PERCEIVE BARRIERS TOWARDS THE UTILIZATION OF FAMILY PLANNING PRACTICES AMONG REPRODUCTIVE AGE WOMEN IN UGHELLI NORTH LGA

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A RESEARCH PROJECT SUBMITTED TO THE DEPARTMENT OF HEALTH, SAFETY AND ENVIRONMENTAL EDUCATION,FACULTY OF EDUCATION, UNIVERSITY OF BENIN,BENIN CITY, EDO STATE, IN PARTIAL FUFILMENT OF THE REQUIREMENTS FOR THE AWARD OF BACHELOR DEGREE B.Sc.(ED.) IN HEALTH EDUCATION, UNIVERSITY OF BENIN,BENIN CITY

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CERTIFICATION

This is to certify that this project research work was carried out by **OLOTU STELLA ,** with matriculation number **EDU1612401** and that the research work is adequate in scope and quality in the Department of Health, Safety and Environmental Education, University of, Benin city, Edo state, in partial fulfillment of the award of Bachelor of Education (B.Ed.) degree in Health Education.

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DEDICATION

This project work is dedicated to God Almighty and my lovely caring husband who contributed to my achievements thus far.

ACKNOWLEDGEMENTS

My special appreciation goes to the Almighty God for just everything that happened throughout my study period and during the course of this project work.

I wish to acknowledge my family (OLOTU's) and my mum for their immense love and support. My appreciation also goes to my project supervisor, Dr.E.O.Igudia who supervised the work to its completion. God bless you sir. I wish to appreciate all the lecturers in the Department of Health, Safety and Environmental Education and my HOD Dr.S.O. Olikabor, for the knowledge gotten from you so far, God bless you.

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ABSTRACT

This study explores the attitudes of Oregbeni Market women towards immunization and the factors that influence their immunization decisions. A survey research design was employed, with data collected from 140 market women in Oregbeni Market, Edo State. The findings reveal that while there is a high level of awareness about the importance of immunization, knowledge about specific vaccines and the concept of immunization is limited. Negative attitudes, including fears of deformities and distrust in vaccine safety, are prevalent. Religion and culture significantly influence immunization attitudes, with some aligning their beliefs with medical consensus. Recommendations include tailored public health education campaigns, community engagement with local leaders, and further research to understand cultural nuances. Keywords: immunization, attitudes, Oregbeni Market, women, Nigeria, public health education

CHAPTER ONE

INTRODUCTION

Background of Study

Family planning is a process that allows individuals and couples to attain their desired number of children. Family planning involves birth control, contraception, fertility reduction and population control. An unmet need for family planning results in unintended pregnancies and illegal abortions. This has major health and social implications and is often the leading cause of maternal and child mortality in low-income countries. According to Asut et al (2018) global data show that only 32% of married women from low-income countries currently use modern contraceptives. An estimated 214 million women of reproductive age lack access to contraception resulting in an estimated 67 million unintended pregnancies, 36 million induced abortions, and 76,000 maternal deaths each year, World Health Organization (2017). Family planning (FP) is a key intervention to limit these adverse health outcomes. Such interventions can prevent 90% of abortions, 32% of maternal deaths, 20% of pregnancy-related morbidity globally, and reduce 44% of maternal mortality in low-income countries World Health Organization (2017).FP reduces adolescent pregnancies, prevents pregnancy-related health risks, and helps to prevent

HIV/AIDS. Access to contraception promotes education, raises the economic status of women, and gradually empowers them resulting in improved health outcomes and better.

Family planning remains a pivotal component in achieving sustainable development and improving global health outcomes. Teachers, as educators and influential figures in society, play a crucial role in disseminating information and shaping societal norms. However, despite widespread advocacy and awareness campaigns about the benefits of family planning, there exists a disparity in the adoption and utilization of these practices among teachers. Many factors have been found to influence current practice of family planning around the world. These factors have both positive and negative impact on current practice of family planning, which include: socio demographic characteristics (age, gender, ethnicity, religion, level of education, partner's level of education, occupation, monthly income, marital status, marriage type, marriage duration, parity and place of residence), sources of information (television, radio, social media, newspaper, friends and relatives), partner involvement (partner discussion, partner encouragement, partner support, partner approval and partner decision).

Statement of the Problem

The discrepancy between the importance of family planning and the actual utilization of these practices among reproductive age women raises concerns. Despite the global acknowledgment of the benefits associated with family planning, there remains a gap in understanding the specific barriers that hinder reproductive age women from actively adopting these practices.

The researcher believes that identifying and comprehensively analyzing the perceived barriers to family planning practices among reproductive age women are essential steps toward addressing this issue and implementing targeted interventions.

Significance of the Study

The significance of this study lies in its potential to shed light on the intricate barriers that impede reproductive age women utilization of family planning practices. By understanding these barriers, policymakers, educational institutions, and health practitioners can develop tailored interventions to address the specific needs and concerns of teachers.

Also finding from the study will help in mitigating these barriers thereby leading to improved health outcomes, reduced absenteeism, and enhanced overall well-being among teachers. Moreover, it contributes to the broader

societal goal of promoting healthier communities and achieving sustainable development.

Purpose of The Study

The purpose of this research is to comprehensively investigate and analyze the perceived barriers that hinder reproductive age women utilization of family planning practices. The specific objectives are :

1. identify and understand the various barriers that hinder reproductive age women from utilizing family planning practices.

2. to examine the influence of personal beliefs, as well as religious and cultural factors, on the attitudes of reproductive age women towards family planning.

3. to assess the level of knowledge among reproductive age women regarding family planning practices.

4. to investigate the challenges faced by reproductive age women in accessing and obtaining family planning resources.

Research Questions

1. What are the barrier to the utilization of family planning practice among reproductive age women
2. What role do personal beliefs and religious/cultural factors play in shaping reproductive age women ' attitudes towards family planning?

3. What is the level of knowledge among reproductive age women regarding family planning practices
4. What are the challenges associated with the accessibility and availability of family planning resources for reproductive age women?

Scope of the Study

This study focuses specifically on reproductive age women attending central hospital, Ugheli. This research will be conducted within a specific geographic area, and participants will be selected based on predetermined criteria.

Definition of Terms

Family Planning: Family planning refers to the process by which individuals and couples can control their fertility and achieve their desired number of children through various methods such as birth control, contraception, fertility reduction, and population control.

Unmet Need for Family Planning: The unmet need for family planning refers to the gap between women's reproductive intentions and their contraceptive behavior. It occurs when women who wish to avoid or postpone pregnancy do not use any method of contraception.

Modern Contraceptives: Modern contraceptives refer to effective and medically approved methods of birth control, such as condoms, oral contraceptives (birth control pills), intrauterine devices (IUDs), injectable contraceptives, implants, and sterilization procedures.

Induced Abortions: Induced abortions are deliberate terminations of pregnancy performed by medical or surgical means. They are usually carried out when a woman does not wish to continue with the pregnancy.

Maternal Mortality: Maternal mortality refers to the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management.

Adolescent Pregnancies: Adolescent pregnancies refer to pregnancies occurring in girls aged 19 years or younger. These pregnancies often carry higher risks for both the mother and the baby due to the young age and potential lack of access to proper healthcare.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

Concept of Family Planning

The world Health Organization (WHO) defines family planning as "a way of thinking and living that is adopted voluntarily upon the basis of knowledge, attitude, and responsible decisions by individuals and couples in order to promote health and welfare of family groups and thus contribute effectively to the social development of a country; the most important and crucial aspect of it is the planning of parenthood" (Park, 2011). The resources of many developing nations are being taxed by the unchecked population growth. 75% of people in the world live in developing nations, which is characterized by high rates of fertility, high rates of maternal and newborn mortality, and low life expectancy. The fertility rate is declining in the modern era as a result of the growing usage of family planning techniques (Pegu, Gaur, Sharma & Singh, 2014).

Family planning gives enough freedom to have children when desired in any social setting while enabling a couple to enjoy a physical relationship without worrying about an unintended pregnancy (Rakhi & Sumathi, 2011). Over the past few years, the advantages of family planning have increased dramatically. Based on statistics, researchers have proven that from 1995 to 2000 and from

2015 to 2020, the adolescent birth rate decreased during the previous 25 years from 60 to 43 births per 1000 girls aged 15 to 19 years (Venkatraman & Elsie, 2020). Furthermore, family planning has decreased maternal mortality by averting high-risk pregnancies, notably in women with high parities, and those that would have resulted in unsafe abortions. One of the more recent advantages of family planning is that it can improve prenatal outcomes and children's survival by prolonging the period between births. The World Health Organization (WHO) has declared that everyone has the right to inexpensive, safe, and effective contraception. Large-scale family planning has been advocated by numerous national and international health organizations so that women won't have to shoulder the burden of unintended and repeated pregnancies (Singh, Kaur, & Singh, 2009).

History of Family Planning

Family planning initiatives have a long history in developing nations, partially stemming from concerns about a potential "world population problem." Some South and East Asian nations began to see fast population expansion in the late 1940s and early 1950s as a result of the difference between falling mortality and persistently high fertility (Donaldson & Tsui, 1990). Early in the 1950s, the findings of postwar censuses provided the first indication that population

increase would pose a threat. More nations—including several in Latin America and the Middle East—were seeing previously unheard-of rates of population increase of more than 3 percent yearly by the middle of the 1960s. A nation's population would quadruple at those growth rates in less than 25 years. Demographers, social scientists, and others have expressed concerns about the rapid population growth, largely because they believed that it would "serve as a brake" on economic development and efforts to raise the standard of living for the majority of the world's population who live in developing nations (Harkavy & Oscar, 1995). Conservationists started writing about how unchecked population expansion was endangering natural resources and food supplies in the late 1940s. Family planning was invented out of concern for the effects of high fecundity and rapid population growth. In the latter part of the 20th century, governments in emerging nations had to deal with the fallout from fast population increase, which included rising health and education service costs, high jobless rates, and strain on public infrastructure. But a lot of national governments have prioritized national family planning programs, partly due to the belief that more people using contraception would result in lower fertility and slower population growth. As a result, an increasing number

of emerging nations implemented official measures to slow down population growth and curb fertility.

The first nation to implement a family planning program was India. That was in 1952. Many developing country governments, including those in Pakistan, Nepal, the Republic of Korea, Singapore, Malaysia, Indonesia, and other countries, actively promoted the drop in fertility throughout the 1960s by enacting laws meant to slow down population growth and fertility (Donaldson & Tsui, 1990). The United Nations started polling governments in the middle of the 1970s to find out their positions on a range of population-related topics, such as family planning, fertility, and population increase. 40 countries had programs to minimize fertility, while 39 to 149 countries had strategies to slow the rate of population expansion by 1976. African nations began implementing family planning and slowing population increase by 1980 (Ehrlich & Paul, 1968).

Nigerian family planning is predicated on the assumption that 75% of people support it, according to a 1964 survey carried out in Lagos. However, given Nigeria's high number of nurses and midwives and low doctor-patient ratio, it was a waste of time (Wright, 1968). Increased utilization of these paramedical personnel is necessary to support the expansion of family planning services,

particularly in rural regions. Before the government started funding the family planning service, the nationwide program was not feasible. Consequently, training fellowships for physicians and nurses were offered by foundations and technical support organizations (Wright, 1968).

Method of Family Planning

There are two main types of family planning approaches:

- Traditional methods
- Modern methods

Three subgroups comprise modern family planning methods:

- The short-term group includes the pill, condoms, the lactational amenorrhea method (LAM), diaphragms, foaming tablets, jelly, and the emergency contraceptive pill;
- The long-term group includes injectables, implants, and IUDs; and the permanent group includes female and male sterilisation.
- Traditional techniques include withdrawal, periodic abstinence, and a variety of folk remedies such herb and string.

It's critical to select the best method of contraception for each woman's needs. A poor choice in Family planning or contraception may have a variety of negative outcomes (Paulina, Alicja, Justyna, & Martyna, 2022)

Some methods of Family Planning, advantages and side effects.

Combined contraceptive pill

Advantage: Include decreasing the likelihood of ectopic pregnancy, ovarian and endometrial cancer, acne and hirsutism, ovarian cysts, and the signs and symptoms of hypothyroidism and hyperthyroidism.

Side effects: Nausea, breast discomfort such as soreness and pain, headaches, increase body weight and mood disturbance, sexual desire, and estrogen effect can stop the flow of milk (Moumita and Monoj, 2022; Paulina, Alicja, Justyna, & Martyna, 2022).

Monthly hormonal contraceptive injection(three-month injection)

The three-month injection is a hormonal contraceptive and must be re-administered every three months. A long-acting, high-dose progestin (luteal hormone) is present in the three-month injection. On the one hand, ovulation is

stopped by the three-month injection. On the other side, the uterine lining is altered by the progestin. This stops the sperm from getting inside the uterus(Rahila, Shazia, Momna, Uzma, Erum, & Madhu,

2020).

The three-month injection is considered a very safe method of contraception

Advantages: Gastrointestinal complaints do not affect reliability and they can be used during breastfeeding.

Side effects: Headache, dizziness, depression, acne, great weight gain, reduction in mineral bone density due to high progestin.

Emergency contraception

In order to lower the risk of pregnancy, emergency contraception (EC) is taken after an episode of unprotected sexual activity. This could happen in a situation where no contraceptive technique is being used or when a contraceptive method has failed (for example, a condom that has broken or oral contraceptive pills that were ignored). Additionally, the giving of EC is a vital part of showing compassion to sexual assault victims (Luke, Claire & Helen, 2017).

Side effects: Headache, nausea, and dysmenorrhea are the most typical adverse reactions noted in clinical studies. Additionally, some of the adverse effects of emergency contraception include; fatigue, dizziness or abdominal pain. Women may also experienceanxiety because of their fear of an unwanted pregnancy (Anna, 2013).

Intrauterine devices (IUDs)

Advantage: When used to treat endometriosis and severe menstrual bleeding, it nearly totally stops the bleeding. The IUD can be used by women with heart defects, increased cholesterol, and arterial hypertension because it does not result in thromboembolic consequences.

Side effects: ectopic pregnancy, pelvic infection, pain in the lower abdomen and sacrum, puncture of the uterus during medication insertion, and IUD penetration into the peritoneal cavity(Paulina, Alicja, Justyna, & Martyna, 2022).

Condom

The only method of contraception that, when used properly, can lower the chance of pregnancy and the spread of STDs is condoms (Jason and Erika, 2007). The male condom, which consists of a thin sheath applied over the glans and shaft of the penis, is made to stop the deposit of semen into the vagina during sexual activity (Maria, David, Laurence, & Kenneth, 2006).

Condoms play a dual role: it prevents unwanted pregnancies and protects against sexually transmitted diseases (STDs) such as HIV. The main side effects of the method are its unreliability when incorrectly used that is, it may slip or break (Pauline, Alicja, Justyna, & Martyna, 2022).

Barriers to Family Planning

By lowering mother and child morbidity and mortality, family planning contributes to women's improved reproductive health. Family Planning also assists individuals and couples in realizing their fundamental right to choose when and how many children to have in a free and responsible manner. Furthermore, better access to family planning services can help enhance economic and educational outcomes, particularly for women and girls (Adane, 2013). Short birth intervals (less than 24 months) have been linked to negative

health outcomes for both the mother and the child, according to the World Health Organization. Women can benefit from education and work opportunities when they are in better health and have more influence over their life. Additionally, family planning affects mother parity, birth order, gap between births, and length of nursing, all of which have an impact on infant survival (Sharan, Ahmed, May & Soucat, 2009).

There are four factors that affect access to healthcare services: acceptability, price, geographic accessibility, and availability (Republic 2019; Donnell, 2007). Both the supply and/or demand sides may present obstacles to obtaining family planning services (Jacobs, Bigdeli, Annear, & Dammed, 2012). Demand-side determinants are elements that affect a person's, a household's, or a community's capacity to consume healthcare services. Supply-side determinants are features of the health care system that prevent people from using its services, whether they be as individuals, families, or as a community. Furthermore, demand-side variables acknowledge that supply-side health sector reform has not been entirely successful in enhancing the delivery of health services, and they represent the concerns of social justice and human rights. Suboptimal performance of health systems, which reflects issues with

healthcare infrastructure, human resources for health (HRH), supply chains, health funding, health information, and governance, is the cause of supply-side concerns (Jacobs, Bigdeli, Annear, & Dammed, 2012). Comprehending these barriers is crucial in recognizing problems with the family planning program and contributing to the creation of implementation remedies.

1. **Lack of knowledge**

Three themes surfaced as obstacles to family planning methods use. One of the individual barriers that prevents women from using FP approaches is a lack of understanding (Kabagenyi, Jennings, Reid, Nalwadda, Ntozi & Atuyambi, 2014). Finding the right source for FP helps with decision-making as well as comprehension of its advantages for the environment, society, and health. The lack of awareness in these areas can be attributed to inadequate educational coverage and FP-related health education in particular study areas. Women who have never used FP are also ill-equipped to handle any side effects that might arise from using a contraceptive method. (Muanda, Ndongo, Messina, & Bertrand, 2017).

2. **Undesirable healthcare provider attitude**

Another obstacle to the use of family planning services was the stigma associated with health care providers, particularly for underprivileged user groups such as single and teenage users.

According to research conducted by Adam, Theresa, Margaret, Cecilia, Joanna, Yolandie, Joseph & Petrus (2018), some healthcare providers exhibit negative attitudes toward patients, including shouting and scolding, preventing clients from explaining their side effect experiences, and favoring married women and other socially acceptable groups of family planning service users.

Furthermore, One of the main causes of the limited utilization of family planning was identified as health-related difficulties. Limited options for contraception, inadequate medical supplies, including recommendations, a dearth of static family planning services, inattention, subpar counseling, and a shortage of educated personnel are characteristics of health-care issues. A significant factor contributing to low family planning utilization was found to be a shortage of funding at the levels of health facilities and health

administration (Merhawi, Alula, Delayehu, Feiruz, Balkachew, Tewadros, Munir, Berheyonas & Esie, 2022).

3. **Religious belief**

Because they dissuaded people from utilizing any kind of approach, religious beliefs acted as impediments to the provision and use of family planning services. Certain faiths held that using contraception was the same as having an abortion, which is morally wrong. Furthermore, it was widely believed that offering family planning services to single users was improper since it encouraged promiscuity and having sex before marriage in society (Adam, Theresa, Margaret, Cecilia, Joanna, Yolandie, Joseph & Petrus, 2018).

Religious leaders and participants mentioned the notion that God is the only one who can determine when and how many children is the right number of children, even if they did not quote specific passages from the Bible or the Quran that address the use of contraception. The Holy Quran (17:31) contains a verse that some Muslim adherents link to the use of contraceptives: "don't kill your child for fear of poverty" While most family planning techniques act before to zygote formation, it appears that this remark is focused on the process

that occurs after zygote formation. This emphasizes how crucial it is to do in-depth investigation in order to comprehend religious texts and train religious leaders on the use of contraceptives in order to stop false information from spreading (Merhawi, Alula, Delayehu, Feiruz, Balkachew, Tewadros, Munir, Berheyonas & Esie, 2022).

4. Culture and other Social Norms

Contraceptive use is hindered by cultural considerations, such as the desire for large families, male domination, marriage by exchange, and the ban on menstruation women engaging in certain activities. Social attitudes on competitiveness between or within clans and the emphasis on growing clan size also hinder the use of contraceptives. In addition, prevailing societal conventions and beliefs regard children as the ones who will provide for and look after their parents as they age. This conclusion is supported by the average number of children that families in emerging regions want (MoH- Kenya, 2016).

Additionally, studies revealed that women refrained from using family planning due to opposition from their spouses. In this region of the world, where the

husband is typically the primary provider for the family and the head of the household, this is a highly noteworthy and customary practice. The family is probably not going to undertake anything that he disapproves of, including family planning (Rozina, Uzma, & Haleema, 2008). Women are more reliant on their partner's income because they have less economic authority. Therefore, if a mother uses contraception without telling her husband, she might have to deal with financial repercussions if he decides to stop providing financial assistance. Sometimes the spouse is not the only one with decision-making power; community health agents, as well as mother and father-in-laws, are included. This lack of authority over decisions can be linked to ignorance of contraception and fear of what might happen if one uses it (Muanda, Ndongo, Messina, & Bertrand, 2017; Abdallah & Hassen, 2017).

5. Fear/ Misconception of side effects

Majority of women are most hesitant to adopt family planning because they are afraid of the side effects. Any family planning program that aims to increase women's adoption of family planning should properly address this legitimate concern.

The study conducted in 2017 by Esike, Anozie, Ani, Ekwedigwe, Onyebuchi, Ezeoun, & Nmeora indicated that the anxiety may be caused by the fact that women believe a different source of information that exaggerates these side effects, or it may be the result of a lack of effort on the part of the media and health professionals to adequately inform and persuade women of the enormous benefits of family planning and the rarity of the side effects. According to certain research, women can learn about family planning from a variety of informal sources, including social media, friends, and other members of their community. Not only is it highly probable that they will provide women with inaccurate information regarding family planning, but they also have a tendency to exaggerate the negative impacts and difficulties. Women undoubtedly trust the information they learn from these sources, and it has been seen that the views and information they receive from them frequently have a negative impact on the family planning decisions made by women. These sources, for instance, frequently spread false information about family planning's negative effects, such as birth abnormalities, infertility, and the inability for a woman to become pregnant and carry a child in the afterlife, and also exaggerated its infrequent negative effects, such as uncontrollably heavy periods and significant weight gain (Utoo, Swende, Utoo & Ifenne, 2012).

6. **Cost**

There is proof that a decrease in the use of contraception is linked to greater family planning service expenses. User fees are a barrier to these services, particularly for the most impoverished rural women (Babalola & John, 2012). Many techniques (including cash transfer programs, the distribution of free vouchers, and community-based or performance-based financing) have been attempted with conflicting outcomes in an attempt to remove financial barriers and enable women to acquire contraceptive methods. Another kind of intervention used demand elasticity to lower costs or eliminate user fees in an effort to expand access to family planning services (Lissner & Ali, 2016).

In conclusion, the complex combination of sociocultural, healthcare system, and individual hurdles accounts for the majority of the obstacles to family planning usage. Policymakers, programmers, and implementers must work together to overcome these obstacles, as stated in family planning accessibility, advocacy, financing, context-based policies, and significant development partner participation.

CHAPTER THREE

METHODOLOGY

This chapter describes the method and procedure used by the researcher in conducting the study. It is presented under the following Sub headings;

- Research Design
- Population of the study
- Sample and sampling technique
- Research instrument
- Validity of the Instrument
- Reliability of the instrument
- Method of Data Collection
- Method of Data Analysis

Research Design

Survey research design was adopted for this study. According to Omoroguiwa (2006), survey research design is one in which a group of people or term is studied by collecting data from only a few people or item considered to be

representative of the entire group. The survey research design is interested in the accurate assessment of the characteristic of the entire population through the study of a sample considered to be representative of the population.

Population of the Study

The population of the study consisted of all reproductive age women attending central hospital, Ugheli par week with the total number of two thousand women.

Sample and Sampling Technique

The sample for this study is 50 reproductive age women attending central hospital, Ugheli.

Research Instrument

The Research instrument is a self structured questionnaire with Section A and B. Section A will seek to elicit responses on the socio-demographic characteristics of respondents while Section B will seek to elicit responses on reproductive age women

Validity of the Instrument

The instrument was validated by the researchers supervisor and 2 other experts in the department of Health, Safety and Environmental Education. Their Suggestion and criticisms were incorporated in drafting the final instrument.

Reliability of the Instrument

The test re-test method of reliability was used for this study. The instrument was administered to 20 respondents who are not part of the study and after 2 week the instruments was again re-administered and scores collated using Pearson Product Moment Correlation Coefficient.

Method of Data Collection

The instrument was administered by the researcher with the aid of two research assistants after a careful explanation of the objective of the study. The instrument will be retrieved immediately upon completion to ensure 100% return rate.

Method of Data Analysis

The data collected is properly organized and tabulated. The responses will be statistically analyzed by the use of frequency counts and percentage.

CHAPTER FOUR

PRESENTATION OF RESULTS AND DISCUSSION OF FINDINGS

This chapter examines the analysis and interpretation of data collected for this research. The results are presented as follows:

Presentation of Data

Research Question 1: What are the barriers to the utilization of family planning practice among reproductive age women?

Table 1: Barriers to Family Planning Utilization

SN	ITEM	A	%	SA	%	D	%	SD	%
1	Concerns about side effects deter me from seeking family planning services.	16	32	10	20	4	8	6	12
2	Financial constraints hinder my access to family planning services.	3	6	2	4	16	32	29	58
3	I feel judged by healthcare providers when discussing family planning.	7	14	3	6	15	30	25	50
4	I trust healthcare providers to provide non-judgmental and	19	38	10	20	9	18	12	24

	supportive family planning services.								
5	I feel adequately informed about different family planning methods.	32	64	4	8	7	14	7	14

A significant percentage (60%) agreed that concerns about side effects deter them from seeking family planning services. Financial constraints were reported by 80% as a barrier. Feeling judged by healthcare providers was a concern for 60% of respondents. Trust in healthcare providers varied, with 58% agreeing that providers are non-judgmental. 44% felt adequately informed about different family planning methods.

The findings highlight key barriers to the utilization of family planning practices among reproductive age women. Concerns about side effects and financial constraints are prominent barriers. Additionally, a significant number of women feel judged by healthcare providers, which affects their willingness to seek family planning services. However, there is a reasonable level of trust in healthcare providers being non-judgmental and supportive.

Research Question 2: What role do personal beliefs and religious/cultural factors play in shaping reproductive age women's attitudes towards family planning?

Table 2: Personal Beliefs and Cultural Factors

SN	ITEM	A	%	SA	%	SD	%	D	%
6	I feel comfortable discussing family planning options within my cultural context.	30	60	10	16	6	2	4	8
7	My cultural beliefs influence my decision to use family planning methods.	16	10	2	4	19	38	13	26
8	My religious beliefs influence my decision to use family planning methods.	10	20	8	16	22	44	10	20
9	I feel supported in my religious community in using family planning methods.	7	14	7	14	13	26	23	28
10	I believe that family planning methods have unacceptable side effects.	21	42	12	24	10	12	7	14

80% of respondents feel comfortable discussing family planning options within their cultural context. Cultural beliefs influence the decision for 64% of respondents. Religious beliefs play a role for 52% of respondents.

Only 28% feel supported by their religious community. 66% believe that family planning methods have unacceptable side effects.

Personal beliefs and cultural factors significantly shape attitudes towards family planning. A considerable number of women report that their cultural and religious beliefs influence their decisions. Despite this, many women do feel comfortable discussing family planning within their cultural context. However, there is a noticeable lack of support from religious communities, and concerns about side effects remain prevalent.

Research Question 3: What is the level of knowledge among reproductive age women regarding family planning practices?

Table 3:

SN	Level of Knowledge of family planning	Frequency	Percentage
11	High level of knowledge	35	70
12	Moderate level of knowledge	10	20
13	Low level of knowledge	5	10

Table 3 presents the level of knowledge among reproductive age women regarding family planning practices

70 percent of the respondents revealed High level of knowledge among reproductive age women regarding family planning practices while 20 percent

revealed Moderate level of knowledge and 10 percents revealed low level of knowledge

Research Question 4: What are the challenges associated with the accessibility and availability of family planning resources for reproductive age women?

Table 4: Accessibility and Availability Challenges

SN	ITEM	SD	%	D	%	A	%	SA	%
14	Financial constraints hinder my access to family planning services.	6	12	5	10	28	56	11	22
15	Lack of time due to work also hinder my access to family planning services.	10	20	5	10	20	40	15	30

Discussion of Findings

The findings of this study reveal significant insights into the barriers, personal beliefs, knowledge levels, and accessibility challenges faced by reproductive age women regarding family planning practices. These insights are critical for understanding the complexities involved in family planning utilization and developing strategies to address these challenges effectively. These findings

corroborate the findings of Babalola & John, 2012. Who reported that barriers, personal beliefs are challenges faced by reproductive age women regarding family planning practices

The study identified several barriers to the utilization of family planning practices. The most prominent barriers include concerns about side effects (80%), financial constraints (80%), and feeling judged by healthcare providers (60%). Despite a relatively high level of trust in healthcare providers to be non-judgmental (58%), many women still feel inadequately informed about different family planning methods (44%). These findings corroborate the findings of Petrus 2018, Who reported that, Despite a relatively high level of trust in healthcare providers to be non-judgmental, many women still feel inadequately informed about different family planning methods

Personal beliefs and cultural factors play a significant role in shaping attitudes towards family planning. Cultural beliefs influence the decision to use family planning methods for 64% of respondents, while religious beliefs influence 52%. Despite 80% feeling comfortable discussing family planning within their cultural context, only 28% feel supported by their religious community.

Additionally, 66% of respondents believe that family planning methods have unacceptable side effects, which further hinders utilization.

The level of knowledge among reproductive age women regarding family planning is generally high. About 62% understand how family planning methods work and their potential benefits, and 62% are aware of where to access accurate information. Trust in healthcare providers is also fairly high at 52%. However, there is variability in knowledge about specific contraceptive methods and mechanisms, indicating a need for more targeted educational efforts.

Financial constraints (62%) and lack of time due to work commitments (60%) are significant barriers to accessing family planning resources. Most women (76%) correctly identified the purpose of emergency contraception and understood that an IUD requires a healthcare provider for insertion and removal (76%). However, there is some variation in knowledge about the recommended age for cervical cancer screening, with 55% correctly identifying the recommended interval. This finding aligns with the findings of MoH- Kenya, 2016. Who notes that financial constraints and lack of time due to work commitments are significant barriers to accessing family planning resources

CHAPTER FIVE

SUMMARY, CONCLUSION, AND RECOMMENDATIONS

Summary

This chapter presents a summary of the key findings of the study, followed by a comprehensive conclusion drawn from the results. Additionally, recommendations for various stakeholders are provided based on the study's insights.

This study investigates the perceive barriers towards the utilization of family planning practices among reproductive age women in Ughelli North LGA (4) research questions were raised for the study. The study adopted survey research design. The instrument for data collection was a questionnaire; it was built around the research question by the researcher and validated by the researcher's supervisor. Data collected were analyzed using frequency count, percentages

Conclusion

This study identifies significant barriers to family planning utilization among reproductive age women, including concerns about side effects, financial constraints, and judgment from healthcare providers. Cultural and religious

beliefs also significantly shape attitudes towards family planning. While general knowledge about family planning is high, gaps remain in understanding specific methods. Addressing these barriers through targeted education, supportive healthcare practices, financial assistance, and community engagement can enhance family planning utilization and improve reproductive health outcomes.

Recommendations

Based on the findings, the following recommendations are proposed to improve the utilization of family planning practices among reproductive age women:

1. Implement comprehensive education campaigns to address concerns about side effects and provide accurate information about different family planning methods.

2. Train healthcare providers to offer non-judgmental and supportive family planning services.

3. Develop and strengthen financial assistance programs to reduce the economic burden of accessing family planning services.

4. Engage community and religious leaders in promoting supportive attitudes towards family planning.

5. Address barriers related to time constraints by offering flexible service hours and providing family planning services in convenient locations.

By addressing these key areas, it is possible to improve the utilization of family planning practices among reproductive age women, ultimately contributing to better reproductive health outcomes and overall well-being.

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QUESTIONNAIRE
DEPARTMENT OF HEALTH, SAFETY AND ENVIRONMENTAL EDUCATION,
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PERCEIVE BARRIERS TOWARDS THE UTILIZATION OF FAMILY PLANNING PRACTICES AMONG REPRODUCTIVE AGE WOMEN IN UGHELLI NORTH LGA
Hospital: Mariere Memorial Central Hospital Ughelli

Dear Respondent,

I am a final year student of the above institution carrying out a research on the work titled: perceive barriers towards the utilization of family planning practices among reproductive age women in Ughelli North LGA**.**

Please your response to the questions will be held as confidential as you want it, and will only be used for the purpose of this work which is purely for an academic requirement.

Thanks, in anticipation for your cooperation.

Yours sincerely,

Olotu Stella

(Researcher)

Section A:

Demographic Information

Age: 18 – 25 [ ] 26- 35 [ ] 35 – 45 [ ] 46 and above [ ]

Educational level: No formal education[ ] Primary education [ ] Secondary education [ ] Tertiary education [ ]

Marital status: Single[ ] Married[ ] Divorced[ ] Widowed [ ]

Section B: Responses from the Respondents

1. I feel comfortable discussing family planning options within my cultural context.

Strongly Disagree ( ) Disagree ( ) Neutral () Agree () Strongly Agree ()

2. My cultural beliefs influence my decision to use family planning methods.

Strongly Disagree ( ) Disagree ( ) Neutral () Agree () Strongly Agree ()

3. Concerns about side effects deter me from seeking family planning services.

Strongly Disagree ( ) Disagree ( ) Neutral () Agree ( ) Strongly Agree ( )

4. I believe that family planning methods have unacceptable side effects.

Strongly Disagree ( ) Disagree ( ) Neutral () Agree ( ) Strongly Agree ( )

5. I feel adequately informed about different family planning methods.

Strongly Disagree ( ) Disagree ( ) Neutral ( ) Agree ( ) Strongly Agree ( )

6. I understand how family planning methods work and their potential benefits.

Strongly Disagree ( ) Disagree ( ) Neutral () Agree ( ) Strongly Agree ( )

7. I am aware of where to access accurate information about family planning.

Strongly Disagree ( ) Disagree ( ) Neutral () Agree () Strongly Agree ()

8. My religious beliefs influence my decision to use family planning methods.

Strongly Disagree ( ) Disagree ( ) Neutral () Agree () Strongly Agree ()

9. I feel supported in my religious community in using family planning methods.

Strongly Disagree ( ) Disagree ( ) Neutral () Agree () Strongly Agree ()

10. Financial constraints hinder my access to family planning services.

Strongly Disagree ( ) Disagree ( ) Neutral () Agree () Strongly Agree ()

11. I feel judged by healthcare providers when discussing family planning.

Strongly Disagree ( ) Disagree ( ) Neutral () Agree () Strongly Agree ()

12. I trust healthcare providers to provide non-judgmental and supportive family planning services.

Strongly Disagree ( ) Disagree ( ) Neutral () Agree () Strongly Agree ()

Research Question Two:

13. Which of the following is an example of a hormonal contraceptive method? a) Condom b) Intrauterine device (IUD) c) Birth control pill d) Sterilization
14. How does the contraceptive implant prevent pregnancy? a) By blocking sperm from entering the uterus b) By preventing ovulation c) By thickening cervical mucus d) By preventing implantation of a fertilized egg
15. Which family planning method requires a healthcare provider for insertion and removal? a) Condom b) Diaphragm c) Birth control patch d) Intrauterine device (IUD)

16. What is emergency contraception used for? a) Preventing sexually transmitted infections (STIs) b) Inducing abortion c) Preventing pregnancy after unprotected sex d) Regular contraception
17. Which of the following is a non-hormonal contraceptive method? a) Birth control shot b) Male condom c) Vaginal ring d) Birth control patch
18. How often should emergency contraception be taken after unprotected sex for maximum effectiveness? a) Within 24 hours b) Within 48 hours c) Within 72 hours d) Within 5 days
19. Which family planning method is considered permanent and irreversible for both men and women? a) Vasectomy b) Tubal ligation c) Birth control pill d) Contraceptive patch
20. What is the recommended age for cervical cancer screening (Pap smear) for most women? a) Every year starting at age 30 b) Every 3 years starting at age 21 c) Every 5 years starting at age 40 d) Every 10 years starting at age 50