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Perceptions and factors influencing the acceptance of family planning among women of reproductive age in Sokoto metropolis, Nigeria

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ABSTRACT

Background: Family planning is essential for reproductive health, helping to reduce maternal and child mortality and improve family well-being. Understanding perceptions and factors influencing its acceptance among women of reproductive age is crucial, particularly in northern Nigeria, where cultural and religious beliefs strongly shape health behaviors. **Aim:** This study aimed to assess the perceptions and factors influencing the acceptance of family planning among women of reproductive age in Sokoto metropolis, Nigeria. **Materials and Methods:** A cross-sectional survey was conducted among 265 women aged 15-49 years, selected using a multi-stage sampling technique. Data were collected through structured questionnaires focusing on socio-demographic characteristics, perceptions of family planning, and its acceptance. Descriptive statistics and chi-square tests were used for data analysis. **Results:** The majority (93.6%) of respondents were aware of family planning, with 83.1% perceiving it as safe. However, about half (50.4%) believed their religion was against it, and 17.4% considered it difficult to use. A third of respondents (35.5%) currently use a modern family planning method, with a significantly ($p < 0.001$) higher acceptance among older women (30-49 years), married women, and employed respondents. Implanon (41.5%) and condoms (22.3%) were the most commonly used methods. **Conclusion:** This study reveals a promising acceptance of family planning among women of reproductive age in Sokoto metropolis, Nigeria. Acceptance is significantly higher among older, married, and employed women, while some expressed some misconceptions. Public health interventions are required to address misconceptions and empower women to make informed reproductive choices, enhancing overall community health and economic resilience.

Keywords: Family planning, perceptions, acceptance, influencing factors, women of reproductive age

INTRODUCTION

Family planning is a vital public health intervention that contributes significantly to improving maternal and child health outcomes globally. In Nigeria, family planning is particularly crucial due to the country's high fertility rate and associated maternal and child morbidity and mortality.[1] The World Health Organization (WHO) and other health institutions advocate for increased access to family planning services to reduce unintended pregnancies, delay childbirth, and provide women with the autonomy to space their children effectively.[2] Despite these advantages, family planning uptake remains low in Nigeria, especially in Northern regions like Sokoto State, where cultural, religious, and socioeconomic factors interplay to shape perceptions and acceptance.[3] The demographic structure of Nigeria highlights a predominantly young population, with approximately 43% under the age of 15, leading to a high dependency ratio.[4] With the current total fertility rate at 5.3 children per woman, Nigeria faces substantial challenges in meeting the needs of its growing population, including healthcare, education, and employment opportunities.[4] Family planning, therefore, becomes a strategic intervention to address population growth by empowering women to decide on the timing and number of children, contributing to both personal and national development.[5]

The prevalence of family planning utilization among women of reproductive age in Nigeria remains relatively low, particularly compared to global averages. According to the NDHS 2018, the overall contraceptive prevalence rate (CPR) for women aged 15-49 in Nigeria was 17%.

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This percentage includes both modern and traditional contraceptive methods, with the modern contraceptive prevalence rate (mCPR) standing at around 12%.[4] The NDHS 2018 data revealed notable disparities across Nigeria's geopolitical zones, with the North East and North West zones (where Sokoto is located) having the lowest modern contraceptive usage rates, with mCPRs around 3% and 4%, respectively, reflecting cultural, religious, and socio-economic factors that discourage family planning. In contrast, the South West and South East zones show higher mCPRs, at around 25% and 17%, respectively, which may be attributed to better healthcare access, education, and supportive community attitudes toward contraception.[4]

Cultural and religious beliefs are significant factors influencing the perception of family planning in Northern Nigeria, including Sokoto State. In predominantly Muslim communities, interpretations of religious doctrine often emphasize procreation, with some religious leaders and adherents viewing family planning as contradictory to divine will.[6,7] It has also been observed that in northern Nigeria, religious leaders' support or opposition strongly influences community members' views on family planning.[6,7] This belief can lead to misconceptions about family planning, associating it with Western ideologies that conflict with local values.[8] Consequently, these cultural and religious perspectives contribute to low acceptance and utilization of family planning services, especially among women who may prioritize adherence to cultural norms over personal health preferences.[9]

In addition to cultural and religious factors, socioeconomic determinants, such as education level, income, and employment status, significantly affect family planning acceptance among women of reproductive age. Studies indicate that women with higher educational attainment are more likely to have a favorable view of family planning and utilize modern contraceptive methods than their less-educated counterparts.[10] Education not only enhances awareness of family planning benefits but also empowers women to negotiate contraceptive use within marriage.[11] Conversely, economic constraints can hinder access to family planning services, especially for low-income women who may prioritize other financial needs over healthcare.[10,11]

Health system-related factors also play a critical role in the acceptance of family planning services. Access to quality healthcare facilities, availability of contraceptive options, and the attitude of healthcare providers can either promote or hinder family planning adoption.[12] In rural and urban areas alike, inadequate supply chains and stock-outs of contraceptives limit women's consistent access to family planning, while a lack of skilled health personnel may discourage potential users due to concerns about side effects and improper administration.[13] Furthermore, healthcare workers' attitudes can influence a woman's decision, especially in contexts where providers hold personal biases against contraceptive use.[14]

Additionally, the role of marital status, spousal approval, and peer influence cannot be overlooked when examining factors influencing family planning acceptance. For many married women in Northern Nigeria, the decision to use contraceptives often depends on the husband's consent, as male partners are typically seen as primary decision-makers in household matters.[15] Studies suggest that a supportive partner significantly increases the likelihood of family planning use, while women without spousal support may experience fear of discord or rejection, leading to low uptake.[10,16] Peer influence is another strong determinant, as women in communities with high family planning acceptance are more likely to adopt contraceptive practices themselves.[17]

The prevalence of myths and misconceptions regarding family planning is also notable, as these can strongly deter acceptance and utilization. Common misconceptions include beliefs that contraceptives cause infertility, are only meant for promiscuous individuals, or have severe health risks.[18] Such myths persist due to inadequate awareness programs and the influence of individuals who discourage contraceptive use without providing evidence-based information.[19] Misinformation can be further exacerbated by poorly trained healthcare providers who may lack the skills to dispel these misconceptions.[20]

The findings from this study aim to contribute to the growing body of knowledge regarding family planning in Northern Nigeria by focusing specifically on Sokoto metropolis, Nigeria. It will explore how perceptions and various sociocultural and economic factors influence family planning acceptance among women of reproductive age. The study's insights could inform policymakers and healthcare providers on effective strategies for promoting family planning in culturally sensitive ways, thus potentially increasing contraceptive

uptake and improving maternal health outcomes in Sokoto, Nigeria.

MATERIALS AND METHODS

Study Design, Population and Area

This was a community-based cross-sectional survey among women of reproductive age (15 to 49 years) in Sokoto metropolis, Nigeria. All those who gave consent to participate in the study were considered eligible and enrolled.

Sample Size Estimation and Sampling Technique

The sample size was estimated at 255 using the Cochrane formula for estimating sample size in cross-sectional studies[21] based on the 17% contraceptive prevalence rate obtained in the Nigerian Demographic and Health Survey 2018,[4] a 5% margin of error, and an anticipated 85% response rate. A multi-stage sampling technique was used to select the eligible participants. In stage 1, one of the four Local Government Areas in Sokoto metropolis (i.e., Wamakko LGA) was selected by simple random sampling using the balloting option. In stage 2, the list of the enumeration areas (EAs) in the selected LGA was obtained from the National Population Commission (NPC) and used to constitute the sampling. The LGA was stratified into 3 clusters using the serial numbers of the EAs on the sampling frame. A cluster of contiguous enumeration areas (with an average of three EAs per cluster) was selected from each section by simple random sampling using a computer-generated random number. In stage 3, in each of the selected EAs, line listing was done to determine the number of households, the proportionate allocation was used to determine the number of households to be selected in each EA, and the households were selected by systematic sampling technique. A woman of reproductive age who met the eligibility criteria was enrolled in the study in each selected household.

Data Collection

A structured interviewer-administered questionnaire containing three sections was used to obtain information on the respondents' sociodemographic characteristics and perceptions and their acceptance of family planning. The questionnaire was reviewed by senior researchers in the Department of Community Health, Usmanu Danfodiyo University, Sokoto, Nigeria, to ascertain content validity. Five research assistants were recruited to assist in data collection. They were trained on the objectives of the study, selection of study participants and administration of the survey instrument. The instrument was pretested on 20 women of reproductive age in one of the enumeration areas that were not selected for the study. This was done to familiarize the research assistants with the survey tools and to detect any ambiguity that requires modifications. The necessary modifications were made to the instrument after the pretesting.

Data Analysis

The returned questionnaires were cross-checked for completeness of responses. Data were analyzed using IBM SPSS version 25 computer statistical software package. Quantitative variables were summarized using mean and standard deviation, while categorical variables were summarized using frequencies and percentages. The chi-square test was used to establish associations between the sociodemographic variables and acceptance of family planning. All levels of significance were set at $p < 0.5$.

Ethical Consideration

Institutional ethical approval was obtained from the Sokoto State Research and Ethics Committee. Advocacy visits were paid to the Local Government Chairman and the traditional heads of the communities concerned for permission to conduct the study. The purpose of the study was explained to the participants, and they were assured of the confidentiality of the information they gave. Informed written consent was also obtained from them before commencing data collection.

RESULTS

Sociodemographic characteristics of respondents

Two hundred sixty-five respondents completed the questionnaire. A larger proportion of respondents, 128 (48.3%), were in the 20-29 age group, followed by those in the 30-39 age group (33.6%). The majority of respondents were Moslems (84.9%), belonged to Hausa ethnic group (56.6%), and were married (83.0%). The majority of respondents had secondary and tertiary education (77.8%), and about half of them (49.9%) were either petty traders or civil servants. The majority of respondents (78.9%) reside in urban communities [Table 1].

Perceptions of family planning by respondents

Most, 248 (93.6%) of the 265 respondents were aware of family planning. Of these, the most common source of information about family planning was the hospital (69.0%). The majority of respondents (83.1%) believed that family planning is safe, while about a third of respondents (35.1%) believed that some methods of family planning can prevent sexually transmitted diseases.

Table 1: Sociodemographic characteristics of respondents

Variables	Frequency (%) n = 265
Age group (years)	
15-19	20 (7.5)
20-29	128 (48.3)
30-39	89 (33.6)
40-49	28 (10.6)
Religion	
Islam	225 (84.9)
Christianity	40 (15.1)
Ethnicity	
Hausa	150 (56.6)
Fulani	25 (20.8)
Yoruba	30 (11.3)
Igbo	19 (7.2)
Others*	11 (4.2)
Marital status	
Single	21 (7.9)
Married	228 (86.0)
Divorced	11 (4.2)
Widowed	5 (1.9)
Level of education	
No formal education	37 (14.0)
Primary	22 (8.3)
Secondary	89 (33.6)
Tertiary	117 (44.2)
Occupation	
Artisan	6 (2.3)
Petty trader	64 (24.2)
Civil servant	68 (25.7)
Housewife	89 (33.6)
Student	38 (14.3)
Residence	
Urban	209 (78.9)
Rural	49 (18.5)

*Others: Ibira, Nupe, etc.

Although only a few respondents (17.4%) believed that family planning is difficult to use, about half of the respondents (50.4%) believed that their religion was against it (Table 2).

Acceptance of family planning by respondents

Whereas the majority, 143 (54.0%) of the 265 respondents, had used a family planning method in the past, only 94 (35.5%) currently do. Among those who currently use a family planning method, the most commonly used methods were Implanon (41.5%) and condoms (22.3%) [Table 3].

Factors influencing the acceptance of family planning by respondents

The sociodemographic factors that influenced the respondents' acceptance of family planning were age, marital status, and employment status. Acceptance of family planning was significantly higher among those aged 30-49 (65.8%) than those aged 15-29 (44.6%), $\chi^2 = 11.841$, $p < 0.001$. It was significantly higher among those who were married (57.9%) than those who were single, divorced or widowed (29.7%), $\chi^2 = 10.020$, $p < 0.001$. Acceptance of family planning was also significantly higher among those who were employed (65.9%) than those who were unemployed (40.9%), $\chi^2 = 16.635$, $p < 0.001$ (Table 4).

Table 2: Awareness and perception of family planning by respondents

Variables	Frequency (%)
Aware of family planning (n = 265)	
Yes	248 (93.6)
No	17 (6.4)
Source of information (n = 248)	
Hospital	171 (69.0)
Mass media	36 (14.5)
Friends and family	41 (16.5)
Perception of family planning (n = 248)	
Believed that family planning decreases sexual urge	18 (7.3)
Believed that some methods of family planning can prevent sexually transmitted diseases	87 (35.1)
Believed that family planning is safe	206 (83.1)
Believed that family planning is difficult to use	43 (17.4)
Believed that their culture is against family planning	38 (15.2)
Believed that their religion is against family planning	125 (50.4)

DISCUSSION

This study assessed the perceptions and factors influencing the acceptance of family planning among women of reproductive age in the Sokoto metropolis, Nigeria. The preponderance of young women aged 20-29 years among the respondents (48.3%) underscores the early marriage practice common in Northern Nigeria. This trend reflects a cultural norm where girls marry young, often before they are physically or emotionally prepared for pregnancy and childbirth. Early marriage is prevalent in many northern Nigerian communities, where over half of the girls are married by the age of 18.[22,23] This practice can have adverse health implications, as young women are more susceptible to pregnancy-related

complications, including obstructed labor and obstetric fistula, due to underdeveloped pelvic structures.[24]

Despite cultural acceptance, early marriage and the consequent early onset of childbearing present challenges for women's health and limit educational and economic opportunities.[23] Addressing early marriage could thus serve as a foundation for improving maternal health and increasing the acceptance of family planning. Community-based interventions targeting early marriage could help shift perceptions toward delayed marriage potentially leading to higher acceptance of family planning among younger women.[25]

Table 3: Acceptance of family planning by respondents

Variables	Frequency (%)
Had used a family planning method in the past (n = 265)	
Yes	143 (54.0)
No	122 (46.0)
Currently using a family planning method (n = 265)	
Yes	94 (35.5)
No	171 (64.5)
Family planning method currently being used (n = 94)*	
IUCD	15 (16.0)
Noristerat	7 (7.4)
Depo Provera	3 (3.2)
COCPs	4 (4.3)
Withdrawal	7 (7.4)
Calendar method	6 (6.4)
Condoms	21 (22.3)
Jadelle	9 (9.6)
Implanon	39 (41.5)

*Multiple responses allowed

A noteworthy finding of this study is the misperception that family planning methods are difficult to use, a sentiment expressed by 17.4% of respondents. Such misconceptions, though not predominant, highlight a barrier to family planning acceptance that has been observed in other Nigerian contexts.[18,26]
Misunderstandings about family planning may arise from insufficient or unclear information provided by healthcare professionals, as well as cultural myths surrounding its use. In many settings, particularly those with conservative cultural or religious norms, misinformation about side effects or complications associated with family planning methods can discourage utilization.[26]

Given that half of the respondents perceived religious opposition to family planning (50.4%), religious beliefs and cultural norms may exacerbate these misconceptions. Studies suggest that targeted educational interventions that involve religious leaders can play a pivotal role in reducing these barriers by dispelling myths and promoting an understanding of the health benefits of family planning.[6,27] Thus, enhancing education about family planning's safety and efficacy could be an effective strategy to address both misperceptions and cultural resistance

The 35.5% modern contraceptive prevalence rate obtained in this study suggests an exponential rise in the acceptance of family planning in Sokoto, Nigeria, within a few years, considering the fact that the region used to have the lowest contraceptive prevalence rate in Nigeria. According to the 2018 Nigeria Demographic and Health Survey (NDHS), the modern contraceptive prevalence rate (mCPR) in Sokoto state was 2%, which was much lower than the 12% national prevalence rate.[4] This study also found a significantly higher acceptance of family planning among women aged 30-49 years and those who are currently married. The acceptance rate for women aged 30-49 years was 65.8%, in contrast to 44.6% among younger respondents ($p < 0.001$). Older and married women may be more inclined toward family planning because they have likely reached or are close to reaching their desired family size and are more aware of the economic implications of additional children.[28,29] Economic hardships in Nigeria, including rising food costs, may further drive these women to control family size as a practical means of reducing household expenses.[29]

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Table 4: Factors influencing acceptance of family planning by respondents

Variables	Currently use a family planning method		Test of significance
	Yes Frequency (%)	No Frequency (%)	
Age group (years)			
15-29	66 (44.6)	82 (55.4)	χ^2= 11.841, p < 0.001*
30-49	77 (65.8)	40 (34.2)	
Religion			
Islam	123 (54.7)	102 (45.3)	χ^2= 0.298, p = 0.585
Christianity	20 (50.0)	20 (50.0)	
Ethnicity			
Hausa / Fulani	110 (53.7)	95 (46.3)	χ^2= 0.034, p = 0.855
Others (Yoruba, Igbo, Ibira, etc.)	33 (55.0)	27 (45.0)	
Marital status			
Married	131 (57.9)	96 (42.1)	χ^2= 10.020, p < 0.001*
Others (single, divorced, widowed)	11 (29.7)	26 (70.3)	
Level of education			
Primary and below	26 (44.1)	33 (55.9)	χ^2= 2.991, p = 0.084
Secondary and tertiary	117 (56.8)	89 (43.2)	
Occupation			
Employed (artisan, petty trader, civil servant)	91 (65.9)	47 (34.1)	χ^2= 16.635, p < 0.001*
Unemployed (housewife, student)	52 (40.9)	75 (59.1)	
Place of residence			
Urban	113 (58.8)	101 (41.2)	χ^2= 0.601, p = 0.438
Rural	30 (52.8)	21 (47.2)	

*Statistically significant (p < 0.05); χ^2= Pearson's Chi square test

Moreover, marital status is a critical factor, as married women were significantly more likely to accept family planning than their single, divorced, or widowed counterparts. This finding may be due to the greater pressure on married women to space or limit births for economic or health reasons, as well as their exposure to family planning counselling through maternal and child health services, which are more accessible to married women.[28,30] Thus, strengthening family planning education and access among married women could help sustain high acceptance rates in this demographic.

Another important factor influencing family planning acceptance in this study is employment status, with significantly higher acceptance among employed respondents (65.9%) compared to unemployed ones (40.9%). Employment and the financial security it provides may empower women to make reproductive choices that are beneficial to their well-being and economic circumstances.[31] Financial independence also allows employed women better access to healthcare services, including family planning, a trend observed in other parts of Nigeria.[31,32] In contrast, unemployed women may lack both the financial means and autonomy to access family planning services, making them more reliant on their partners' preferences or cultural norms that may oppose family planning.[29] Addressing this disparity requires policies that ensure family planning is affordable and accessible to all women, regardless of employment status. Strategies such as subsidized family planning services and community-based health insurance could mitigate financial barriers and promote equitable access.[33]

The findings from this study are consistent with prior research conducted in various regions of Nigeria, where similar sociodemographic factors have been observed to influence family planning acceptance.[1,12,31,32] Similar to the findings in this study, age, marital status, and employment status significantly impact family planning acceptance, with older and employed women generally showing higher rates of acceptance, with some variations in the studies cited. These studies also highlight that misconceptions and cultural beliefs can deter family planning acceptance, a challenge mirrored in the present study's findings.

However, this study adds subtlety to previous findings by highlighting the role of economic hardships as a recent factor influencing family planning decisions, especially among married and older women. Economic pressures have intensified in recent years, suggesting that financial concerns may increasingly drive reproductive choices. This shift implies that family planning programs should address both informational and economic barriers to maximize acceptance.[28]

STUDY LIMITATIONS

The limitations of this study include its reliance on self-reported data, which may be subject to social desirability and recall biases. Participants may have underreported or overreported their attitudes and practices regarding family planning due to cultural and religious sensitivities in the region. Additionally, the cross-sectional design limits the ability to establish causality between socio-demographic factors and family planning acceptance, as it only captures a single point in time without examining changes over time. Another limitation of the study is the fact that it was conducted in urban areas of Sokoto metropolis, Nigeria, which may limit the generalizability of the findings to women in rural areas who may have different attitudes, access to information, and socio-economic constraints impacting family planning acceptance.

CONCLUSION

The findings of this study underscore the substantial improvement in the acceptance of family planning among women of reproductive age in Sokoto metropolis, Nigeria, in recent years, with significant associations between family planning acceptance and factors such as age, marital status, and employment status. The higher acceptance rates among older, married, and employed women align with studies from other regions in Nigeria and sub-Saharan Africa, suggesting that socio-demographic factors, economic conditions, and cultural beliefs shape attitudes toward family planning in these populations. Addressing these factors effectively will require targeted public health interventions, improved family planning education, and economic support initiatives to enhance access to family planning services and promote informed reproductive health choices among Nigerian women.

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Conflict of interest

None declared.

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