THE EFFECT OF EDUCATION LEVEL QUALIFICATION ON FAMILY PLANNING AMONG WOMEN IN NIGERIA

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CERTIFICATION

This is to certify that Ipinlaye Damilola Peter of the Department of Demography and Social Statistics, Faculty of Social Sciences, Federal University Oye-Ekiti, Nigeria carried out a research on the topic **"The effect of education level qualification on family planning among women in Nigeria"** in partial fulfilment of the requirement for the award of Bachelor of Science (B.Sc) in Demography and Social Statistics under my Supervision.

....   21/03/19...............

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DEDICATION

I dedicate this project to Almighty God, the creator of everything, the giver of life.

He alone helped and strengthened me during the course of this project. He deserves

all glory and honor. I also dedicate this project to my ever supporting parents and

family who have always being there through thick and thin.

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ABSTRACT

The issue of family planning among women in Nigeria has become a contentious problem. The study examined the effect of education level qualification on family planning among women in Nigeria, using 2013 Nigeria Demographic and Health Survey women recode dataset Characteristics of respondents were examined at the univariate level with the use of frequency distribution table, bivariate level with the use of chi square and binary logistic regression was employed in the multivariate analysis. Bivariate analysis showed significant association between the following variables: level of education and contraceptive practice(χ^2=3771.51, P=0.0000), women age and contraceptive practice(χ^2=860.97, P=0.0000), place of resident and contraceptive practice(χ^2=1399.99, P=0.0000), marital status and contraceptive practice(χ^2=103.71, P=0.0000), ethnicity and contraceptive practice (χ^2=4140.79, P=0.0000), region and contraceptive practice(χ^2=4197.36, P=0.0000), religion and contraceptive practice(χ^2=3131.70, P=0.0000), wealth status and contraceptive practice(χ^2=3233.35, P=0.0000), occupation and contraceptive practice(χ^2=565.66, P=0.0000), knowledge of contraceptive methods and contraceptive practice(χ^2=1291.27, P=0.0000). The multivariate analysis showed that there is significant relationship between level of education and family planning in the study area (OR1.95=, P<0.05, CI=1.61-2.35; OR=2.26, P<0.05, CI=1.88-2.72; OR=2.59, P<0.05, CI=2.11-3.19). The study further revealed that age of women, marital status, ethnicity, region, religion, wealth status and occupational status had significant influence on family planning. This study concludes that base on the facts from the result that there is significant relationship between level of education and contraceptive use where p-value greater than five percent level of significant. Other socio-demographic variables (age, marital status, ethnicity, region, religion, wealth status and employment status) influencing contraceptive use where p-value less than five percent level of significant.

CHAPTER ONE

INTRODUCTION

1.0 BACKGROUND TO THE STUDY

Globally the practice of family planning has attracted global attentions due to its importance in decision making about population growth and development issues. According to World Health Organization (2001) defined" family planning as the practice that helps individuals or couples to attain certain objectives such as avoiding unwanted pregnancies, bringing about unwanted babies at the right time, regulating the interval between pregnancies, controlling the time at which birth occurs in relation to the ages of the parents and determining the number of children in the family" (World Health Organization, 2001). Family planning refers to an important decision on reproduction that could be taken by couples to curtail the number of children they want to have. The issue of family planning had been explain further to refers to the provision of birth prevention information services and appliances, likewise the spacing of birth, preventing unwanted pregnancies or securing wanted pregnancies (Onokerhoraye, 1997 and Almuam, 2007).

In almost all regions of the world, contraceptives as a method of family planning are used by the majority of women in the reproductive age 15-49 years who are married or in a union. Family planning has steadily decreased as an international priority in recent years, despite its documented impact on both maternal and child health and overall development (World Bank, 2013). The proportion of reproductive age married women who use a modern or traditional contraceptive method rose from 55% to 63% between 1990 and 2010. Most of the increase was

due to a 10 percentage point rise in contraceptive prevalence in the developing world, although contraceptive use also increased in developed countries (Alkema, Kantorova, Menozzi, Biddlecom, 2013). Also, 63 per cent of these women were using some form of contraception. Contraceptive use was above 70 per cent in Europe, Latin America and the Caribbean, and Northern America, while being below 25 per cent in Middle and Western Africa (United Nation, 2017).

Modern contraceptive were 58 per cent of married women or in union of reproductive age that were using a modern method of family planning, comprising 92 per cent of all contraceptive users and the proportion of women currently using a modern method among all women who have a need for family planning was 78 per cent. Across regions this proportion was lowest in Africa, at 56 per cent, and above 75 per cent in all other regions (United Nation, 2017).

In sub-Saharan Africa the level of contraceptive use among married or in-union women is lower than in any other region of the world (United Nation, 2015). When considering contraceptive use among women in Africa by marital status, data have shown that unmarried women are more likely to use contraception than currently married women. Similarly, the Latin America and Caribbean region shows higher levels of contraceptive use among unmarried women than married women (Howse, 2014). This region has the highest level of contraceptive use of any developing region worldwide (United Nations, 2015).Unmarried women usually want to avoid becoming pregnant. Thus, despite more sporadic sexual activity compared with married women, unmarried women tend to have a higher prevalence of contraceptive use (Cleland, Ali, and Shah, 2006).They also are more likely than their married counterparts to negotiate contraceptive use with their partners and among all women at risk of becoming pregnant, a larger proportion are

married than those that are unmarried and sexually active (Wellings, Collumbien, Slaymaker, Singh, Hodges, Patel, and Bajos, 2006).

Nigeria's family planning program began in 1964 with the National Family Planning Council of Nigeria. Before the 1980's, however, family planning programs were not a priority for the government of Nigeria and consequently were driven by development partners and non-governmental organizations. Following analysis of the consequences of unregulated population growth on health and development in Nigeria, starting in the late 1980's the country began formulating various policies aimed at improving reproductive health outcomes and reducing fertility levels through family planning (Ejembi, Dahiru, and Aliyu, 2015).

According to Federal Ministry of Health, it was reported that the 2012 London Summit on family planning, Nigeria developed a blue print for accelerating uptake of family planning with a target of increasing the national contraceptive prevalence rate to 36% by 2018 (Federal Ministry of Health, 2014).Currently, family planning services are provided by both the public and private sectors, with the commodities provided free in public sectors facilities. In spite of the various investments in family planning programs in the country, it is saddening to know that contraceptives prevalence has not shown any sign of increasing. The knowledge of contraceptives is generally high, uptake is low; only 15% of married women of reproductive age are using any contraceptives method, only 10% are using modern family planning method, while unmet need for contraception is 16%.Therefore, the promotion of family planning in countries with high birth rates has the potential to reduce poverty and hunger and avert 32% of all maternal deaths and nearly 10% of childhood deaths (National Population Commission, 2009).

Fortunately, it was reveal that majority of Nigerian women are aware of family planning, but very few of them make use of it for birth control. Different factors such as culture, low

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education, poverty and poor access among other numerous factors have been identified by scholars to militate against the use of family planning methods (USAID, 2008)

According to the World Health Organization it was reveal that women in many underdeveloped countries do not have enough knowledge about contraception. Hence, women in Tanzania know almost nothing about contraception and in Nigeria only 34% women have ever heard about contraception, while only 21% know about modern methods of contraception, the best known is a condom, then oral pills and an intra-uterus spiral (WHO, 2000). Health education is defined as consciously constructed opportunities for learning about health, including improving knowledge and developing life skills conducive to individual and community health (Bankole, 2006).Therefore it is necessary to examine the effect of educational level qualification on family planning.

1.1 STATEMENT OF PROBLEM

The issue of family planning among married women in Nigeria has become a contentious problem. In the year 2000, it was estimated that the population of the world was growing by about 78 million per year at the rate of 1.4%, and was projected to rise to over 8 billion in 2025 (United Nations Funds for Population, 1999).Among the black nations in the world today, Nigeria is the most populous and recent estimates indicate a total population of 177 million people with a growth rate of 3.2% and a TFR of 5.5 (World Population Bureau, 2014). Despite this progress made in the status of women world over, Nigeria is still among the few countries in Sub-Sahara Africa with consistently low contraceptives use of 15% among married women whose average rate is 5.5. Furthermore, it was showed that while fertility rate of 5.5 in 2013 was a slight drop from previous years of 5.7 in 2003 and 2008, contraceptive use has experienced only a gradual increase of 2% (National population Commission and ICF International,2014)

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Against this backdrop, married women tend to give birth to many children, forgetting the importance and benefit of family planning. Ignorance, illiteracy, African traditional values and norms, husband dominance among others have come against the practice of family planning among married women.

This is a problem, serious problem in that in view of the global economic challenge and that of security, where children that are not catered for by parents turn out to be security threats or wayward (Suntaia and Destiny, 2016). Low or non-use of contraceptives leads to high population growth that ultimately results to problems such as food shortages, pressure on social facilities like hospitals, schools, unemployment and social problems like crime. Low and non-use of contraceptives is also attributable to the high prevalence of abortion. Maternal and neonatal morbidity and mortality levels in Nigeria have remained unacceptably high (Ministry of Public Health and Sanitation, 2009).Literacy, particularly female literacy was seen to influence greater acceptance of family planning methods and observed that only 23.2% of couples where both husband and wife were illiterate had undergone sterilization. Studies have also indicated positive relation between education and use of contraceptive methods. (Kamal, 1985).This study aims at examining the effect of educational level qualification on family planning among women in Nigeria.

1.2 RESEARCH QUESTIONS

1. What is the prevalence of contraceptive knowledge among women in Nigeria?

2. Is there any significant relationship between level of education qualification and contraceptive use among women in Nigeria?

1.3 OBJECTIVE OF THE STUDY

1.3.1 GENERAL OBJECTIVE

1. The general objective is to examine the effect of education level qualification on family planning among women in Nigeria.

1.3.2 SPECIFIC OBJECTIVES

1. To examine the prevalence of contraceptive knowledge among women in Nigeria.

2. To investigate the significant relationship between level of education qualification and contraceptive use among women in Nigeria.

3. To examine the influence of level of educational qualification on contraceptive use among women in Nigeria.

1.4 JUSTIFICATION OF THE STUDY

Family planning programs that offer a variety of safe, effective, acceptable and affordable contraceptive methods helps women to prevent unwanted pregnancies and sexually transmitted diseases (STDs) and also achieve their child bearing goals. Method mix is a key determinant of the fertility impact of contraceptive practice. The use of more effective methods even by a smaller proportion of eligible couples can produce a greater decline in fertility than can the use of less effective methods by a large proportion of couples (Magadi and Curtis, 2003). According to Nigeria Demographic and Health Survey, 2013 shows the proportion of currently married women, and sexually active unmarried women who are currently using specific family planning methods, according to age. Overall, 15 percent of currently married women in Nigeria are using a contraceptive method, an increase of only 2 percentage points since the 2003 NDHS.

Most of these contraceptive users rely on a modern method(10 percent); 5 percent use traditional methods. Injectables (3 percent), male condoms (2 percent), and the pill (2 percent) are the most commonly used modern methods. Other modern methods are used by 1percent of women or less. Interestingly, 3 percent of currently married women use withdrawal as a method of contraception (NDHS, 2013).This research would have its contribution to examine the effect of level of educational qualification on family planning in Nigeria. The study will contribute immensely to the existing knowledge on level of educational qualification on family planning in various household and society at large.

1.5 OPERATIONAL DEFINITION OF TERMS

Family Planning: means working out a plan by a couple on when and how many children to have and how to prevent unwanted pregnancies. The planning of when to have children, and the use of birth control and other techniques to implement such plans.

Current Contraceptives Use: Contraceptive method the study respondent was using at the time of interview. Excludes all other method used prior to the interview.

Maternal Mortality: The death of a woman occurring as a result of pregnancy, either due to its direct complications or its effect on other medical condition of the affected woman.

Modern Contraceptive Method: Contraceptives that are based on scientific knowledge of the process of conception.

Traditional Contraceptive Method: Contraceptives which are prescribed or supplied by traditional healers or methods used traditionally in specific cultures without any prescription

Natural Contraceptive Method: The use of calendar or rhythm of a woman's menstrual cycle to time sexual intercourse with the aim of preventing conception.

Educational Level: This refers to the acquisition of knowledge by women whether primary, secondary or tertiary. This also reveals the state of acquiring knowledge about family planning.

CHAPTER TWO

LITERATURE REVIEW

2.0 INTRODUCTION

This section reviewed related materials and studies on methods, types, knowledge of family planning and education level qualification.

2.1.1 GLOBAL OVERVIEW OF FAMILY PLANNING

In Latin America and the Caribbean, more than one half of pregnancies are unintended, even though about 65% of married women of reproductive age use modern contraceptives. Almost two-thirds of pregnancies in Caribbean (62%) and South America (63%) are unintended, as are 43% of pregnancies in Central America (including Mexico).Modern family planning services include counseling, provision of contraceptives and follow up (UNFPA, 2009).The proportion of reproductive age married women who use a modern or traditional contraceptive method rose from 55% to 63% between 1990 and 2010. Most of the increase was due to a 10 percentage point rise in contraceptive prevalence in the developing world, although contraceptive use also increased in developed countries (Alkema. Kantorova, Menozzi, & Biddlecom, 2013.)

Also, 63 per cent of these women were using some form of contraception. Contraceptive use was above 70 per cent in Europe, Latin America and the Caribbean, and Northern America, while being below 25 per cent in Middle and Western Africa (United Nation, 2017).Modern contraceptive methods account for most of the contraceptive use worldwide, among married or in-union women of reproductive age, the proportion of the demand for family planning that was satisfied by modern contraceptive methods, 58 per cent of married women or in union of reproductive age were using a modern method of family planning, comprising 92 per cent of all

contraceptive users and the proportion of women currently using a modern method among all women who have a need for family planning was 78 per cent. Across regions this proportion was lowest in Africa, at 56 per cent, and above 75 per cent in all other regions (United Nation, 2017).

2.1.2 FAMILY PLANNING IN SUB-SAHARA AFRICA

Research reveal that Sub-Saharan Africa has the highest fertility rates of any world region by 5.4 births per woman on average double that of Asia (excluding China) and more than three times that of Europe. One of the factors underlying high maternal mortality rate is the low use of modern contraception. Only 18% of married women in Sub-Saharan Africa use modern methods of family planning. An estimated 35 million women in Sub-Saharan Africa have unmet need for family planning. They want to delay or stop childbearing but are not using any method (Smith et al., 2009).The relatively high birth rate in Nigeria which has been accompanied by stead declines in death rates has resulted in high rates of population growth.

Nigeria's annual rate of population growth of about 2.87 % has been a major concern for population experts and policy makers for some time. With an estimated doubling period of less than 25 years at the current rate of population growth, the current level of consumption can only be maintained if production of goods and services will also double in less than 25 years. Unfortunately, this is almost impossible to achieve as all available literature indicates that the rate of growth of the economy has been lower than the rate of growth of the population. Standards of living tend to worsen when the rate of population growth exceeds the rate of economic growth. Within the last four decades, there have been increased pressure towards family limitation in Nigeria (Oyedokun, 2004).These are the results of the rapid growth of the large towns, the very great extension of educational facilities, and among the elite, the far greater difficulty of securing top jobs that have come with independence. In response to this situation, a

national policy on population for development, unity, progress and self-reliance was formulated in 1998 and revised in 2004. The major goal of the policy is a reduction in fertility through increased adoption of contraception (Federal Government of Nigeria, 2004). SouthAfrica's demographic transition is considerably more advanced than those of other Sub-Saharan African nations; its total fertility rate (TFR) has declined from approximately 6.0 births per woman in 1980 to 2.2 in 2007 (US Bureau of Census, 2008).

Furthermore, over the same period, contraceptive use among the four major population groups (black, white, colored and Asians) has increased (Swartz, 2002; Burgard, 2004).Yet the overall modern contraceptives prevalence of 61% (urban 66%,rural 53%) masks wide racial disparities and injectable represent 30% of all use. Contraceptive method of choice is a fundamental indicator of quality of care in a family planning program. The more contraceptive methods that are available, the more likely it is that a program can meet the range of contraceptive needs of a diverse client population.

2.1.3 FAMILY PLANNING IN NIGERIA

In Nigeria, according to the population census of 2006, there were, at that time, 44,152,637 women of reproductive age. The Nigerian Demographic and Health Survey (NDHS) 2013 reported that only 15.1 percent of married women of reproductive age were using any contraceptive. Ten percent of currently married women reported using a modern method, and 5 percent use other methods of contraception. In addition, there is a significant unmet need for family planning in Nigeria; 16 percent of married women have an unmet need for family planning (NDHS 2013). With more than 175 million people, Nigeria is the most populous

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country in Africa and the seventh most populous country in the world. Annual population growth is 3.2 percent, and the total fertility rate is 5.5, with variations across states and regions (National Population Commission and ICF International, 2014).

Most projections place Nigeria as the third most populous country behind India and China by 2050. There are approximately 35 million women of reproductive age in Nigeria, and the country had nearly 7 million births in 2012 alone. To reveal the trends in current use of family planning can be used to monitor and evaluate the success of family planning programmes over time. Trends in current use of specific contraceptive methods among currently married women from 1990 to 2013. Over the 23-year period, contraceptive prevalence increased from 6 percent in 1990 to 15 percent in 2013. Use of modern methods increased from 4 percent to 10 percent. The South West zone has the highest proportion of women currently using a family planning method (38 percent), followed by the South East (29 percent). The lowest proportion of married women using a family planning method is in the North East (3 percent). Among the states, Lagos and Kwara have the highest percentages of women using any method (48 percent and 40 percent, respectively). In six states Jigawa, Kano, Katsina, Kebbi, Sokoto, and Yobe, only 1 percent of women use any method of contraception (National Population Commission and ICF international, 2014)

2.1.4 FAMILY PLANNING, INFANT AND CHILD MORTALITY

Infant and child mortality have been defined as, 'the probability of an infant dying beforethe 1st birthday and the probability of dying between the 1st and 5th birthday respectively (CSO et al., 2007). According to the UNFPA (2004), there is a relationship between maternal, infant and child mortality as maternal deaths have a significant impact on infant and child mortality. This is because the chance of survival of the baby becomes slim after the death of the

mother. It was reported by Smyke, 1991 that too closely spaced pregnancies among other factors such as nutrition and access to specialized health care facilities also have an effect on infant and child mortality. This entails that with the reduced number of pregnancies due to family planning, there will be reduced cases of infant and child deaths. In addition, mothers will be able to give extra care to the children, thus reducing the number of children dying between their 1st and 5th birthdays (Smyke, 1991).

The United Nations (2004) reports that infants that are spaced more than 3 years apart are more than 3 times as likely to survive as infants than those born less than one and half years apart. Considering that each year 10 million children under 5 years die primarily from preventable causes, and in poor countries as well as an additional half a million mother die in childbirth or pregnancy, it is clear that family planning must remain on top of any development agenda.

2.1.5 FAMILY PLANNING AND MATERNAL MORTALITY

According to Feuerstein, 1993, maternal mortality is, 'the death of a woman while pregnant or within 42 days of termination pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. Maternal mortality in many developing countries remains at distressingly high levels despite improvements in hospital obstetrics. The World Health Organization estimates that quarter a million maternal deaths occur each year, 99% of which are in developing countries. In Sub-Saharan Africa maternal deaths are associated with infections, health service factors, and reproductive health factors, socio-economic and cultural factors (Nsemukila, 1994; Shah et al., 1989). It is argued that one of the most important indicators in assessing a country's quality of health including safe motherhood is maternal mortality data. This

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provides revealing measure of the status of women, their access to health care and the ability of the health care system to respond to their needs.

There is a relationship between maternal mortality and contraceptive use. In a study in Bangladesh, maternal mortality ratio dropped by 22% over a period of 12 years because of the increase in contraceptive use (Berer, 2007).Thus, reducing the number of pregnancies use of contraceptives reduces the risks of maternal deaths thereby saving women's life. Contraceptive use therefore gives women respite from unwanted and too closely spaced pregnancies. In countries such as China, Cuba, Egypt, Jamaica, Malaysia, Sri Lanka, Thailand and Tunisia, significant declines in maternal mortality had occurred as more women gained access to family planning and skilled birth attendance with backup emergency obstetric care (UNFPA, 2004).

According to the UNFPA, 2009 family planning use influences the maternal mortality ratio only to the extent that it reduces the proportion of pregnancies to high-risk women. The maternal mortality rate can be substantially influenced by the prevalence of contraception, but it is primarily the reduction in the number of births that exerts the influence (UNFPA, 2009). In developing countries, modern obstetric care is often available only in a few teaching hospitals but family planning programs are feasible even in remote areas. While implementing family planning programs is not easy, it more feasible than the implementation of significant improvements in the quality and availability of obstetric care. The contribution of family planning to lower maternal mortality and morbidity should not therefore be underestimated.

2.1.6 BENEFITS OF FAMILY PLANNING

The importance of family planning cannot be over emphasized. The United Nations Population Fund has recorded some of the health benefits of family planning which include reduction in the risks associated with fetal deaths, birth defects, infant mortality, maternal mortality and general improvement of the health of the mother and child. The other benefit is that of having more relaxed sexual relations between men and women when they are confident that intercourse will not lead to unwanted and ill-timed pregnancies (UNFPA, 2004). According to the United States Agency for International Development (USAID), family planning is important for the health of the children and the mother, and for the economic situation of the family. The financial impact of having children includes the medical costs of a pregnancy and birth, and the subsequent cost for raising children. Because parents have a responsibility to provide food, clothing, shelter and education for their children, family planning has a significant and long-term impact on a family's financial situation (USAID, 2012).

2.1.7 WOMEN EDUCATION

Female education has been seen as a key determinant of contraceptive use (NPC and ORC Macro 2004). Better-educated women are argued to be more willing to engage in innovative behavior than are less educated women and in many Third World context, the use of contraception remains innovative (Oyedokun, 2007). Better educated women are also argued to have more knowledge of contraceptive methods or of how to acquire them than are less educated women because of their literacy, greater familiarity with modern institutions and greater likelihood of rejecting a fatalistic attitude towards life. According to Koc, 2000 reveal a positive association between the educational level of both spouses and the use of contraceptive methods in Turkey (Koc, 2000).

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2.1.8 KNOWLEDGE OF CONTRACEPTION AND EDUCATIONAL LEVEL

Contraceptive choice is also a central element of quality of care in the provision of family planning services and an important dimension of women's reproductive rights. To increase prevalence of use, family planning programs should offer a variety of safe, effective, acceptable and affordable contraceptive methods to help women prevent unwanted pregnancies and sexually transmitted diseases (STDs) and to help them achieve their childbearing goals (Magadi and Curtis, 2003).Young people have a real need for reproductive health and family planning information and services. The age at which young people have their first sexual experience is falling, while the number of unmarried sexually active young people is growing significantly (National Research Council, 2006).

According to Nigeria Demographic and Health Survey, 2013 it was shown that knowledge of any contraceptive method is widespread in Nigeria, with 85 percent of all women and 95 percent of all men knowing at least one method of contraception. Modern methods are more widely known than traditional methods; 84 percent of all women know of a modern method, while only 56 percent know a traditional method. Similarly, 94 percent of all men know of a modern method, while 65 percent know of a traditional method (National Population Commission and ICF international, 2014). Although many adolescent claim to know about contraception and safe sex, their actual knowledge is often quite poor (Bankole et al., 2007). Many young people believe that you can't get pregnant the first time you have sex, for example, or that you can't get pregnant if you have sex standing up (Boonstra, 2007).As a result of incomplete knowledge about family planning, adolescents are vulnerable to sexually transmitted infections and unwanted pregnancy. A conservative estimate of the total number of abortions among adolescents in developing countries ranges from 2.2 to 4 million annually. Research

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shows that unmet need for contraceptive among sexually active adolescents, those who express a desire to prevent pregnancy but are not using any contraception, is high in many regions (Djamba, 2004).

Many societies disapprove of premarital sex and consider reproductive health care for young people in appropriate. As a result parents, educators and health care providers often are unwilling to give young people the information and services they need.

2.1.9 TYPE OF CONTRACEPTION AND EDUCATIONAL LEVEL

Contraceptive use among women is seen as pivotal to protecting women's health and rights, impacting upon fertility and population growth, and promoting economic development particularly in much of sub-Saharan Africa. Globally, contraceptives help prevent an estimated 2.7 million infant deaths and the loss of 60 million years of healthy life (Darroch, Singh, & Nadeau, 2008).At the same time, there is a growing call for population policy to shift away from a narrow concern with improving family planning services to also consider the wider social and societal influences regarding the determinants and consequences of women's position in society (Casterline & Sinding, 2000). In this light, a large body of research has emphasized the association between increasing women's education and increasing usage of contraceptives. Education has long been associated with declining fertility and increasing contraceptive use since the publication of the results of the first World Fertility Survey in the mid-1970. Findings from across the developing world show that the better educated a women is, the more likely she is to use contraception (Ainsworth, Beegle, & Nyamete, 1996)

According to Nigeria Demographic and Health Survey, 2013 it was shown that the modern method most commonly known among women is the pill by 71 percent and injectables

and male condoms by 68 percent and 67 percent, respectively. Although the least known modern methods are male sterilization, female condoms, and implants by 16 percent, 29 percent, and 25 percent, respectively, knowledge of these three methods has increased markedly since 2008, when the proportions were 8 percent, 15 percent and 10 percent, respectively. Currently married women are less likely than sexually active unmarried women to know of a contraceptive method by 85 percent and 98 percent, respectively. Among traditional methods, withdrawal and rhythm are the most commonly known by 45 percent and 41 percent respectively among women. Overall, women know a mean of 5.6 contraceptive methods (National Population Commission and ICF International, 2014).

2.1.10 SOURCES OF INFORMATION ABOUT CONTRACEPTION AND EDUCATIONAL LEVEL

Information on where women obtain their contraceptive method is important for programme managers and implementers in designing family planning policies and programmes. According to Demographic and Health Survey, (2013) it was shown that the private medical sector is the most common source for users of modern contraceptive methods by 60 percent. Less than one-third, that is 29 percent of current users of modern methods obtain their method from the public sector, mostly public government hospitals by 17 percent. Nine percent of users of modern methods use other sources. The public sector supplies the majority of implants and IUDs by 65 percent each, injectables by 58 percent and female sterilization by 56 percent. The private sector is the main source for male condoms by 74 percent and oral contraceptives by 72 percent. Use of the public sector as a source has increased over the past five years increase from 23 percent to 29 percent (National Population Commission and ICF International, 2014).

Furthermore, the most common source of information about family planning in this study was health workers, this finding is however at variance with that of another Nigerian studies in

which the most common source of family planning information was the mass media (Ikechebelu, 2005). The important role the mass media can play in spreading family planning information cannot be underestimated. Finding is also at variance with that of Mao et al in India in which 44% of their study population got information about contraceptive methods through friends (Omolase, Faturoti, 2009). However the importance of adequate health education of the populace by health workers cannot be overemphasized .An individual that is well informed about health issue will not hesitate to seek health care when the need arises. Thus the more knowledgeable people are about reproductive health the more likely are they to access family planning.

2.2 THEORETICAL FRAMEWORK

2.2.1 LEWIN 'S THEORY

Lewin's research suggested that individual cultural habits are more pliable to change through group discussion and decision than through an approach to the individual. One of the causes of resistance to change in the group situation lies in the relationship of the individual to the values and standards of the group. Stated in theoretical terms, a level of behavior is maintained by a balance of psychological forces in a state of dynamic equilibrium. These psychological forces may facilitate or resist change in behaviour. Behavior can be changed by either increasing the facilitating change forces or reducing the resisting forces or both. In the beginning, members of the discussion group may or may not know of the advantages of family planning, or the state position in support of it.

The group is then urged by the leader to make a decision in favor of family planning, not in any way setting a group goal but as an individual decision. This procedure has the effect of unfreezing, moving, and freezing at a new level of performance. The group setting increases the

individual's readiness to change and helps him to keep close to group standards and social values. It serves as a link between motivation to become the socialist man and the action one takes to limit births. This level of freezing, of course, is supported and reinforced by the grass root workers whose job is to deliver the services. The barefoot doctor keeps a record of all those who participate in family planning. Periodically, the record is made public so that the number of adopters using various contraceptive methods is revealed. Non participation suggests one is being left out of an event which is important to the community. Family planning adoption by women signifies emancipation and renewal. But before a new behavior pattern is adopted or any action takes place, people need to perceive past error and gain a new sense of direction. All point noted that the cathartic process may lead the participants to admit some guilt even while evading some, or shock themselves out of complacency, or vent pent-up hostility until they are receptive to new facts or different points of view. Thereafter, the restructuring of attitudes and perception can begin.

2.3 CONCEPTUAL FRAMEWORK

INDEPENDENT VARIABLES   SOCIOECONOMIC VARIABLES   DEPENDENT VARIABLE

<u>**SOCIO-DEMOGRAPHIC**</u>
<u>**CHARACTERISTICS**</u>

- Age
- Ethnicity
- Occupation Status
- Wealth Index
- Region
- Place Of Residence
- Religion Etc

<u>**DEPENDENT VARIABLE**</u>

Family planning (use or non-use)

<u>**MAIN INDEPEDENT VARIABLE**</u>

Educational level

- No education
- Primary education
- Secondary education
- Higher education
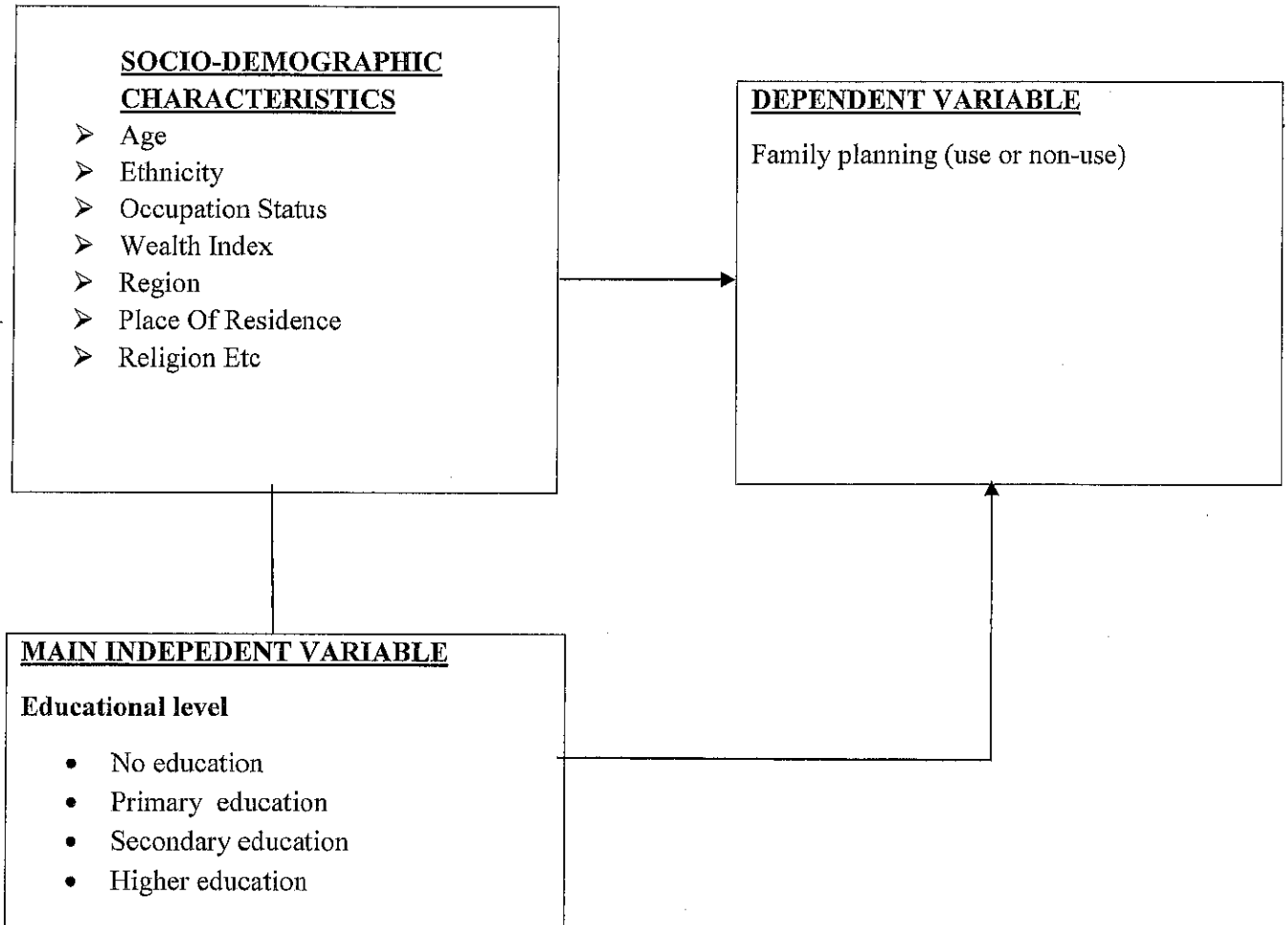
Source: Author's work, 2018

Looking at this diagram above, illustrates the independent variable and socioeconomic variable which has effect on the dependent variable positively or negatively. Socioeconomic variables(Age, working status, religion, place of residence, wealth index status) affects the independent variable (Educational level qualification) which will in turn determine the dependent variable (Family Planning) and will determine whether women use contraceptives or not. The educational status of mother matters and shows either she will use contraceptive or not. Better educated women are also argued to have more knowledge of contraceptive methods.

2.4 STATEMENT OF HYPOTHESIS

H_0: There is no significant relationship between educational level qualification and family planning.

H_1: There is significant relationship between educational level qualification and family planning.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 INTRODUCTION

This chapter seeks to explain the plan and approach for executing the research work. It covers the description of the study area, target population, source of data, sampling design and sample size, method of data collection, measurement of variables and method of data analysis.

3.1 DESCRIPTION OF THE STUDY AREA

Nigeria is a West African country located between latitudes 4°16' and 13°53' north and longitudes 2°40' and 14°41' east. It is extends from Gulf of Guinea in the south to the fringes of the Sahara Desert in the north. The country is bordered by Niger Republic and Chad in the north, Cameroon on the east, and the Republic of Benin on the west. With a population of 140,431,790 (NPC, 2006), Nigeria is the most populous country in Africa and the 14th largest in land mass (World Bank, 2012). Nigeria has great geographical diversity, with its topography characterized by two main land forms: lowlands and highlands. The uplands stretch from 600 to 1,300 meters in the North Central and the east highlands, with lowlands of less than 20 meters in the coastal areas. The lowlands extend from the Sokoto plains to the Borno plains in the North, the coastal lowlands of western Nigeria, and the Cross River basin in the east. The highland areas include the Jos Plateau and the Adamawa Highlands in the north, extending to the Obudu Plateau and the Oban Hills in the southeast. Other topographic features include the Niger-Benue Trough and the Chad Basin.

Nigeria has a tropical climate with wet and dry seasons. Its climate is influenced by the rain-bearing southwesterly winds and the cold, dry, and dusty northeasterly winds, commonly referred to as the Harmattan. The dry season occurs from October to March with a spell of cool,

dry, and dusty Harmattan wind felt mostly in the north in December and January. The wet season occurs from April to September. Nigeria marked its centenary in 2014, having begun its existence as a nation-state in 1914 through the amalgamation of the northern and southern protectorates. Before this time, there were various cultural, ethnic, and linguistic groups, such as the Oyo, Benin, Nupe, Jukun, Kanem-Bornu, and Hausa-Fulani empires. These groups lived in kingdoms and emirates with sophisticated systems of government. There were also other strong ethnic groups such as the Igbos, Ibibios, Ijaws, and Tivs. The establishment and expansion of British influence in both northern and southern Nigeria and the imposition of British rule resulted in the amalgamation of the protectorates of southern and northern Nigeria in 1914.

3.2 TARGET POPULATION

The category of eligible respondents in this study focus currently on women, which was collected by the Nigeria Demographic Health Survey (NDHS) 2013.

3.3 QUANTITATIVE DATA SOURCE

This study analyses data from individual or women recode of Nigeria Demographic and Heath Survey (NDHS) 2013 dataset.

3.4 SAMPLE DESIGN FOR THE 2013 NDHS

The sample for the 2013 NDHS was nationally representative and covered the entire population residing in non-institutional dwelling units in the country. The survey used as a sampling frame the list of enumeration areas (EAs) prepared for the 2006 National Census of the Federal Republic of Nigeria, provided by the Population Commission. The sample was designed to provide population and health indicator estimates at the national, zonal and state

levels. The sample design allowed for specific indicators to be calculated for each of the six zones, 36 states, and the Federal Capital Territory, Abuja. The 2013 NDHS sample was selected using a stratified three-stages cluster design consisting of 904 clusters, 372 in urban areas and 532 in rural areas. A representative sample of 30,327 households was selected for the survey, with a minimum target of 943 completed interviews per state. A fixed sample take of 45 households were selected per cluster.

All women who was either permanent residents of the households in the 2013 NDHS sample or visitors present in the households on the night before the survey were eligible to be interviewed(NPC &ICF international, 2014).

3.5 SAMPLE SIZE

All women age 15-49 years who were either permanent residents of the household in the 2013 NDHS sample or visitors present in the households on the night before the survey were eligible to be interviewed. The sample size of women age 15-49 years that will be used are 38,948.

3.6 VARIABLE DESCRIPTION

DEPENDENT VARIABLE

The study use the NDHS concepts of contraceptives use to denote the prevalence of family planning. the criteria of contraceptive that is type of contraception. The type of contraceptive coded by no and yes, although there are 13 different types of contraceptives as explained by the NDHS, these are pills, condoms, injectable, IUD, diaphragm, Female sterilization, periodic abstinence, withdrawal, female condom, implants, Lactational Amenorrhea Method (LAM), other modern methods and standard days methods. Women who are not using any form of contraceptives are coded No =0,and those are currently using are coded Yes = 1.

INDEPENDENT VARIBLES

The dependent variables considered are the direct proxies for level of educational qualification. This is a categorical variable that will be divided into four categories. These would be coded has no Education =0, Primary=1, Secondary=2, Education=3.

INTERVENING VARIABLE

Knowledge of contraceptive would be coded has knows no method and knows method. Women who knows no method are coded as No=0 and those that knows any methods among which are folkloric method, traditional method and modern method are coded as Yes=1

Sources of information about contraception would be from health facilities and women who received information from non-health facilities will be coded has No=0 and those that received information from health facilities would be coded as Yes=1.

NAME OF VARIABLE	VARIABLE MEASUREMENT AND CODES	DATA RECORDED AND MANIPULATION
Dependent Variable: • Contraceptive use	**V312** (Categorical)	No Yes
INDEPENDENT **VARIABLE:** • Level of education	**v106** Categorical) No education, primary, secondary, Higher.	The same categories
Socio economic factors: • Age	**V013** (categorical) 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, and 45-49.	The same categories
• Wealth index	**v190** (categorical) Poorest, Poorer, Middle, richer, richest.	Poor Middle Rich
• Place of residence	**v025** (Categorical)	The same categories

| | Urban

Rural | |
|---|---|---|
| • Occupation | **v717** (categorical)

not working, sales, professional/technical/managerial, agricultural, household and domestic service, manual, clerical | Not employed

Employed |
| **Demographic factors:**

• Religion | **v130** (Categorical)

Catholic, Other Christian, Islam, Tradition, Others | Three main ethnic group:

Yoruba, Hausa, Igbo and other Minority ethnic groups |
| • Ethnicity | **v131** (categorical)

Fulani, Hausa, Ibibio, Igala, Igbo, Ijaw/izon, Kanuri/beriberi, tiv, Yoruba, Others. | Three main ethnic group:

Yoruba, Hausa, Igbo and other Minority ethnic groups |

Source: Author's work, data extracted from NDHS

3.7 DATA PROCESSING AND ANALYSIS

The NDHS datasets from 2013 women recode will be processed and analyzed using Stata application package (STATA 13.0). The data processing will be necessary before the proper analysis in order to measure the variables in this study accurately as well as to make the analysis well presentable and easily interpretable. The tools for data manipulation were employed on the STATA application package to achieve this task.

Univariate analysis will be carried out using tables of frequency distribution to describe the background characteristics of the respondents and the bivariate analysis will be done using the Chi-square (χ^2) test to show the association between knowledge, type, source of information about contraception and educational level qualification with other socio economic characteristics that are categorical variables in the datasets. Furthermore, binary logistic regression is used in the multivariate analysis to identify the strength of association and examine the influence of educational level qualification with other socioeconomic characteristics on contraceptive use in the study area.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.0 INTRODUCTION

This chapter deals with presentation, analysis and interpretation of the data collected from secondary sources Nigeria Demographic and Health Survey (NDHS, 2013) to show the women level of education with socio-demographic characteristics effect on contraceptive use among women in Nigeria. For the purpose of analysis, this study makes use of descriptive analysis and inferential analysis. However, in supportive of descriptive statistics, inferential analysis, Pearson Chi-square test was used to ascertain relationship while binary logistic regression analysis was used in testing the study hypothesis.

4.1. Distribution of Women by Socio-Demographic Characteristics by Weighted Percentage.

Results in Table 4.1 below showed women socio-economic and demographic characteristics. Women age 15-19 years reported with higher proportion by 20.1%, age 20-24 years and age 25-29years were closely reported with same proportion by 17.4% and 18.3% respectively, age 30-34 years and age 35-39 years by 14% and 12.1% respectively, the leat were age 40-44 years and age 45-49 years by 9.3% and 8.8% respectively. Women from rural area were more reported than women from urban area by 57.9% to 42.1%. More women reported with no formal education by 37.8%, women with secondary and primary education were reported by 35.8% and 17.3% respectively, the least were women with highest level of education by 9.1%. Also women were mostly reported to be married by 71.5%, single women by 23.9% and the least were women reported to be widowed and separated by 2.5% and 2.1% respectively.

Women were mostly reported from Hausa ethnicity by 34.1%, Igbo and Yoruba ethnic group were closely related by 14.5% and 14.1% respectively. Women from northern region were more likely to report by 59.6% and those reported from southern region by 40.4%. Muslim women were mostly reported by 52%, Christian women by 47.1% and those reported to be least were traditional by 0.9%. Women reported to be rich were 43.45, those reported to be poor by 37.4% and women that were categorized into middle wealth status were 19.2%. Employed women were mostly reported by 63.2% and not employed by 36.8%. Women reported not using contraceptive were 84% and those reported using were 16%. Women reported to knows modern method by 83.8% and those reported to knows no methods were 14.8%.

Table 4.1 Distribution of Women by Socio-Demographic Characteristics by Weighted Percentage.

Background Characteristics	Frequency	Percent
Age		
15-19	7,819	20.1
20-24	6,757	17.4
25-29	7,145	18.3
30-34	5,467	14.0
35-39	4,718	12.1
40-44	3,620	9.3
45-49	3,422	8.8

Place of residence		
Urban	16,414	42.1
Rural	22,534	57.9
Level of Education		
No education	14,729	37.8
Primary	6,734	17.3
Secondary	13,927	35.8
Higher	3,558	9.1
Marital Status		
Single	9,326	23.9
Married	27,829	71.5
Widowed	967	2.5
Separated	826	2.1
Ethnicity		
Yoruba	5,482	14.1
Hausa	13,263	34.1
Igbo	5,636	14.5
Others	14,566	37.4
Region		
North Central	5,572	14.3
North East	5,766	14.8
North West	11,877	30.5

South East	4,476	11.5
South South	4,942	12.7
South West	6,314	16.2
Religion		
Christianity	18,237	47.1
Islam	20,149	52.0
Traditional	369	0.9
Wealth Status		
Poor	14,559	37.4
Middle	7,487	19.2
Rich	16,902	43.4
Employment Status		
Not employed	14,260	36.8
Employed	24,513	63.2
Contraceptive Use		
Not Using	32,722	84.0
Using	6,227	16.0
Knowledge of Contraceptive Methods		
Knows no method	5,779	14.8
Knows folkloric	272	0.7
Knows traditional	255	0.7
Knows modern	32,642	83.8
Total	**38,948**	**100.0**

Source: Author's work extracted from NDHS

4.2. Distribution of Women by Level of Education, Socio-Demographic Characteristics and Contraceptive Practice.

Result from table 4.2 below revealed the level of association between level of education with socio-demographic characteristics and contraceptive practise among women (P<0.05). This showed the association between level of education and contraceptive practice where women with no formal education did not utilize contraceptives by 43.8% and women increase the uses of contraceptives has their level of education increases, women with secondary and higher level of education uses contraceptives more by 52.6% and 21.3% respectively with a significant association (χ^2=3771.51, P=0.0000). Also, there is association between women age and contraceptive practice, has the age of women increases they tends to increase in contraceptive practice, women age 15-19 years did not uses contraceptive by 22.4% a and reduce in contraceptive use by 7.7%, women age 25-29 years did not use contraceptives by 17.8% and those reported to use it, in this age group were 21.1% with a significant association (χ^2 =860.97, P=0.0000). Women from rural areas were less to uses contraceptive to women from urban area, women from rural area do not uses contraceptive by 61.9% and women from urban area uses contraceptive by 63.6% with a significant association (χ^2 =1399.99, P=0.0000).

Furthermore, single women uses contraceptives by 28.4% and married women by 67.7% with a significant association (χ^2=103.71, P=0.0000). Hausa women did not uses contraceptive by 39.9%, women reported to use more of contraceptives were from Yoruba ethnic group by 30.8%, Igbo by 25.5% and the least were Hausa by 3.5% with a significant association (χ^2) =4140.79, P=0.0000). Women from northern region did not practice more of contraceptive by 65.9% and women from southern region practice more of contraceptives by 75.4% with a

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significant association (χ^2=4197.36, P=0.0000). Muslim women reported not to use contraceptives by 58.1% and Christian women use contraceptives by 79.6% with a significant association (χ^2=3131.70, P=0.0000). Poor women tends not uses contraceptives by 42.8% and rich women tends to use more of contraceptives by 74.2% with a significant association (χ^2=3233.35, P=0.0000). Employed women tends to uses contraceptive by 76.6% than unemployed women by 23.4% with a significant association (χ^2=565.66, P=0.0000). Women that knows no method did not use contraceptive by 17.7% and all women that knows modern method uses contraceptive by 100% with a significant association (χ^2=1291.27, P=0.0000).

Table 4.2. Distribution of Women by Level of Education, Socio-Demographic the Characteristics and Contraceptive Practice.

Background Characteristics	Contraceptive Use		Statistics
	No	Yes	
Level of Education			
No education	43.8	6.3	
Primary	16.8	19.8	χ^2=3771.51
Secondary	32.6	52.6	Pr=0.0000
Higher	6.8	21.3	
Age			
15-19	22.4	7.7	
20-24	17.1	18.6	
25-29	17.8	21.1	χ^2=860.97
30-34	13.3	17.8	Pr=0.0000
35-39	11.4	15.6	
40-44	8.7	12.3	

45-49	9.2	6.8	
Place of Residence			
Urban	38.1	63.6	χ^2=1399.99
Rural	61.9	36.4	Pr=0.0000
Marital Status			
Single	23.1	28.4	
Married	72.2	67.7	χ^2=103.71
Widowed	2.7	1.6	Pr=0.0000
Separated	2.1	2.3	
Ethnicity			
Yoruba	10.9	30.8	
Hausa	39.9	3.5	χ^2=4140.79
Igbo	12.4	25.5	Pr=0.0000
Others	36.9	40.2	
Region			
North Central	14.6	12.8	
North East	17.1	2.9	χ^2=4197.36
North West	34.2	8.87	Pr=0.0000
South East	10.0	19.1	
South South	10.8	22.7	
South West	12.9	33.6	
Religion			
Christianity	40.9	79.6	
Islam	58.1	19.9	χ^2=3131.70

Traditional	1.0	0.5	Pr=0.0000
Wealth Status			
Poor	42.8	9.0	
Middle	19.7	16.8	χ^2=3233.35
Rich	37.5	74.2	Pr=0.0000
Employment Status			
Not employed	39.3	23.4	χ^2=565.66
Employed	60.7	76.6	Pr=0.0000
Knowledge of Contraceptive Methods			
Knows no method	17.7	0.0	χ^2=1291.27
Knows method	82.3	100.0	Pr=0.0000.

Source: Author's work, data extracted from NDHS

4.3 Odds Ratio Based on Logistic Regression Analysis of Level of Education and Socio-Demographic Characteristics and Contraceptive Practice.

Table 4.3 below showed the result of binary logistic regression showed the adjusted relationship of level of education with socio-demographic characteristics on contraceptive practice among women. Result from the model showed that women with primary education were

95% likely to use contraceptives to women with no formal education (RC). Women with secondary education were 2.26 more likely to practice contraceptives to women with no formal education (RC). Women reported with highest level of education were 2.59 more likely to practice contraceptives than women with no formal education (RC).

More so, women age group 20-24 years were 3.48 more likely to practice contraceptives than women age 15-19 years (RC). Women age 25-29 years by 4.11 more likely to practice contraceptives than women age group 15-19 years (RC). Women age group 30-34 years were 4.64 more likely to uses contraceptives to women age 15-19 years (RC). Women age group 35-39 years were 5.11 more likely to use contraceptives to women in age group 15-19 years (RC). Women age group 40-44 years were 5.75 more likely to uses contraceptives to women age group 15-19 years (RC). Women age group 45-49 years were 3.38 more likely to practice contraceptives than women age group 15-19 years (RC). Married women were 29% less likely to practice contraceptive use to single women (RC). Widowed women tend to less likely to practice contraceptive use by 75% to single women (RC). Separated women tend to less likely to practice contraceptive use by 43% to single women (RC). Women from north-east were 0.45 less likely to practice contraceptive use to women from north-central (RC). Women from south-south were 43% more likely to practice contraceptive use than women from north-central (RC). Women from south-west were 34% more likely to practice contraceptive use than women from north-central (RC). Muslim women were 25% less likely to practice contraceptive use to Christian women (RC). Women in the middle wealth status were 38% more likely to practice contraceptive use than poor women (RC). Rich women were 72% more likely to practice contraceptive use than poor women (RC). Employed women reported to uses more of contraceptive by 25% than unemployed women (RC).

Table 4.3. Odds Ratio Based on Logistic Regression Analysis of Level of Education and Socio-Demographic Characteristics and Contraceptive Practice.

Background Characteristics	Odd Ratio	Lower Confidence interval	Upper Confidence interval
Level of Education			
No education(RC)	**1.00**		
Primary	1.95***	1.61	2.35
Secondary	2.26***	1.88	2.72
Higher	2.59***	2.11	3.19
Knowledge of Contraceptive Method			
Knows no method(RC)	**1.00**		
Knows method	1	0.0	0.0
Age			
15-19(RC)	**1.00**		
20-24	3.48***	2.99	4.05
25-29	4.11***	3.46	4.89
30-34	4.64***	3.89	5.54
35-39	5.11***	4.24	6.16
40-44	5.75***	4.78	6.92
45-49	3.38***	2.72	4.21
Place of Residence			
Urban(RC)	**1.00**		

Rural	0.93	0.84	1.04
Marital Status			
Single(RC)	**1.00**		
Married	0.71***	0.62	0.81
Widowed	0.25***	0.19	0.32
Separated	0.57***	0.44	0.74
Ethnicity			
Yoruba(RC)	**1.00**		
Hausa	0.12***	0.08	0.18
Igbo	0.76**	0.63	0.91
Others	0.69***	0.59	0.81
Region			
North Central(RC)	**1.00**		
North East	0.45***	0.36	0.57
North West	1.37	0.99	1.91
South East	1.23	0.97	1.54
South South	1.43***	1.21	1.69
South West	1.34**	1.13	1.59
Religion			
Christianity(RC)	**1.00**		
Islam	0.75***	0.67	0.85
Traditional	0.63	0.34	1.16
Wealth Status			
Poor(RC)	**1.00**		

Middle	1.38***	1.21	1.58
Rich	1.72***	1.49	1.99
Employment Status			
Not employed(RC)	**1.00**		
Employed	1.25***	1.12	1.39

RC means the reference categories *P<0.05 **p<0.01 ***p<0.001

Source: Author's work, data extracted from NDHS

HYPOTHESIS TESTING

H_0: There is no significant relationship between level of education and contraceptive practices.

H_1: There is significant relationship between level of education and contraceptive practices.

DECISION

From the binary logistic regression, the relationship between level of education adjusted with other socio-demographic characteristics and family planning is statistically significant in ($P < 0.05$), from this, we can conclude that there is a significant relationship between level of education (primary, secondary and tertiary) and contraceptive practice by (OR=1.95,P<0.05, CI=(1.61-2.35),OR=2.26,P<0.05, CI=(1.88-2.72),OR=2.59,P<0.05, CI=(2.11-3.19)).

4.4 DISCUSSION OF FINDINGS

The findings showed that women of reproductive age not using contraceptive was higher by 84% and using by 16%. Age group 20-34 years use more contraceptive more by 57.5%. Study carried out by Stephen, Galla and Alege (2016) stated that in Nigeria women age 20-34 years use contraceptive methods by more than 50% and this is mostly common among married women by 67.7% (Stephen,Galla andAlege, 2016)..

The result at the bivariate analysis showed that there is significant association between level of education and contraceptive practice (χ^2=3771.51, P=0.0000). Likewise the multivariate analysis showed that there is significant relationship between level of education and family planning in the study area (OR1.95=, P<0.05, CI=1.61-2.35; OR=2.26, P<0.05, CI=1.88-2.72; OR=2.59, P<0.05, CI=2.11-3.19). This was supported by a research carried out by Oyedokun (2007) who stated that better-educated women are argued to be more willing to engage in innovative behavior than less educated women and in many Third World context, the use of contraception remains innovative (Oyedokun,2007).

The limitation is that this study did not explore several aspects pertaining to family planning use including duration of use, methods discontinuation and switching, and dual methods use. Understanding these aspects is important for ongoing family planning promotion and also for further interpretation of the preferences and intentions to use family planning methods that have been reported in this study. Despite these limitation, the findings have got clear implications of level of education with other socio-demographic characteristics on family planning promotion in Nigeria.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECCOMENDATIONS

5.0 INTRODUCTION

This chapter is devoted to the presentation of the summary of findings, conclusion and recommendations drawn from the analysis of the research study. The overall objective of this study is to explore the effect of level of education on contraceptive use among women in Nigeria. The study was based on the sample size of 38, 948 women of reproductive ages in the study area.

5.1 SUMMARY OF THE FINDINGS

Based on the outcome of the analysis, the result showed women socio-economic and demographic characteristics. Women age 15-19 years were reported with higher proportion by 20.1%, age 20-24 years and age 25-29years were closely reported with same proportion by 17.4% and 18.3% respectively, age 30-34 years and age 35-39 years by 14% and 12.1% respectively, the least were age 40-44 years and age 45-49 years by 9.3% and 8.8% respectively. Women from rural area were more reported than women from urban area. More women reported with no formal education followed by women with secondary and primary education and the least were women with highest level of education. Also women were mostly reported to be married followed by single women and the least were women reported to be widowed and separated. Women were mostly reported from Hausa ethnicity, Igbo and Yoruba ethnic group were closely reported at the same proportion. Women from northern region were higher than those reported from southern region. Muslim women were mostly reported than Christian women and traditionalist. Women reported to be rich were higher than those reported to be poor

and women that were categorized into middle wealth status. Employed women were mostly reported than not employed. Women reported not using contraceptive were higher than those reported using contraceptives. Women reported to knows modern method than those reported to know no methods.

Furthermore, there is a significant association between the following socio-demographic characteristics (level of education, age, place of residence, marital status, ethnicity, region, religion, wealth status, occupation, knowledge of contraceptives) and contraceptive use when p-value less-than 0.05. There is a significant association between level of education and contraceptive use when p-value less-than 0.05.

In the multivariate analysis result showed the significant of level of education, socio-demographic characteristics and contraceptive use. Result from the model showed that women with primary education were 95% likely to use contraceptives to women with no formal education (RC). Women with secondary education were 2.26 more likely to practice contraceptives to women with no formal education (RC). Women reported with highest level of education were 2.59 more likely to practice contraceptives than women with no formal education (RC).

More so, other women socio-demographic showed a significant relationship with contraceptive use among which were the following (age, marital status, ethnicity, region, religion, wealth status and employment status) at p-value less than 0.05 percent.

5.2 CONCLUSION

It is necessary to promptly begin the promotion of the use of modern methods for family planning in order to prevent the occurrence of unwanted pregnancies, reduce the number of

abortions, and preserve the reproductive health of women. Health education significantly increases the knowledge of respondents about all types of contraceptives and significantly improves attitudes towards contraceptives and their usage. However, due to various reasons, some contraceptive methods are poorly or never used, despite health education intervention. To improve the currently low contraceptive prevalence rate in Nigeria, increased and sustained health education in family planning methods is recommended.

Thus this study concludes that base on the facts from the result that there is significant relationship between level of education and contraceptive use where p-value greater than five percent level of significant. Other socio-demographic variables (age, marital status, ethnicity, region, religion, wealth status and employment status) influencing contraceptive use where p-value less than five percent level of significant.

5.3 RECOMMENDATION

The findings suggest that there is a need to create more awareness about family planning amongst the populace through health education. The media should play a more prominent role in enlightening the populace about family planning. Based on the findings from the study some recommendations are:

1. Education should be given at the point of service to enable choice of method depending on the type of need for contraception (limiting and spacing)

2. There is need for advocacy on girl child education. From the findings, it is found that contraceptive use is low among who have no education and primary education and who are not working. Therefore, field worker should give more attention to this target reproductive age group. Appropriate intervention should also be taken to increase education among these women.

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3. There is need to economically empower women to make them self-sustaining. The results show that contraceptive use rate is low among respondents without adequate income. Social self-help support groups can be empowered through the process of starting businesses, which would put more income in women's hands.

4. It is important to stress men's shared responsibility and promote their active participation in responsible parenthood and sexual and reproductive behavior, including family planning and other reproductive rights. Men should be continuously involved in family planning education.

5. Research should be replicated in a rural set up. Further research will also be needed to find out the status of reproductive health of adolescents, premarital sex and knowledge of the risk of early pregnancy.

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