR00010	1.1000	.30779	20
VAR00011	1.9000	.96791	20
VAR00012	1.2000	.52315	20
VAR00013	1.0500	.22361	20
VAR00014	1.1000	.30779	20
VAR00015	1.0500	.22361	20
VAR00016	1.2000	.69585	20
VAR00017	1.1500	.36635	20
VAR00018	1.1500	.36635	20
VAR00019	1.1500	.36635	20
VAR00020	1.2500	.55012	20
VAR00021	1.4000	.82078	20
VAR00022	1.5500	.99868	20
VAR00023	1.0500	.22361	20
VAR00024	1.1000	.30779	20
VAR00025	1.1000	.30779	20
VAR00026	1.0500	.22361	20
VAR00027	1.1500	.36635	20
VAR00028	1.1500	.36635	20
VAR00029	1.1000	.30779	20

VAR00030	1.4000	.59824	20
VAR00031	1.5500	.99868	20
VAR00032	1.5000	.82717	20
VAR00033	1.6000	1.09545	20
VAR00034	1.4000	.94032	20
VAR00035	1.5500	1.09904	20
VAR00036	1.3000	.73270	20

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
VAR00001	45.6500	91.082	.258	.850
VAR00002	45.4500	91.945	.107	.856
VAR00003	45.8000	90.168	.511	.847
VAR00004	45.7000	89.800	.287	.850
VAR00005	45.8000	89.432	.608	.845
VAR00006	45.8500	87.608	.706	.842
VAR00007	45.1000	87.884	.207	.858
VAR00008	45.2500	92.829	.023	.861
VAR00009	45.6500	90.766	.211	.852
VAR00010	45.9000	89.568	.799	.844
VAR00011	45.1000	97.674	-.224	.869
VAR00012	45.8000	88.589	.554	.845
VAR00013	45.9500	91.629	.616	.848
VAR00014	45.9000	92.621	.270	.851
VAR00015	45.9500	91.629	.616	.848
VAR00016	45.8000	85.747	.627	.841
VAR00017	45.8500	88.345	.848	.842
VAR00018	45.8500	90.239	.566	.846
VAR00019	45.8500	89.818	.628	.845
VAR00020	45.7500	88.092	.573	.844
VAR00021	45.6000	91.200	.156	.854
VAR00022	45.4500	94.892	-.081	.865
VAR00023	45.9500	91.629	.616	.848
VAR00024	45.9000	91.463	.468	.848
VAR00025	45.9000	89.568	.799	.844
VAR00026	45.9500	91.629	.616	.848
VAR00027	45.8500	90.239	.566	.846
VAR00028	45.8500	90.555	.520	.847
VAR00029	45.9000	91.779	.414	.849

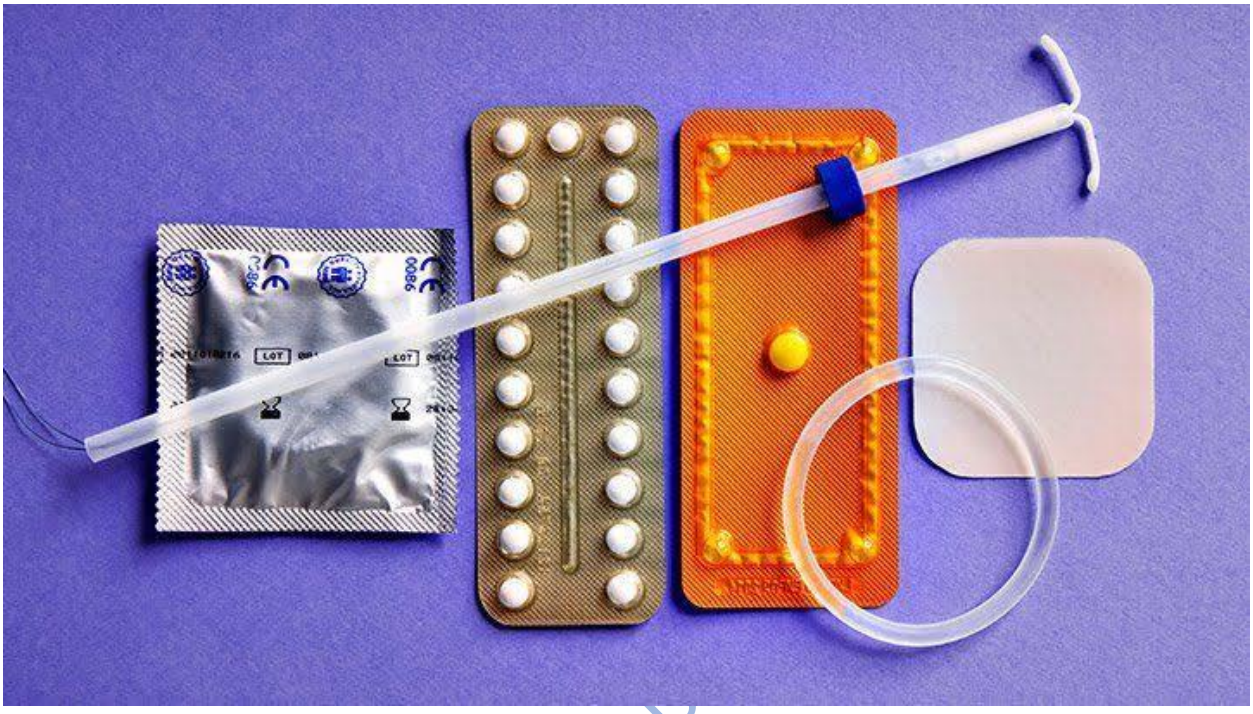
VAR00030	45.6000	90.042	.345	.848
VAR00031	45.4500	83.208	.555	.842
VAR00032	45.5000	84.684	.588	.841
VAR00033	45.4000	83.516	.479	.845
VAR00034	45.6000	83.095	.603	.840
VAR00035	45.4500	84.682	.417	.847
VAR00036	45.7000	85.274	.629	.841

Scale Statistics

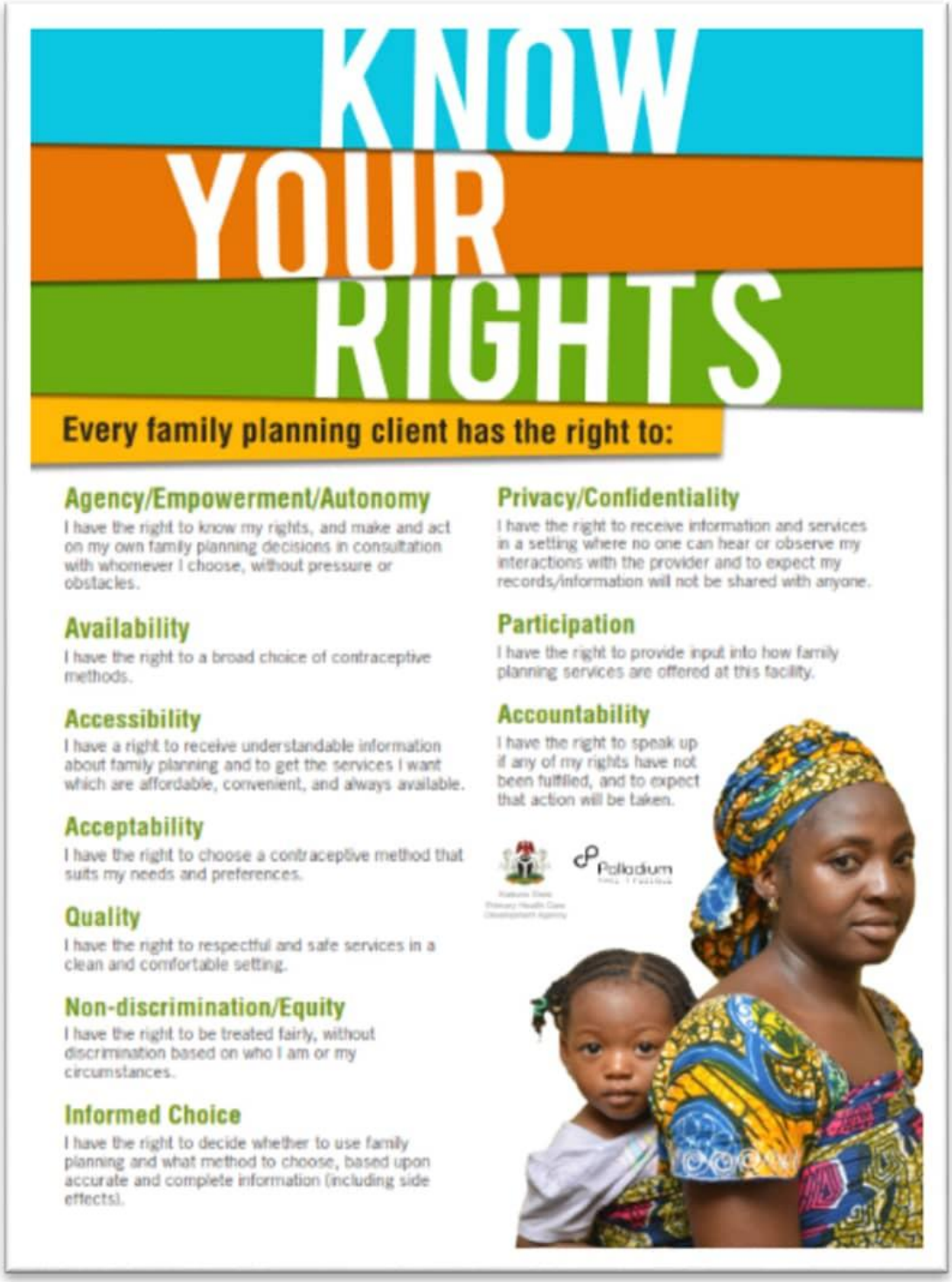
Mean	Variance	Std. Deviation	N of Items
47.0000	94.316	9.71163	36

Appendix v

Appendix vi

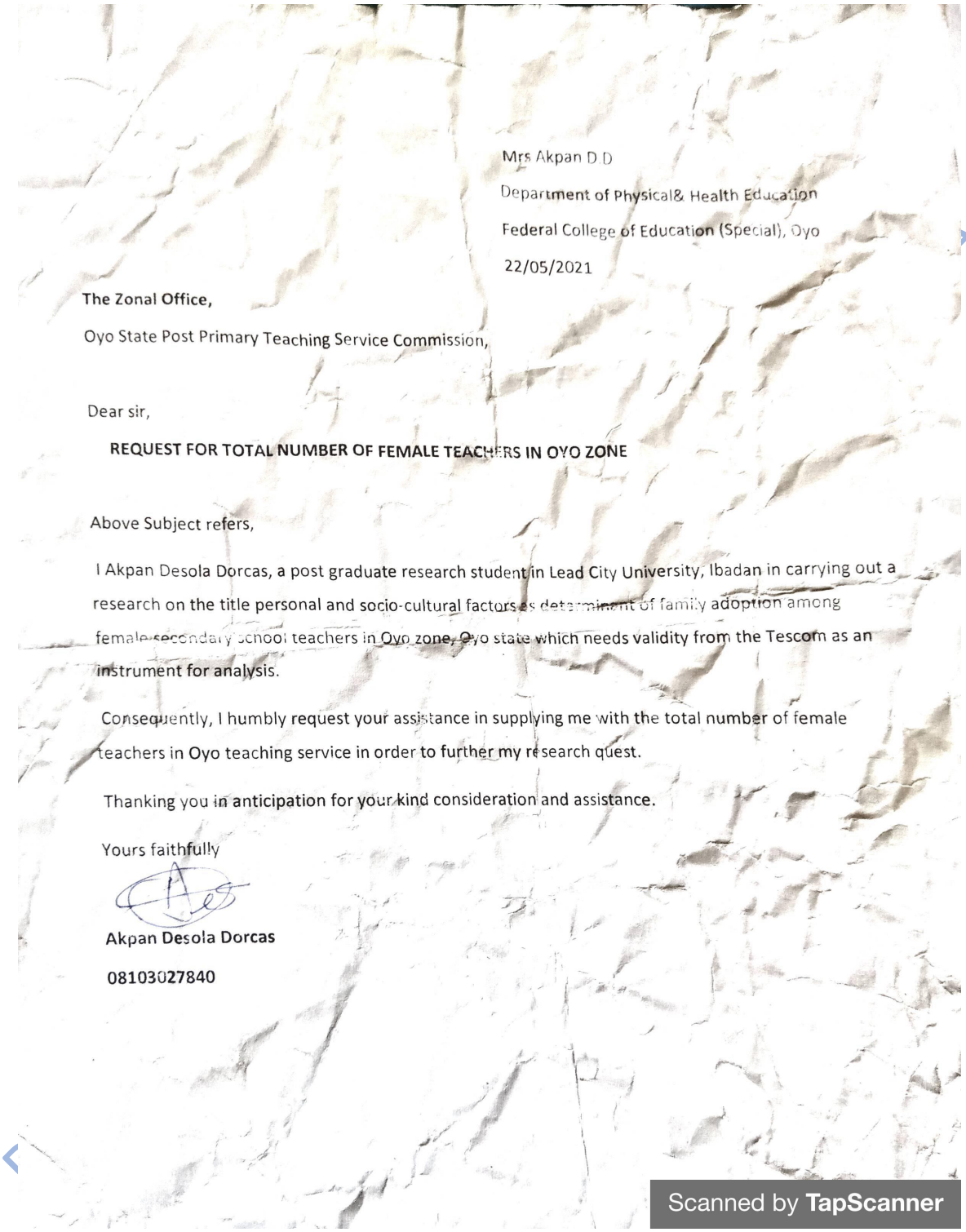


Appendix vii



Appendix viii

Appendix ix



Mrs Akpan D.D

Department of Physical& Health Education

Federal College of Education (Special), Oyo

22/05/2021

The Zonal Office,

Oyo State Post Primary Teaching Service Commission,

Dear sir,

REQUEST FOR TOTAL NUMBER OF FEMALE TEACHERS IN OYO ZONE

Above Subject refers,

I Akpan Desola Dorcas, a post graduate research student in Lead City University, Ibadan in carrying out a research on the title personal and socio-cultural factors es determinant of family adoption among female secondary school teachers in Oyo zone, Oyo state which needs validity from the Tescom as an instrument for analysis.

Consequently, I humbly request your assistance in supplying me with the total number of female teachers in Oyo teaching service in order to further my research quest.

Thanking you in anticipation for your kind consideration and assistance.

Yours faithfully

Akpan Desola Dorcas

08103027840

Appendix x

OYO WEST LOCAL GOVERNMENT AREA

1.	A.D.S GRAMMAR SCHOOL, OPAPA, OYO	- 24
2.	A.D.S HIGH SCHOOL, OPAPA, OYO	- 19
3.	BAPTIST COMMUNITY HIGH SCHOOL, ISOKUN, OYO	- 38
4.	COMMUNITY HIGH SCHOOL, AWUMORO, OYO	- 38
5.	COMMUNITY SECONDARY SCHOOLS, IDI-OPE, OYO	- 29
6.	LADIGBOLU GRAMMAR SCHOOL I, OYO	- 43
7.	LADIGBOLU GRAMMAR SCHOOL II, OYO	- 47
8.	FASOLA GRAMMAR SCHOOL, FASOLA, OYO	- 11
9.	ARMY CHILDREN SECONDARY SCHOOL, OYO	- 43
10.	OBJONGBODU GRAM. SCHOOL, OJONGBODU, OYO	- 25
11.	TAIWO MEM. SEC. SCHOOL, OLUWATEDO, OYO	- 04

TOTAL = 321

OVERALL TOTAL = 1,277

ATIBA LOCAL GOVERNMENT AREA

1.	ALAAFIN HIGH SCHOOL I, OYO	24
2.	ALAAFIN HIGH SCHOOL II, OYO	17
3.	BODE THOMAS MEM. GRAMMAR SCHOOL	13
4.	COMMUNITY JNR. SEC. SCHOOL, OKE-OLOLA, OYO	19
5.	COMMUNITY SNR. SEC. SCHOOL, OKE-OLOLA, OYO	14
6.	COMMUNITY JNR. HIGH. SCHOOL, OKE-OLOLA, OYO	19
7.	COMMUNITY SNR. HIGH. SCHOOL, OKE-OLOLA, OYO	19
8.	COMMUNITY SEC. SCHOOL, IJAWAYA-ASIPA, OYO	03
9.	ISALE-OYO COM. GRAMMAR SCHOOL I, OYO	25
10.	ISALE-OYO COM. GRAMMAR SCHOOL II, OYO	18
11.	ISALE-OYO COM. COMM. SEC. SCHOOL, OYO	19
12.	COMMUNITY SECONDARY SHOOL, LAGUNNA	03
13.	ORANYAN GRAMMAR SCHOOL I, OYO	28
14.	ORANYAN GRAMMAR SCHOOL II, OYO	26
15.	COMMUNITY GRAMMAR SCHOOL, OTEFON	02

TOTAL = 249

OYO EAST LOCAL GOVERNMENT

1.	ABIODUN ATIBA MEMORIAL INST. OYO	49
2.	ANGLICAN METH. SEC. SCHOOL I, AJAGBA, OYO	30
3.	ANGLICAN METH. SEC. SCHOOL II(JNR), AJAGBA, OYO	31
4.	ANGLICAN METH. SEC. SCHOOL II(SNR), AJAGBA, OYO	23
5.	COMMUNITY HIGH SCHOOL, AJAGBA, OYO	32
6.	COMMUNITY HIGH SCHOOL, DURBAR, OYO	34
7.	DURBAR GRAMMAR SCHOOL, DURBAR, OYO	44
8.	OLIVET BAPTIST SNR. HIGH SCHOOL, OYO	31
9.	OLIVET BAPTIST JNR. HIGH SCHOOL, OYO	44
10.	OBA ADEYEMI IGH SCHOOL, OYO	38
11.	ST. BERNARDINE'S GIRLS GRAMMAR SCHOOL, OYO	37

TOTAL = 393

OYO STATE
TEACHING SERVICE

POST PRIMARY SCHOOLS
COMMISSION

OYO ZONAL OFFICE,
Opp. Ajayi Crowther University
Main Gate, Oyo

YourRef. No:.....
All communications on this matter
Should be addressed to the chairman
Teaching Service Commission quoting:
Our Ref. No:

29TH OCTOBER, 2021.

ANALYSIS OF FEMALE TEACHERS ON LOCAL GOVERNMENT BASIS IN PUBLIC SECONDARY SCHOOLS IN OYO ZONE.

AFIJIO LOCAL GOVRNMEMENT AREA

1.	AWE HIGH SCHOOL, AWE	- 24
2.	OLADOKUN GRAMMAR SHOOL, AWE	- 19
3.	AKINMORIN GRAMMAR SCHOOL	- 21
4.	COMMUNITY HIGH SCHOOL, FIDITI	- 14
5.	COMMUNITY HIGH SCHOOL, ILU-AJE	- 03
6.	COMMUNIT HIGH SCHOOL, OKE-APO	- 04
7.	COMMUNITY SECONDARY SCHOOL, JOBELE	- 20
8.	FIDITI GRAMMAR SCHOOL, FIDITI	- 15
9.	ILORA BAPTIST GRAMMAR SCHOOL I, ILORA	- 32
10.	ILORA BAPTIST GRAMMAR SCHOOL II, ILORA	- 40
11.	ILORS COM. COMMERCIAL HIGH SCHOOL, ILORA	- 42
12.	IMINI GRAMMAR SCHOOL, IMINI	- 03
13.	METHODIST SECONDARY SCHOOL, IWARE	- 08
14.	METHODIST SECONDARY SCHOOL, FIDITI	- 20
15.	BAPTIST SECONDARY SCHOOL, OKE-ISANMI, ILORA	- 30
16.	COMMUNITY SECONDARY SCHOOL, ONIFA, ILORA	- 04
17.	ST. JOSEPH'S SECONDARY SCHOOL, AWE	- 15
	TOTAL	= 314

Appendix xi

Bio data

Full Name	Desola Dorcas AKPAN
Sex	Female
Date of Birth	9th January,1992
L.G.A	Ewekoro
State of Origin	Ogun
Nationality	Nigerian
Marital Status	Married
Language Spoken	English and Yoruba
Residential Address	No 27, lane 6 Alawe quarters Awe,Oyo State
Email Phone Number	akpan.desola2342@fces.edu.ng 08103027840

Institution Attended with Dates

Lead city University Ibadan	2019 to Date
Ekiti State University	2015
Posit College of Pure and Applied Science, Ibadan, Oyo State	2010
I.D.C Primary School, Ibadan, Oyo State	2004

Academic and Professional Qualification with Dates

M.Ed. Health Education in view

B.SC(Ed) Health Education	2015
Senior Secondary School (SSCE)	2009

Membership of Professional Bodies

Member Teachers Registration Council of Nigeria (TRCN)

Member, Women of Colleges of Education (WICE)

Member, Science Teacher Association of Nigeria (STAN)

Working Experience

Iso bendege Community Secondary School (NYSC)	2015-2016
Shallom Private Academy School	2017-2017
Fisrt Bank of Nigeria	2017-2017
Federal College of Education (Special), Oyo	2017-date

Publication:

Akpan, D.D (2018). The Inpact of the global financial crisis on the Nigerian economy and its education implications

_____ _____

Signature **Date**

The University Compliances Form

This is to certify that the thesis by Desola Dorcas AKPAN in the Department of Kinesiology, Sport Science and Health Education, Faculty of Arts and Education, Lead City University, Ibadan, Oyo State is in full compliance with the approved University Format and Style

_____ _____

Signature Date