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Original Article

Determinants of Family Planning Utilization Among Women of Reproductive Age in Ilorin East Local Government Area, Nigeria

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ABSTRACT

Introduction: Family planning plays a crucial role in promoting reproductive health and ensuring the well-being of mothers and children. Although various awareness campaigns have been implemented in Nigeria, the uptake and consistent use of family planning services remain inadequate, particularly in rural and peri-urban communities. This study examined the level of knowledge, utilization, and the factors influencing family planning practices among women of reproductive age in selected communities within Ilorin East Local Government Area, Nigeria.

Methodology: The study employed a descriptive cross-sectional survey design, involving 420 women of reproductive age who completed a structured, interviewer-administered questionnaire. The respondents were selected using a multistage sampling technique. Data were collected on participants' socio-demographic characteristics, awareness and sources of information on family planning, usage patterns, and perceptions regarding accessibility, affordability, and cultural influences. Data analysis was conducted using descriptive and inferential statistics, including chi-square tests, to determine associations between key variables.

Results: Findings indicated that 83.3% of respondents were aware of family planning, with health workers and the media serving as the main sources of information. Pills (40.5%) and injectables (24.8%) were the most commonly known methods. Despite high awareness levels, only 64.3% of respondents reported using contraceptives, with pills (25.5%) and condoms (13.3%) being the most utilized. Pharmacies (38.8%) and government health centers were the primary sources of contraceptives. Educational attainment and income significantly influenced both awareness and usage. Other factors affecting family planning decisions included partner support, fear of side effects, and religious beliefs. The p-value was 0.000 (chi-square association). This indicates a statistically significant association at the conventional threshold (i.e.,) between partner support for family planning and religious influence on family planning decisions

Conclusion: The study underscores a persistent gap between family planning awareness and actual utilization. Addressing this requires community-focused education, active male participation, and improved access to culturally sensitive, high-quality family planning services. Health workers should also be equipped to dispel myths and fears surrounding contraceptive use. Efforts to improve family planning uptake should emphasize comprehensive community education, especially for women with low educational backgrounds, and should include information on all available contraceptive methods. Promoting male involvement and fostering open spousal communication are essential for improving acceptance and shared decision-making.

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Introduction

Family planning (FP) remains one of the most significant public health interventions aimed at improving reproductive health outcomes and promoting sustainable development. It enables individuals and couples to make informed decisions about childbearing, including the timing and spacing of pregnancies, thereby reducing the risks associated with unintended pregnancies, unsafe abortions, and maternal deaths (Babatunde et al., 2019). Despite its critical importance, the utilization of family planning services remains remarkably low in many parts of sub-Saharan Africa, including Nigeria, largely due to entrenched socio-cultural, religious, and gender-related barriers (Blackstone & Iwelunmor, 2017).

In many patriarchal societies, men exercise significant control over reproductive decisions, often determining whether their wives can access modern contraceptive methods. This dynamic renders many women powerless in matters of their reproductive health and exposes them to the risks of frequent and unintended pregnancies. Studies have shown that women in such contexts may resort to unsafe abortions when denied access to contraceptives, a situation that contributes significantly to maternal morbidity and mortality (Okigbo et al., 2015; Blackstone & Iwelunmor, 2017). According to the Nigeria Demographic and Health Survey (NDHS, 2018), only 10% of married women of reproductive age in Nigeria use modern contraceptives, a rate substantially lower than the sub-Saharan African average of 17%. This low uptake is further complicated by regional disparities, with contraceptive prevalence ranging from as low as 0.3% in Jigawa State to as high as 41.6% in Lagos State (Fayehun, 2017).

The International Conference on Population and Development (ICPD) and the Fourth World Conference on Women emphasized the need for gender-inclusive reproductive health policies, underscoring the importance of male involvement in family planning (UNFPA, 2019). In developed nations, family planning programs have contributed to significant reductions in maternal mortality. However, in Nigeria, maternal mortality rates remain among the highest globally, with approximately 814 deaths per 100,000 live births (World Bank, 2020). The World Health Organization (WHO, 2015) estimates that about 830 women die daily from preventable pregnancy-related complications, while UNICEF (2016) reports that Nigeria loses approximately 145 women of childbearing age daily, making it one of the world's largest contributors to maternal and child mortality. These figures highlight the urgent need for interventions that enhance family planning access and utilization, especially at the community level.

Methodology

Research Design

This study employed a cross-sectional, observational design to assess the determinants of family planning utilization among women of reproductive age**.**

Target Population

The target population for this study comprised of women of reproductive age (25 - 49 years) residing in Ilorin East LGA.

Study Area

The study will be conducted in Ilorin East Local Government Area (LGA), Kwara State, Nigeria. Ilorin East is a predominantly urban and semi-urban area with diverse socio-economic and cultural characteristics. The LGA has numerous health facilities, including primary health centers and hospitals, which provide family planning services. The choice of this area is based on its high population of women of reproductive age and the varying levels of family planning utilization observed in the region.

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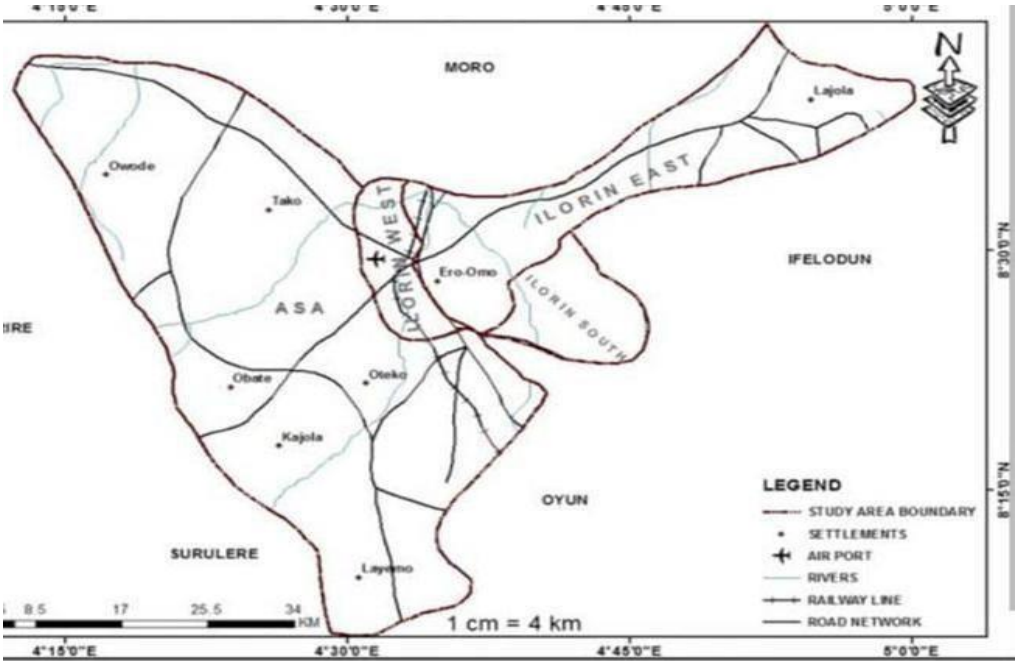

Source: Onah et al., (2020).
Figure 1: A Map of Ilorin East LGA

Sample Size and Participant Recruitment

The sample size was calculated using Fisher's formula which is $n = \frac{Z^2 pq}{d^2}$ n minimum sample size, Z-score corresponding to desired confidence level, i.e, 1.96 for 95% p is estimated prevalence using a previous study of 30 % (Fayehun, 2017) at a 95% confidence level and a 5% margin of error a total of 403 subjects was calculated. To accommodate possible non-response or incomplete data, a 10% allowance was added, 420 questionnaires was distributed to improve the power of the study. A multistage sampling technique was used to select five wards by simple random sampling. From each community, a systematic random sampling technique was used to select respondents for the sample study. Households within the selected communities will be selected using the Dice method, whereby dice is tossed and the head points to the desired direction of the street. Thereafter a systematic approach where households are chosen at regular intervals along the streets until the required sample size is met. This method ensured geographical and socio-economic diversity while maintaining scientific rigor. Advocacy visits were paid to the Baale or Mogaji of Ilorin East LGA, Kwara State intimating them with the research and soliciting for their support.

Method of Data Collection and Data Analysis

Data were collected using a structured, interviewer-administered questionnaire developed from relevant literature and adapted to the local context. It comprised five sections: socio-demographic characteristics, knowledge and awareness of family planning, utilization of family planning services, factors influencing utilization, and strategies for improvement.

The instrument was validated by experts and pretested among women in a non-study area to ensure clarity and reliability. Six trained research assistants administered the questionnaire under close supervision.

Independent variables included socio-demographic factors, knowledge, beliefs, service accessibility, and spousal influence, measured using categorical and Likert-type scales. The dependent variable—family planning utilization—was measured as a binary variable (use: yes/no) and by method type. Questionnaires were checked for completeness, entered into SPSS version 29, and analyzed using descriptive (frequencies, percentages, means) and inferential statistics. Chi-square tests assessed associations, while logistic regression identified predictors of family planning utilization at a 5% significance level.

Ethical Considerations

Ethical considerations in research are critical. Ethics are the norms or standards for conduct that distinguish between right and wrong. They help to determine between acceptable and unacceptable behaviors. Bearing in mind the ethics of a research work like this, this study religiously sticks to the tenets of research. Some of the ethics considered are: the truthfulness in the data presented, no data is falsified; consents of the

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respondents are sought before administering the research tool and they are not forced to respond while treating their confidentiality with utmost priority. The law of copyright is also respected as all sources quoted are duly acknowledged.

A written permission was obtained prior to study from the Department of Public Health, School of Basic Medical Sciences, Kwara State University, Malete. Ethical approval for this study was sought from the Ethical review Committee of the Kwara State Ministry of Health but yet to be granted. Verbal informed consent was obtained from the target population of this study, who agreed to participate in the study, as they were told that participation is voluntary and they would not suffer any consequences if they chose not to participate. Anonymity and confidentiality of all information from respondents was maintained and assured throughout the study process. Information collected was kept confidential and the respondents name were not asked in the questionnaire

Results

Table 1: Socio-demographic characteristics and features of family planning of respondents

N = 420

Variable	Frequency	Percentage
Age		
16-20	47	11.2
21-25	91	21.7
26-30	115	27.4
20-35	73	17.4
36-40	62	14.8
40-45	23	5.5
46-50	9	2.1
Marital Status		
Married	266	63.3
Single	92	21.9
Divorced	43	10.2
Widowed	19	4.5
Religion		
Islam	270	1.8
Christianity	124	98.2
Traditional	26	
Level of education		
No formal education	46	11.0
Primary	64	15.2
Secondary	140	33.3
Tertiary	170	40.5
Occupation		
Unemployed	64	15.2
Trader	239	56.9
Civil servant	60	14.3
Artisans	23	5.5 4.8
Farmers	20	3.3
Others	14	
Place of residence		
Rural	270	64.3
Urban	150	35.7
Tribe		
Yoruba	320	76.2

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Hausa	38	9.0
Igbo	56	13.3
Others	6	1.4
Number of children		
1-5	322	76.7
6-10	33	7.9
No children	65	15.5
Monthly income		
Less than 10,000	78	18.6
10 000 – 30 000	39	33.1
Greater than 30,000	203	48.3

About 21.2% of the respondents were aged 21-25, 27.4% were 26-30, 17.4% were 31-35, 14.8% were 36-40, 5.5% were 41-45, and 2.1% were 46-50. The majority of respondents (63.3%) were married, 21.9% were single, 10.9% were divorced, and 3.9% were widowed. Most respondents (64.3%) practiced Islam, 21.7% practiced Christianity, and 14.0% followed Traditional religion. Regarding education, 11.0% had no formal education, 15.2% had primary education, 33.3% had secondary education, and 40.5% had tertiary education. Occupationally, 15.2% were unemployed, 56.9% were traders, 14.3% were civil servants, 5.5% were artisans, 4.8% were farmers, and 3.3% were others. The majority (64.3%) resided in rural areas, while 35.7% lived in urban areas. Ethnically, 76.2% were Yoruba, 9.0% were Hausa, 1.9% were Igbo, and 12.9% were others. Regarding the number of children, 76.7% had 1-5 children, 7.9% had 6-10, and 15.5% had no children. Monthly income was reported as 18.6% less than 10,000, 33.1% between 10,000-30,000, and 48.3% greater than 30,000.

Table 2: Knowledge and Awareness of Family Planning

Question	Response Option	Frequency	Percentage (%)
Have you heard of family planning?	Yes	350	83.3
	No	70	16.67
If yes, where did you hear about it?*	Health workers	205	48.8
	Media	124	29.5
	Friends/Relatives	69	16.4
	Religious institutions	13	3.1
	Others	9	2.1
Which methods are you aware of?*	Pills	170	40.5
	Injectables	104	24.8
	Implants	84	20.0
	IUD	43	10.2
	Condoms	12	2.9
	Natural methods	7	1.7

About 83.3% of the respondents reported that they had heard of family planning, while 16.7% had not. Among those who had heard of it, the most common source of information was health workers (48.8%), followed by media (29.5%). Friends or relatives accounted for 16.4% of the awareness, while 3.1% mentioned religious institutions and 2.1% cited other sources.

In terms of knowledge of specific family planning methods, 40.5% of respondents were aware of pills, 24.8% were aware of injectables, and 20.0% recognized implants. Awareness of IUDs stood at 10.2%, while only 2.9% and 1.7% were familiar with condoms and natural methods, respectively. These findings suggest that while general awareness of family planning is high, knowledge of a broader range of contraceptive methods remains limited, especially concerning barrier and natural options.

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Table 4: Utilization of Family Planning Services

Question	Response Option	Frequency	Percentage (%)
Are you currently using any method?	Yes	270	64.3
	No	150	35.7
Which method are you currently using?	Not applicable	150	35.7
	Pills	107	25.5
	Injectables	19	4.5
	Implants	51	12.1
	IUD	32	7.6
	Condoms	56	13.3
	Natural methods	5	1.2
Where did you obtain family planning?	Not applicable	150	35.7
	Government hospital	42	10.0
	Private clinic	13	3.1
	Pharmacy	163	38.8
	Health center	52	12.4
How long have you been using it?	Not applicable	150	35.7
	5–8 months	61	14.5
	1–5 years	134	31.9
	6–10 years	75	17.9

About 64.3% of the respondents reported that they were currently using a method of family planning, while 35.7% were not. Among those currently using any method, pills were the most commonly used (25.5%), followed by condoms (13.3%), implants (12.1%), IUDs (7.6%), injectables (4.5%), and natural methods (1.2%). This distribution indicates a higher preference for oral contraceptives and short-term methods among users.

Regarding the sources of family planning services, 38.8% obtained their method from pharmacies, making it the most common source. Government hospitals accounted for 10.0%, private clinics 3.1%, and health centers 12.4%. Notably, 35.7% of respondents were not using any method, and thus did not indicate a source.

In terms of duration of use, 31.9% of respondents had been using family planning for between 1– 5 years, 14.5% for 5–8 months, and 17.9% for 6–10 years. This suggests that a significant proportion of users had sustained engagement with family planning services over time

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Table 5: Perceptions and Influences on Family Planning Decisions

Response	Strongly (%) Agree	Agree (%)	Disagree (%)
My partner supports the use of family planning	157 (37.4)	188 (44.8)	75 (17.9)
Religion influences my decision	156 (37.1)	105 (25.0)	159 (37.9)
Fear of side effects affects my decision	104 (24.8)	178 (42.4)	138 (32.9)
I can access family planning service	153 (36.4)	254 (60.5)	13 (3.1)
I can afford family planning	152 (36.2)	249 (59.3)	19 (4.5)
I believe family planning is beneficial to my health	179 (42.6)	194 (46.2)	47 (11.2)

A majority support the use of family planning (37.4% strongly agree, 44.8% agree) and believe it is beneficial to their health (42.6% strongly agree, 46.2% agree). Access to family planning services is widely acknowledged (36.4% strongly agree, 60.5% agree), as is affordability (36.2% strongly agree, 59.3% agree). However, decision-making is influenced by religion (37.1% strongly agree, 25.0% agree) and fear of side effects (24.8% strongly agree, 42.4% agree). Relationship between partner support for family planning and the influence of religion on family planning decisions was statistically significant, with the levels of agreement on partner support and religion influence among the respondents.

Predictor	AOR	95% CI	p-value
Partner support (1 vs 0)	2.10	1.45–3.04	0.000
Religion influence (1 vs 0)	0.68	0.49–0.95	0.025
Fear of side effects (1 vs 0)	0.62	0.45–0.85	0.003
Awareness (yes vs no)	1.95	1.10–3.45	0.022

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Knowledge count (per method)	1.12	1.05–1.20	0.001
Education: Secondary (vs ≤Primary)	1.34	0.93–1.93	0.114
Education: Tertiary (vs ≤Primary)	1.72	1.19–2.49	0.004
Income: 10–30k (vs <10k)	1.21	0.81–1.81	0.347
Income: >30k (vs <10k)	1.57	1.08–2.27	0.018
Urban (vs rural)	1.28	0.92–1.78	0.142
Access (1 vs 0)	1.39	0.83–2.32	0.203
Affordability (1 vs 0)	1.31	0.78–2.19	0.303

Research objectives on family planning in Ilorin east

Discussion

The analysis of socio-demographic data reinforced the representativeness of the study population, with 27.4% aged 26–30 and 21.7% aged 21–25 mirroring national trends where reproductive-aged women form the demographic majority (NPC & ICF, 2019). The predominance of married respondents (63.3%) aligns with Adelekan *et al.* (2019), who observed that marital unions facilitate greater engagement in family planning decisions due to spousal dialogue and reproductive planning within households.

A majority (83.3%) had heard of family planning, which is consistent with Nkwoka and Mubarak (2024), who reported 93.6% awareness among urban women in Sokoto. The principal source of information for health workers (48.8%) reflects findings by Oje-Adeniran *et al.* (2019), highlighting the trusted role of healthcare providers in reproductive health education. Media follow-up as the second most common source is supported by Ajaero *et al.* (2016), who found mass media significantly increased contraceptive uptake (OR=1.94, p<0.0001).

Despite high awareness, specific knowledge was narrower: 40.5% recognized pills, while only 10.2% were aware of IUDs. This mirrors Egbe *et al.* (2020), who reported limited method knowledge in Cameroon, indicating an information gap regarding long-term contraceptive options. Such discrepancies underscore the need for enhanced counselling and education to broaden method awareness, as advised by the Family Health research network (Ankomah *et al.,* 2015).

Current method utilization was 64.3%, far exceeding Nigeria's average modern contraceptive prevalence rate (~17%) from NDHS 2018 (NPC & ICF, 2019). The dominance of pills (25.5%) and condoms (13.3%) mirrors Aliyu *et al.* (2019), who noted short-acting method preference due to ease and fewer side effect concerns. However, continued reliance on pharmacies (38.8%), consistent with Schwandt *et al.* (2017), suggests potential gaps in counseling and quality assurance outside formal clinical settings.

Duration of use data showed that 31.9% had used family planning for 1–5 years, indicating sustained engagement comparable to Feleke *et al.* (2021), who found long-term use linked with improved maternal–child health outcomes when consistent access was available.

Perceptual factors revealed that partner support was strong, with 82.2% signaling approval— aligning with Ijadunola *et al.* (2021), who documented that spousal backing significantly enhances method uptake. Access and affordability were rarely barriers (<5%), in line with improvements in service delivery documented in Lagos (PMC turn0search6). Yet, religious influence remained a barrier for 62.1% of respondents, consistent with Nkwoka & Mubarak (2024), who observed that ~50% of respondents believed their religion discouraged family planning. Fear of side effects (67.2%) also aligns with Sedgh & Hussain (2016), who identified health concerns as primary reasons for contraceptive discontinuation globally.

The chi-square test confirmed a statistically significant association (p<0.001) between perceived partner support and religious influence, a finding that reinforces Ankomah *et al.* (2015) and Dudgeon & Inhorn (2018), who demonstrated that male approval often mitigates religious or cultural resistance. In summary, high awareness of family planning coexists with selective method knowledge, strong partner support, and improved utilization, yet is underpinned by cultural/religious reservations and concerns over side effects. Addressing these gaps requires targeted education— including partner and community engagement, dispelling misconceptions, and broadening knowledge of long-term options—to support informed contraceptive choices in Ilorin East.

Conclusion

Awareness of family planning among women in Ilorin East LGA is high, yet actual utilization remains limited and concentrated on short-term methods. Socio-demographic factors such as education, income, and marital status strongly influence uptake, while partner support helps overcome cultural and religious

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barriers. Persistent fears of side effects and reliance on informal outlets highlight gaps in counseling and service quality. Strengthening community education, promoting male involvement, and ensuring access to diverse, reliable contraceptive options are essential to improve utilization and advance maternal and child health outcomes. Here's a set of recommendations based on your study findings on Determinants of Family Planning Utilization among Women of Reproductive Age in Ilorin East LGA, Kwara State, Nigeria:

Recommendations

1. Strengthen Community-Based Education

Intensify awareness campaigns led by health workers and peer educators.

Expand knowledge beyond pills and condoms to include long-acting reversible contraceptives (LARCs) such as implants and IUDs.

Use culturally appropriate messaging to dispel myths and misconceptions about infertility and side effects.

2. Promote Male Involvement

Encourage spousal communication and shared decision-making in reproductive health.

Develop programs that specifically target men to foster support for family planning.

Engage community and religious leaders to normalize male participation.

3. Address Fear of Side Effects

Provide personalized counseling to women and couples on contraceptive safety.

Establish follow-up systems to monitor and manage side effects effectively.

Share success stories and testimonials to build trust in modern methods.

4. Improve Access and Service Quality

Strengthen collaboration between government health facilities and private outlets (pharmacies, clinics) to ensure quality assurance.

Train pharmacists and community health workers to provide accurate information and counseling.

Expand mobile outreach services to rural areas where access is limited.

5. Enhance Affordability and Equity

Subsidize contraceptive costs for low-income women.

Integrate family planning services into primary health care to reduce financial and logistical barriers.

Provide free or low-cost contraceptives through government programs and NGOs.

6. Empower Women Socio-Economically

Promote female education as a long-term strategy to increase contraceptive uptake.

Support income-generating activities for women to enhance autonomy in health decisions.

Link family planning programs with women's empowerment initiatives.

7. Policy and Monitoring

Align local interventions with national strategies and Sustainable Development Goals (SDGs 3 & 5).

Establish monitoring systems to track utilization trends and evaluate program effectiveness.

Encourage evidence-based policymaking using localized data from studies.

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