



Original Article

Unmet Needs for Family Planning Among Women of Reproductive Age in Ogbomosho Metropolis of Oyo State, Nigeria

Oluwatosin Ruth Ilori¹, Bode Oluyinka Kayode^{2*}, Akeem Olayinka Busari³

¹Department of Epidemiology & Community Health, Ladoke Akintola University of Technology, Ogbomosho, 210214, Nigeria.

²Department of Public Health, Faculty of Health Sciences, Al-Hikmah University Ilorin, 240212, Nigeria.

³Department of Medical Laboratory Science, Ladoke Akintola University of Technology, Ogbomosho, 210214, Nigeria.

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Corresponding Author

Professor Bode Oluyinka Kayode

Department of Pulic Health,

Faculty of Health Sciences,

Al-Hikmah University Ilorin, Kwara State, Nigeria.

Phone Number: +2347034238965

Email: bodekayode49@gmail.com

Zip code: 240212

ABSTRACT

Background: An estimated 17% of married women in the developing world have an unmet need for contraception. Understanding the magnitude of unmet contraceptive need and the underlying reasons of this phenomenon will help to reduce the number of unwanted pregnancies as well as reducing the menace of increase maternal mortality rate worldwide, most especially in the developing world,

Objective: To assess the extent of unmet need for family planning among women in the reproductive age group (i.e., 15-49 years) within Ogbomosho Metropolis and to explore the common reasons for unmet need for family planning.

Materials and Methods: A community-based cross-sectional study was conducted in Ogbomosho Metropolis. The study subjects consisted of all married women in the age group of 15-49 years. Women who were divorced, widows, those who refused to participate were excluded from the study.

Result: It was observed that out of 400 respondents, 373(93.2%) had knowledge of contraceptive method and it was obtained mainly from health workers (93.8%). Less than half 169 (42.2%) were currently using contraceptives out of which most of them are using injectables (41.5%) followed by IUCD (28.0%). Unmet need for family planning was present in 41.7% among all women under study; 25.7% women revealed unmet need for spacing and 16.0% women unmet need for limiting. A statistically significant association was found between religion, literacy and discussion with spouse about contraception ($P < 0.05$). Husband's approval of contraception had a statistically significant protective association with unmet need ($p = 0.003$), and discussion about family planning within the couple had a highly statistically significant protective association with unmet need ($p = 0.001$). The major reason for non-use of contraception among women with unmet need was the fear of side effects.

Conclusion: The prevalence of unmet need of family planning among women in Ogbomosho is high. Husband's approval of contraception and couples' discussion about family planning are two major factors to be considered when planning interventions to reduce unmet need for family planning.

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Introduction

Family Planning is a principal strategy in controlling population growth and promoting maternal and child health through an adequate spacing of births and avoiding unwanted pregnancy (Gebre, 2016). One of the major targets of the Millennium Development Goals (MDGs) is to improve maternal health. Family planning (FP) has been described as a means to achieving all the MDGs. Family planning programmes are now widely considered a key part of any comprehensive development strategy. Family planning not only gives couples the freedom to space and plan the number of children they wish, but also contributes to the health and overall quality of life of the population. The two main indicators in use to measure FP success are contraceptive prevalence and unmet need (Alaba, 2015). The current prevalence rate for contraceptive use in Nigeria is approximately 11%-13% (Monjok *et al.*, 2010).

FP enables couples or family/women to plan when to have children and use birth control to delay (spacing) or number of children FP prevents unwanted pregnancies and reduce the course to abortion (Amosun *et al.*, 2006). Both short and long inter pregnancy interval is associated with adverse pregnancy outcomes such as preterm birth, low birth weight, small for gestational age and perinatal death (Paulo, 2015). To prevent these adverse pregnancy outcomes, birth spacing has been considered as an effective intervention. In the 1960s, the data obtained on conducting surveys of contraceptive knowledge, attitude and practice (KAP) revealed that a major section of women avoided the use of contraceptives, in spite of their will to have a gap and prevent pregnancy, which led to the evolution of the concept of unmet need. Later on, this disparity, the "KAP-gap" was termed as the unmet need for contraception (Fikrewood and Assefa, 2011). Unmet need for family planning is defined as percentage of all fecund reproductive age women who are married and in consensual union and presumed to be sexually active but are not using any method of contraception, either do not want to have more children. "Limiter" want to postpone their next birth for at least two years, "Spacer" therefore, all reproductive women either married or co-habiting and are so alleged to have regular sex, who avoid the use of contraceptive, and who either desire to stop having children (unmet need for limiting births) or delay the subsequent childbirth by some years (unmet need for spacing births belong to the category of women with unmet need. (Khasakala and Omwago, 2006)

In sub-Saharan Africa, 25 % of women of reproductive age who are married or in union have an unmet need for family planning (UN, 2012). Unintended pregnancy related to unmet need is a worldwide problem that

affects women and their families and societies at large. About 40% of all births that occurred globally in 2012 were unwanted posing hardships for families and jeopardizing the health of millions of women and children (Singh and Sedgh, 2010). In addition to these health benefits, the resulting reduction in fertility and population growth would bring substantial socioeconomic and environmental benefits" (Ezeh *et al.*, 2012).

The leading contributory factor to unwanted pregnancy in Nigeria is low contraceptive usage (Oye-Adeniran *et al.*, 2005; MPC 2011; Lamina, 2015). Many women wished they delay or stop bearing child but are not using any form of contraceptives. These are said to have an unmet need for family planning (Fikrewood and Assefa, 2011). Unmet need for family planning in Africa is still very high (Atem *et al.*, 2016). According to literature, diverse factors including age, marital status, level of education, religion, occupation, and household wealth have been found to be significantly associated to unmet need for family planning. (Atem *et al.*, 2016).

Materials and Methods

Study Area

The area selected for this study was Ogbomosho in Oyo State, located in the south-western part of Nigeria. It is -95 km north-west of the Oyo State capital (Ibadan). Ogbomosho is made up of five local government areas (LGAs) and each of the local government contain ten wards. The LGAs include Ogbomosho North, Oriire, Ogbomosho South, Ogo-Oluwa and Surulere. The population of Ogbomosho is approximately 654,183 and the women in the reproductive age group are estimated to be 163,546 (Adeyemi *et al.*, 2008). The state lies within the tropical rain forest belt with thick, deciduous vegetation in the southern part which becomes grassland towards the North and it has numerous natural resources, a vast growing ecosystem, a growing economy and diverse culture. The inhabitants are predominantly Yorubas, though the state has a few other Nigeria ethnic groups and foreigners. The religions generally practiced in the state include Christianity, Islam and Traditional religion. More than half (about 60%) of the residents in the state reside in the rural areas while the remaining 40% live in the urban areas. Majority of the people in the rural areas are farmers while in the urban areas, they are mostly traders, artisans, cloth dyers and civil servants. There are two main local Governments within Ogbomosho Metropolis namely Ogbomosho North and Ogbomosho South.

Study Design

A descriptive cross-sectional study

Study Population

This involved married women within the reproductive age group in Ogbomoso Metropolis, Nigeria.

Inclusion Criteria

Currently married women of childbearing age (15-49 years)

Exclusion Criteria

Women within the reproductive age group but not willing to participate. Critically ill patients too were excluded.

Sample Size Determination

To determine the sample size for the study, the fisher formula modified by Bolarinwa (2020) was used for population greater than 10,000 was used:

$$n = \frac{Z^2 pq}{d^2}$$

$$n = \frac{(1.96)^2 0.317 \times 0.683}{0.05^2}$$

$$n = 333$$

Where

n= the minimum sample size when the population is more than 10,000.

z= the standard normal deviate was set at 1.96, which corresponds to 95% confidence level

p= contraceptive prevalence rate (CPR) in South-West Nigeria which was 0.31720 (Adeyemi *et al.*, 2016).

q=1- p

d=degree of accuracy desired, which was set at 0.05

After adding the anticipated non- response rate of 10%, the sample size became 367. However, 410 questionnaires were administered in which only 400 were correctly and completely filled giving a response rate of 97.6%.

Sampling Technique

A multi-stage sampling technique will be adopted as follows:

First stage: Two wards each were selected from the two Local Government Areas in Ogbomoso. The two wards selected in Ogbomoso North were Sabo Tarea and Masifa while the two selected wards in Ogbomoso South were Ijeru and Osupa making a total of four wards.

Second stage: From the four selected wards, two settlements were selected by balloting making a total of eight settlements in all.

Third stage: Using the grid method, a pen was spanned at the imaginary center of the settlements. Sampling started in the direction of the tip of the pen.

Two houses were left in between the houses. Eligible respondents in the selected households were interviewed. In households where there were more than one eligible respondent, one person will be chosen by balloting.

Study Instrument

Quantitative method was used with the aid of semi-structured, interviewer-administered questionnaire which was divided into five sections to collect relevant information.

Section A - Socio-Demographic Characteristics of respondents

Section B-Reproductive History

Section C-Knowledge of respondents about Contraception

Section D-Attitude of Women within reproductive age group about contraception.

Section E-Practices of contraceptives by Women in reproductive age group.

Statistical Analysis

Copies of questionnaires were checked for errors and omissions at the end of each day. Data were entered and analyzed using Statistical Package for Social Sciences (SPSS) version 22. Data errors were checked for and corrected. Summary statistics were presented using frequency tables, charts, means and rates. Inferential statistics to test for associations between categorical variables was done using Chi-squared test for qualitative variables. Logistic regression analysis was done to identify independent factors for unmet need for contraception. Level of statistical significance was set at 5% i.e. $p \leq 0.05$ at confidence interval of 95% for all inferential analysis.

Ethical Approval

The approval to conduct this research was obtained from Ethical Review Committee of Uniilorin Teaching Hospital for ethical clearance. Written/ Verbal informed consent was obtained from each participant after explaining the purpose of the study to them. Respondents were given the right to decline or withdraw from the study at any time. They were assured that refusal to participate or withdraw will not attract any penalty.

Limitations of the Study

The issue of family planning could be very sensitive and confidential, and due to socio-cultural factors some of the respondents were initially inappropriately predisposed to participate in the study. Participants were however assured of confidentiality and thus encouraged to answer questions truthfully.

Results

Table 1: Socio-demographic Characteristics of Respondents

Variables n=400	Frequency n=400	Percentages (%)
<i>Age</i>		
15-19	8	2.0
20-24	40	10.0
25-29	87	21.8
30-34	94	23.5
35-39	77	19.2
40-44	62	15.5
45-49	32	8.0
<i>Mean age</i>	400	32±7.5
<i>Religion</i>		
Protestant	227	56.8
Islam	104	26.0
Catholics	61	15.2
Traditionalist	8	2.0
<i>Marital Setting</i>		
Monogamous	328	82.0
Polygamous	72	18.0
<i>Order n=2</i>		
First	23	31.5
Second	39	53.4
Third	9	12.3
Forth	1	1.4
Others	1	1.4
<i>Education Status</i>		
Illiterate	21	5.2
Primary	57	14.2
Secondary	244	61.0
Tertiary	78	19.5
<i>Occupation</i>		
Housewife	22	5.5
Unemployed	20	5.0
Unskilled	74	18.5
Semiskilled	256	64.0
Skilled	28	7.0

Twenty-three point five of respondents were within the ages of 30 and 34 years of age while the mean age was 32±7.5. Majority of them were in monogamous relationships of which 39 (9.8%) were second wife of their husbands. Most of the respondents had secondary

school level of education (244, 61.0%) and semi-skilled 256 (64.0%). Two hundred and twenty-seven respondents (56.8%) were protestants, 104(26.0%) were practising Islam, 61(15.3%) were Catholics and only (2.0) were traditionalists.

Table 2: Practise of Contraceptives by ever used respondent

Variables	Frequency (n=82)	Percentage (%)
<i>Age at first use</i>		
15-19	1	1.2
20-24	21	25.6
25-29	34	41.5
30-34	17	20.7
35-39	5	6.1
40-44	4	4.9
<i>Number of children at first use</i>		
0-2	59	26.7
3-5	22	0.02
6 and above	1	
<i>Contraceptives used before</i>		
Pill	13	15.9
IUCD	23	28.0
Injectables	34	41.5
Implant	6	7.3
Condom	4	4.9
Natural Methods	2	2.4
<i>Reason for discontinuing contraceptives</i>		
Fear of side effect	46	56.1
Fear of infertility	12	14.6
Medical problem	6	7.3
Preferred method not available	5	6.1
Desire to have more children	13	15.9
Little perceived risk of pregnancy	13	1.2
Unacceptable to my culture	1	1.2
Religion prohibition	1	4.9
Financial reasons	4	
<i>Possibility of using contraceptives later in the future</i>		
Yes		59.8
No	49	32.9
Undecided	27	7.3
	6	

Out of those who had contraceptives at one point in time before but are not currently on any method, 34 (41.5%) used injectables, 23 (28.0) IUCD, 13 (15.9%) used pills, 6 (7.3%) used implants, 4 (4.9%) used condom and 2 (2.4%) natural methods. Fear of side effect, 46 (56.1%) took the highest proportion of the reason why ever used respondents discontinued the use of contraceptives, followed by the desire to have more children and little perceived risk of getting

pregnant 13, (15.9%) each. Other were fear of infertility (14.6%), medical problems 6 (7.3%), preferred method not available 5, (6.1%), financial reason 4 (4.9%), cultural and religious prohibition 1 (1.2%) each. Out of the 82 who had ever used contraceptives before, 49 (59.8%) felt they will still use contraceptives later in the future, 27 (32.9%) wouldn't use, 5 (6.1%) were undecided and 1 (1.2%) don't know if she would use any form at latter times.

Table 3: Contraceptive Practise for Non-users

Variables	Frequency (n=149)	Percentage
<i>Intention of delaying pregnancy</i>		
Yes	75	50.3
No	68	45.6
Undecided	6	5.0
<i>Why are you not on contraceptives?</i>		
Partner refusal	1	0.7
Relative opposed	9	6.0
Know no method	7	4.7
Know no source	5	3.4
Health concern	60	40.3
Fear of side effect	3	2.0
Lack of access/too far	9	6.0
Little perceived risk	4	2.7
Too much cost	2	1.3
Inconvenient to use	24	16.1
To have more children		

For respondents who had never used any form of contraceptives, fear of side effect, 60 (40.3%) was the main reasons why they had never used any method, followed by the desire to have more children,

24(16.1%), partner's refusal 20 (13.4%). Others were little perceived risk of pregnancy, 9 (6.0%), know no method, 9 (6.0%), Health concern 5(3.4%) and opposition from relative 1, (0.7%).

Table 4: Level of Unmet Need for Family Planning among respondents

Unmet Need	Frequency (N=400)	Percentage (%)
Yes	190	41.7
No	210	58.3
Total	400	100.0

Out of the 400 respondents, 210 (41.7%) had unmet need for family planning while 190 (58.3%) do not have.

Table 5: Bivariate analysis between unmet need and Socio-demographic Characteristics of Respondents

Socio Demographic Characteristics	Yes (n=210)	Unmet (N=400) No(n=190)	needs Total	Statistics
<i>Religion</i>				
Catholics	19 (31.1)	42 (68.9)	61 (100.0)	X ² =13.996 Df=3 *p-value=0.003
Protestants	124 (54.6)	103 (45.4)	227 (100.0)	
Islam	62 (59.6)	42 (40.4)	104 (100.0)	
Traditionalists	5 (62.5)	3 (37.5)	8 (100.0)	
<i>Ethnicity</i>				
Yoruba	203 (52.2)	186 (47.8)	389 (100)	X ² =4.086 Df=3 p-value=0.252
Igbo	2 (50.0)	2 (50.0)	4 (100.0)	
Hausa/Fulani	1 (33.3)	2 (66.7)	3 (100.0)	
Others	4 (100.0)	0 (0.0)	4 (100.0)	
<i>Educational Status</i>				
No education		8 (38.1)	21 (100.0)	X ² =1.324 Df=3 p-value=0.723
Primary	13 (61.9)	25 (43.9)	57 (100.0)	
Secondary	32 (56.1)	120 (49.2)	244 (100.0)	
Tertiary	124 (50.8)	37 (47.4)	78 (100.0)	
	41 (52.6)			
<i>Educational Husband's Status</i>				
No education		7 (38.9)	18 (100.0)	X ² =1.900 Df=3 p-value=0.593
Primary	11 (61.1)	21 (56.8)	37 (100.0)	
TSecondary	16 (43.2)	107 (46.5)	230 (100.0)	
Tertiary	123 (53.5)	55 (47.8)	115 (100.0)	
	60 (52.2)			
<i>Respondents' Occupation</i>				
House wife		7 (31.8)	22 (100.0)	*X ² =23.468 Df=4 Pvalue=0.000
Unemployed	15 (68.2)	11 (55.0)	20 (100.0)	
Unskilled	9 (45.0)	53 (71.6)	74 (100.0)	
Semi-skilled	21 (28.4)	107 (41.8)	256 (100.0)	
Skilled	149 (58.2)	12 (42.9)	28 (100.0)	
	16 (57.1)			
<i>Husbands' Occupation</i>				
Unemployed	18 (46.2)	21 (53.8)	39 (100.0)	X ² =1.280 Df=3 Pvalue=0.723
Unskilled	105 (51.7)	98 (48.3)	203 (100.0)	
Semi-skilled	29 (52.7)	26 (47.3)	55 (100.0)	
Skilled	58 (56.3)	45 (43.7)	103 (100.0)	

*Statistically significant at p<0.05

The above table shows the relationship between unmet needs and respondents' socio demographic characteristics. There was statistically significant difference between religion (p=0.03) and occupation

of respondents (p>0.001). Protestants tend to have more unmet needs compared to other occupations. Also, a greater proportion of unskilled worker (53, 71.6%) do not have unmet need.

Table 6: Factors associated with unmet need for FP among women in reproductive age group in Ogbomosho Metropolis

Variables	Unmet need		COR (95% Overall p value C1)	
	Yes	No		
<i>Religion</i>				
Catholic	19 (31.1)	42 (68.9)	0.420, 11.799	0.616
Protestant	124 (54.6)	103 (45.4)	0.258, 5.894	0.660
Islam	62 (59.9)	42 (40.4)	0.223, 5.348	0.908
Traditionalist	5 (62.5)	3 (37.5)	3.456, 8.987	0.988
<i>Level of Education</i>				
No school				
Primary	13 (61.9)	8 (38.1)	0.087, 1.788	0.228
Secondary	32 (56.1)	25 (43.9)	0.165, 1.497	0.214
Tertiary	124 (50.8)	120 (49.2)	0.297, 1.854	0.524
	41 (52.6)	37 (47.4)	1.003, 5.456	0.944
<i>Respondents' occupation</i>				
Unemployed	15 (68.2)	7 (31.8)	0.260, 5.385	*0.039
Housewife	9 (45.0)	11 (55.0)	0.820, 14.556	
Unskilled	21 (28.4)	53 (71.6)	1.890, 23.695	
Semi-skilled	149 (58.2)	107 (41.8)	0.602, 5.264	
Skilled	16 (57.1)	12 (42.9)		
<i>Husbands' attitude towards contraceptives</i>				
Approve	102 (39.7)	155 (60.3)	0.034, 10.567	*<0.001
Disapprove	55 (73.3)	20 (26.7)	5.698, 12.679	*<0.001
Indifferent	54 (79.4)	14 (20.6)	0.054, 12.897	

After descriptive analysis was done, bivariate and multivariate logistic regression analysis were carried out. In the analysis of bivariate logistic regression, variables with p-value of <0.5 or associated with outcome variable were, religion, respondent's occupation, ever discussed proposed number of

children with husband, discussion with spouse about contraception and husbands' attitude towards contraception. In the multivariate analysis, only respondents' occupation and husbands' attitude towards contraception were statistically significant.

Discussion

Findings show that the awareness about family planning methods is very high among the respondents as 93.2% of the total respondents agreed to have heard about family planning. and majority of them claimed to know where to obtain. This finding is similar to other study relating to the reproductive health issues in Pakistan. (Hashim and Mustafa, 2008). The highest source of information about family planning as found in this study was through the health workers, followed by radio, television and friends. This shows the ability to pass across vital health information during antenatal or immunization services. If enhanced, attitudinal change could be affected. This is in congruent with similar other studies (Sherpa, 2013; Pegu *et al.*, 2014; Rahila and Bahaa, 2015) where health personnel

happened to be the greatest source of information. However, this is slightly different from that gotten from South-Eastern Nigeria where mass media happened to be the commonest source of information (Obiajulu *et al.*, 2005). Majority of the respondents knew Government hospitals as a place where contraceptives could be obtained, followed by health centers, then the private clinics. This could be due to vast number of government hospitals as well as health centers present in the study area. This finding is in consistence with another study done in Uganda where government hospitals are the widely known place to obtain family planning (Henry *et al.*, 2016). Most of the respondents had a good understanding that family planning could help prevent an unwanted pregnancy. Similar finding was also obtained in a study done in

India (Pegu *et al.*, 2014) where a sizeable number of respondents have adequate knowledge about what the advantages of contraceptives were. Most of the participants had knowledge of at least one modern contraceptive method of contraceptives among married women similarly found in some other studies (Jabeen *et al.*, 2011; Faturoti *et al.*, 2009; Jimmy *et al.*, 2014). Surprisingly, in this study, most of the respondents (45.8%) do not know how pills are used. This is similar to the finding in a similar study in Saudi Arabia where the understanding of how to use oral contraceptive pills was very low. This could be a pointer to the fact that people no longer get interested in the services provided them howbeit the increase failure rate of OCPs.

In this study, there was a difference in the knowledge of contraceptives among the respondents as regards this religion. This is similar to another study done in where Catholics had the poorest knowledge of contraceptives (Fikrewood and Assefa, 2011). However, this is different from a study carried out among married women in Ethiopia, where religion was not associated with the use of contraceptives. This may not be surprising as the Catholics do not support the use of modern contraceptives by her members. Only natural method is advocated and permitted. Therefore, all avenue to educate women in this particular age group will be almost impossible. If a reorientation of this particular religious' caste is not done, contraceptives use by them will perpetually be null. This will invariably lead to increase birth rate and mortality rates will still be high. It was observed that the educational status of respondents also significantly determines their knowledge about contraceptives. This is similar to various other studies where education if respondents is significantly associated with their level of knowledge about contraceptives (Matthew and Pascal, 2015; Hadiza and Chikaike, 2013). A plausible reason for this is that illiterates or those with low educational status may not have the avenue to be educated about the availability not have avenue where they could be educated about the availability and use of contraceptives compared with the more educated ones. Even if they have the avenue to be taught, they may not be able to comprehend what they are being taught as a result of their level of Intelligence. In this study, majority of respondents wanted to know more about family planning and more than two third approved of its use by the couples. This is similar to another study done in Jinma where almost all the participants wish they had the opportunity to be more enlightened about contraceptives. It is however different from another study done in Malawi (Effie *et al.*, 2010) where participants were not willing to hear about contraceptives at all. This might be due to the unpalatable experiences they or someone close to them

have witnessed with contraceptives. Spouse (husband) involvement is seen to play a pivotal role in deciding whether to use a birth control method and it is also equally vital with regards to the number of children a couple desire to have. In this study, more than half of the respondents have never discussed contraceptive use with their husbands. This is in consonance with another study where very minute number of participants have ever discussed family planning or its use with their husbands. This could be that they actually see no reason why they should discuss it with them or they are afraid their husbands might not support its use. When asked about the stand of their husbands, about two third of the respondents claimed that their husbands approve of its use. This finding is also comparable with another study done in Nigeria (Peter *et al.*, 2009; Ademola *et al.*, 2014) where most of the husbands support the use of contraceptives. In this study in which just about half of the participants' spouses knew whether their wives were using or not using any form of contraceptive. This is also similar to a study done in Kenya (Laili *et al.*, 2015). This actually revealed the poor communication between couples with regard to contraceptive use. In this study, about four in ten women were presently on a form of contraceptives. This is relatively lower than that in Kenya where more than two third of respondents were on contraceptives as at the time the study was been carried out. For the current users, the main purpose for the use of contraceptive was to space in between pregnancies. Injectables happened to be the most used contraceptives among respondents currently on contraceptives which different from that gotten in Asia where female sterilization is the widely used form of contraception (Anil *et al.*, 2015) and Osogbo where IUD was the widely used form of contraceptives (Adeyemi, 2009) The difference gotten from the Asia could actually be because of the socio-cultural and political view towards fertility. Asian countries are known for low fertility which is presently legalised and so the permanent form of contraceptives will be more advocated. Unmet need prevalence for family planning in this study stands at 41.7% which is lower than the result gotten in Ghana where total unmet need stood at 50 in line with another study done in Ethiopia which had an unmet need of 21.4% for spacing 14.5% for and for limiting 6.9% (Gebre, 2015), Cameroon 20.4% (Atem, 2016). However, this is different from another study done in another state in Nigeria where the prevalence of total unmet need for family planning is 9.1% and 11.4% (Bamboye, 2016). Among the multiple factors evaluated in a study done in Cameroon, only partner's approval of contraception and discussion of family planning within the couple were found to be significantly associated with unmet need for family planning (Atem *et al.*, 2016).

However, in this study, it was discovered that a woman whose husband approved of family planning was unlikely to have an unmet need than a woman whose husband disapproves of it ($p=0.001$). Also, a woman who is semi-skilled e.g. trader is more likely to have an unmet need for family planning. Spousal discussion about contraception cannot be over emphasized. We live in a society where the decision and authority of the husband is as biding as ever thought. A woman who carries her husband along about the need for family planning is definitely likely to be compliant with the method.

Conclusion

This study showed that the level of awareness about family planning was high among women in reproductive age group in a sexual union. However, the in-dept understanding of the mode of action of modern contraceptives was lacking. Majority of respondents have favourable attitude towards couple using it but less than half of them are currently on a form of contraceptives or the other. The most widely known contraceptives in this study was IUCD while for those currently on a method of contraception, injectable was the commonest used contraceptive method. Fear of side effect stood out to be the major

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reason why ever used stopped contraception and non-user wouldn't use contraception. The level of unmet need among the respondents was high. Discussion with spouses about the use of contraception as well as the occupation of respondents were statistically significant with logistic regression.

Experts in family planning should work vehemently to reduce the side effect of family planning methods in order to increase its use, consequently reducing the unmet need for family planning worldwide.

Recommendations

Based on the findings of this study, areas of further investigations should include the following:

1. Family planning experts should prioritize further research and development into minimizing the side effects of contraception.
2. All health care providers should ensure appropriate information, to all eligible couples and should clear all doubts regarding use of contraceptives and reinforce the advantages of various methods
3. Interventions involving information education and communication (IEC) campaigns geared to men and promoting male involvement in family planning could contribute to increased contraceptive prevalence.

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