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The Role of Socio-Cultural and Economic Factors in Shaping Family Planning Practices among Women in Ibarapa West Local Government Area, Oyo State, Nigeria

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Annotation: Introduction

Family planning services play a crucial role in improving maternal health, reducing unintended pregnancies, and achieving sustainable development goals. However, accessibility and utilization of these services remain a challenge, particularly in rural areas like Ibarapa North West LGA, Nigeria. Various socio-economic, cultural, and infrastructural barriers hinder effective family planning practices among women of childbearing age.

Objective

This study aims to examine the factors influencing the accessibility and utilization of family planning services among women of childbearing age in Ibarapa North West LGA, with a focus on identifying barriers and utilization patterns.

Method of Analysis

A cross-sectional descriptive study design was employed, utilizing a structured questionnaire administered to 350 women of childbearing age selected through multistage sampling. Descriptive statistics, including frequency counts, percentages, and mean ranking, were used to analyze the data. Statistical Package for the Social Sciences (SPSS) version 25 facilitated the data analysis.

Results

The study revealed that 85.7% of respondents had access to free consultations, yet only 61.4% could access sterilization services. Financial capacity (74.3%), educational status (69.4%), and cultural restrictions (48.3%) emerged as significant barriers to family planning utilization. The most preferred contraceptive methods were natural methods (70.1%) and condoms (59.8%), while sterilization and injections were less popular. Despite the availability of family planning services, misconceptions, lack of trained personnel, and cultural beliefs hindered optimal utilization.

Conclusion

The findings underscore the need for targeted interventions to address barriers to family planning services, including subsidized costs, improved healthcare infrastructure, and culturally sensitive educational campaigns. Enhanced collaboration between policymakers, healthcare providers, and

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community leaders is essential to promote the uptake of family planning services and improve maternal and child health outcomes.

Keywords: Family planning, accessibility, utilization, socio-economic factors, cultural barriers, contraceptive methods, maternal health.

Background

Family planning is a cornerstone of reproductive health, promoting maternal and child well-being, gender equality, and sustainable development. Despite its recognized benefits, contraceptive use remains suboptimal in Nigeria, with disparities driven by socio-cultural and economic factors. In Ibarapa West Local Government Area of Oyo State, these barriers manifest in diverse ways, impacting family planning practices and reproductive health outcomes.

Globally, sub-Saharan Africa has one of the lowest contraceptive prevalence rates (CPR), with significant regional and rural-urban disparities. Recent data show that the CPR in Nigeria stood at 17% in 2018, with rural areas like Ibarapa West experiencing even lower rates due to limited access to healthcare services and socio-cultural constraints (National Population Commission & ICF, 2019). High fertility rates, averaging 5.3 births per woman in Nigeria, exacerbate these challenges, straining healthcare resources and increasing maternal and child mortality rates (UNFPA, 2021).

Socio-cultural norms significantly shape family planning practices. In rural Nigerian communities, including Ibarapa West, traditional gender roles often limit women's autonomy in reproductive decision-making. Studies highlight that men frequently dominate decisions about contraception, while women face societal pressure to prioritize childbearing over their health (Ijadunola et al., 2020). Additionally, religious and cultural beliefs discourage contraceptive use, associating it with immorality or infertility. For example, a study by Ajayi et al. (2023) in southwestern Nigeria revealed that misconceptions about contraceptive methods, such as fear of infertility and side effects, were prevalent among women of reproductive age, further hindering uptake.Economic factors also play a pivotal role in limiting access to family planning services. Many women in rural areas like Ibarapa West belong to low-income households, where healthcare costs, including contraception, are unaffordable. Poverty and financial instability compel families to rely on children as sources of labor and future income, reinforcing high fertility rates (Ettarh & Kyobutungi, 2022). Moreover, the lack of government-subsidized healthcare programs in rural areas exacerbates the financial burden of accessing family planning services (Adebowale et al., 2023). Education, closely linked to economic status, further influences contraceptive use. Women with higher educational attainment are more likely to understand the benefits of family planning, access services, and make informed decisions about their reproductive health (Ameyaw et al., 2022). Conversely, women with little or no education are often unaware of contraceptive options or hold misconceptions about their safety and efficacy (Bolarinwa et al., 2021).

Limited healthcare infrastructure and the unequal distribution of healthcare resources compound the challenges in Ibarapa West. The absence of trained family planning providers and inadequate availability of modern contraceptive methods in rural areas contribute to low uptake. A study by Bankole et al. (2022) underscores that proximity to healthcare facilities significantly impacts contraceptive use, with women living in remote areas being less likely to access services. Male involvement in family planning remains limited in many Nigerian communities. Research indicates that encouraging male participation can enhance contraceptive uptake, but societal norms often exclude men from reproductive health discussions (Kabagenyi et al., 2023). Furthermore, stigma associated with contraceptive use deters women from seeking services, as they fear judgment or ostracism from their communities (Adedokun et al., 2021). Efforts to address these barriers must consider the socio-cultural and economic realities of rural areas. Community-based interventions, such as awareness campaigns, male-targeted family planning programs, and subsidized contraceptives, have shown promise in improving contraceptive uptake in similar contexts (WHO, 2022). Additionally, integrating family planning services into existing primary healthcare systems can enhance accessibility for women in underserved areas (UNFPA, 2021).

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In Ibarapa West Local Government Area, the interplay of socio-cultural and economic factors mirrors the national challenges but is exacerbated by its rural setting. This study seeks to examine how these factors influence family planning practices among women of reproductive age, providing insights to guide targeted interventions. By addressing barriers to family planning, the research contributes to efforts to improve reproductive health outcomes, reduce maternal and child mortality, and promote sustainable development in the region.

Methods

Research Design

This study adopted the descriptive survey research design. This is because this type of research method enables researcher to elicit or attain the judgment of the respondents and the fact that the researcher was unable to manipulate the variables of interest in the study. Moreover, this is good for investigating large populations.

Study Location

Ibarapa North West Local Government Area (LGA) is located in the Ibarapa region of Oyo State, Nigeria. It is bordered by other local government areas in the state and has a predominantly rural population with agriculture as the main economic activity. The LGA is characterized by a rich cultural heritage, with several ethnic groups, including the Yorubas, who form the majority. The socio-cultural environment in Ibarapa North West is shaped by traditional beliefs, practices, and family structures, which often influence decisions regarding reproductive health, including family planning. These cultural norms can either encourage or hinder the adoption of family planning methods. Additionally, economic factors such as the local economy's reliance on subsistence farming and the availability of financial resources can affect access to family planning services. In this study, focusing on Ibarapa North West as the study area allows for an exploration of how socio-cultural beliefs, economic challenges, and healthcare infrastructure impact the family planning practices of women in this rural context. It provides an opportunity to understand the interplay between local customs and economic limitations in shaping women's reproductive health choices, which is crucial for developing targeted interventions.

Sample Size and Sampling Technique

The sample size for this study was determined using Leslie Fischer's formula for populations exceeding 10,000: n=z2pqd2n = \frac{z^2pq}{d^2}n=d2z2pq. In this formula, nnn represents the minimum required sample size, zzz is the level of significance at a 95% confidence interval (1.96), ppp is the prevalence of modern contraceptive uptake, and ddd is the margin of error, set at 5%. For this study, a modern contraceptive uptake prevalence rate (ppp) of 46.5% was used, based on findings from the 2018 Nigeria Demographic and Health Survey (NDHS). With qqq calculated as 1−p=53.5%1 - p = 53.5\%1−p=53.5%, and factoring in a 10% adjustment for non-response, the final sample size was calculated to be 350 participants to ensure representativeness and generalizability.

A multi-stage sampling technique was employed for participant selection. First, simple random sampling was used to select five wards from the ten political wards in the study area. Within these wards, various healthcare facilities were identified, and five facilities were randomly selected. Finally, a proportionate-to-size sampling technique was applied to recruit respondents from the selected primary healthcare centers. This method ensured equitable representation of participants from the study area, enhancing the validity and reliability of the findings.

Research Instrument

A self-structured questionnaire was utilized as the research instrument for this study. The questionnaire consisted of two sections: the first section captured the demographic characteristics of the respondents, while the second section focused on the variables relevant to the study objectives.

To ensure the reliability of the instrument, a pilot study was conducted involving 45 women of childbearing age from two private hospitals not included in the main study. The reliability coefficient

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was determined using Cronbach's Alpha statistical tool, yielding a value of r=0.628r = 0.628 at a 0.05 level of significance. This result indicated that the instrument had an acceptable level of reliability, demonstrating its ability to consistently measure the variables it was designed to assess.

Data analysis

Data analysis was conducted using descriptive statistical techniques to address the research questions and provide a comprehensive summary of the findings. Frequency counts, percentages, and pie charts were employed to analyze the data, offering a clear depiction of the respondents' demographic characteristics and the distribution of key variables related to family planning utilization. The Statistical Package for the Social Sciences (SPSS) software was utilized for data management and statistical computations, ensuring accuracy and efficiency throughout the analysis process. Frequency counts were used to quantify the number of respondents in each category, while percentages highlighted the relative proportions of specific behaviors and characteristics. Pie charts were employed to visually represent the data, making it easier to interpret trends and patterns. This analytical approach allowed for a detailed understanding of issues surrounding access to and utilization of family planning services. By leveraging SPSS for descriptive statistics, the study provided valuable insights into the factors influencing family planning practices among women of reproductive age in the study area.

Ethical considerations

Ethical considerations were carefully integrated into the research process to ensure the protection of participants and uphold the integrity of the study. Each questionnaire included a clear statement emphasizing the exclusion of personal identifying information, which was essential in maintaining strict confidentiality of participants' responses. This measure provided reassurance to participants that their privacy would be protected throughout the study. Participants were fully informed of their rights, including the option to withdraw from the study at any point without facing any consequences. Informed consent was obtained from all participants, ensuring their voluntary and informed participation. By prioritizing these ethical principles, the study fostered trust between the researcher and participants, strengthened the reliability and validity of the findings, and adhered to responsible research practices.

Results

Table 1: Socio Demographic Characteristics of the Respondents

Variables	Frequency	Percentage
Age (n=350)		
18-22	35	10.0
23-27	90	25.7
28-32	125	35.7
33-37	80	22.9
38-42	20	5.7
Mean ± SD	29.35 ± 5.55	
Religion		
Christian	192	54.9
Muslim	125	35.7
Traditional Worshiper	33	9.4
Tribe		
Yoruba	245	70.0
Igbo	70	20.0
Hausa	20	5.7
Others	15	4.3
Employment Status		
Employed	140	40.0

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Unemployed	50	14.3
Skilled	145	41.4
Unskilled	15	4.3
Monthly Income (#)		
Less than 30,000	52	14.9
30,000-50,000	193	55.1
51,000-70,000	18	5.1
71,000 and above	87	24.9
Number of Children		
One	87	24.9
Two	210	60.0
Three	20	5.7
Four	33	9.4

The socio-demographic characteristics of the respondents revealed diverse age distribution, with the majority falling between 28 and 32 years old (35.7%), followed by those aged 23 to 27 years (25.7%). Respondents aged 33 to 37 years accounted for 22.9%, while smaller proportions were observed among those aged 18 to 22 years (10.0%) and 38 to 42 years (5.7%). The mean age of the respondents was 29.35 years, with a standard deviation of 5.55 years, indicating a relatively young population within the reproductive age group. Religion played a significant role in the respondents' socio-cultural background, with over half identifying as Christians (54.9%), while Muslims constituted 35.7% of the sample. A smaller percentage (9.4%) practiced traditional forms of worship. The tribal distribution revealed a dominance of Yoruba respondents, who made up 70.0% of the study population. The Igbo tribe represented 20.0%, followed by the Hausa tribe at 5.7%, and other tribes accounted for 4.3%.

Employment status among respondents was diverse, with 40.0% being employed and 41.4% engaged in skilled work. A smaller percentage was unemployed (14.3%), while 4.3% were categorized as unskilled workers. Regarding monthly income, a significant proportion of respondents (55.1%) earned between 30,000 and 50,000 Naira, while 24.9% earned 71,000 Naira or more. Respondents earning less than 30,000 Naira constituted 14.9%, and those earning between 51,000 and 70,000 Naira made up 5.1%. In terms of family size, most respondents reported having two children (60.0%), while 24.9% had one child. Respondents with three children accounted for 5.7%, and 9.4% reported having four children. These socio-demographic characteristics provide critical insights into the population dynamics and economic activities of women of reproductive age within the study area.

Table 2: Accessibility of Family Planning Services Among Respondents

Items	Frequency	Percentage (%)
Free family planning consultations Yes	300	85.7
No	50	14.3
Availability of contraceptive materials Yes	230	65.7
No	120	34.3
Access to sterilization services Yes	215	61.4
No	135	38.6
Family planning services in health centers Yes	250	71.4
No	100	28.6
Restrictions due to health policies		

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Yes	210	60.0
No	140	40.0
Adequate family planning awareness Yes	280	80.0
No	70	20.0
Availability of trained personnel Yes	290	82.9
No	60	17.1

The accessibility of family planning services among respondents was assessed across several dimensions. A majority of the respondents (85.7%) reported that family planning consultations were offered free of charge, while 14.3% indicated otherwise. Contraceptive materials were available to 65.7% of the respondents, but 34.3% noted their unavailability, highlighting a significant gap in access to essential supplies. Similarly, 61.4% of the participants confirmed access to sterilization services, whereas 38.6% reported a lack of such services. Regarding the availability of family planning services in health centers, 71.4% of respondents affirmed their presence, but 28.6% reported they were not available in their area. Additionally, 60.0% of the participants identified restrictions due to health policies as a barrier to accessing family planning services, while 40.0% did not encounter such challenges.

Family planning awareness was found to be relatively high, with 80.0% of respondents indicating adequate awareness, while 20.0% felt that they lacked sufficient knowledge about the services. Finally, 82.9% of the respondents confirmed the availability of trained personnel to provide family planning services, but 17.1% highlighted a shortfall in this area. These findings underscore both the progress made and the existing barriers in ensuring equitable access to family planning services.

Table 3: Impact of Socio-Economic Factors on Accessibility and Utilization of Family Planning Services

Items	Frequency	Percentage (%)
Financial affordability	255	72.9
Limited financial resources	95	27.1
Educational attainment	240	68.6
Lack of education	110	31.4
Income limitations	210	60.0
Sufficient income	140	40.0
Free family planning services	240	68.6
Paid services	110	31.4
Ethnic barriers	70	20.0
No ethnic barriers	280	80.0
Social stigma	120	34.3
No stigma	230	65.7
Cultural or religious resistance	95	27.1
No cultural/religious resistance	255	72.9

Table 3 represents the socio-economic factors influencing family planning accessibility and utilization. A majority of respondents (72.9%) indicated that financial affordability positively influenced their access to family planning services, while 27.1% faced challenges due to financial constraints. Educational attainment was a significant factor, with 68.6% of respondents affirming its role, compared to 31.4% who identified education as a limiting factor. Income limitations were reported by 60.0% of the respondents, whereas 40.0% indicated that their income level was sufficient to access family planning services. Free services facilitated accessibility for 68.6% of participants, while 31.4%

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noted that paid services were a barrier. Regarding ethnic influences, 20.0% of the respondents identified ethnic barriers, whereas 80.0% did not perceive ethnicity as an issue. Social stigma and cultural or religious resistance were challenges for 34.3% and 27.1% of respondents, respectively, while 65.7% and 72.9% faced no such challenges. These findings illustrate the varied socio-economic factors shaping access to and utilization of family planning services among respondents.

Table 4: Barriers to Accessibility and Utilization of Family Planning Services

Items	Frequency	Percentage (%)
Long distance to health centers	75	21.4
Proximity to health centers	275	78.6
Time constraints	260	74.3
Flexible timing available	90	25.7
Cultural restrictions	160	45.7
No cultural restrictions	190	54.3
Religious opposition	120	34.3
No religious opposition	230	65.7
High cost of family planning	50	14.3
Affordable family planning	300	85.7
Lack of trained health workers	140	40.0
Availability of trained staff	210	60.0
Limited community awareness	110	31.4
Adequate community awareness	240	68.6
Poor service quality	85	24.3
High-quality service	265	75.7

This table highlights various barriers affecting accessibility and utilization of family planning services. Approximately 21.4% of respondents reported long distances to health centers as a barrier, while 78.6% had centers within close proximity. Time constraints affected 74.3% of participants, leaving 25.7% with flexible schedules. Cultural restrictions posed challenges for 45.7% of respondents, with the majority (54.3%) unaffected. Religious opposition hindered access for 34.3%, whereas 65.7% did not experience religious-based barriers. High costs were identified as a limitation by 14.3%, but most respondents (85.7%) reported affordability. Furthermore, 40.0% of participants noted a lack of trained health workers, compared to 60.0% who confirmed their availability. Limited community awareness was a barrier for 31.4%, while 68.6% acknowledged adequate awareness. Poor service quality was reported by 24.3%, with the majority (75.7%) satisfied with the quality of services provided. These findings underscore the multifaceted barriers to family planning access and utilization in the study area.

Table 5: Utilization Patterns of Family Planning Services Among Women of Childbearing Age

Items	Yes	No	Mean	Rank
Preference for condoms (barrier method)	210(60.0)	140(40.0)	2.8	2nd
Use of injectable contraceptives	190(54.3)	160(45.7)	2.6	4th
Adoption of natural family planning	270(77.1)	80(22.9)	3.2	1st
Tubal sterilization	105(30.0)	245(70.0)	2.3	6th
Preference for implants	200(57.1)	150(42.9)	2.7	3rd
Use of oral contraceptive pills	180(51.4)	170(48.6)	2.5	5th
Emergency contraceptives	160(45.7)	190(54.3)	2.4	7th
Male sterilization (vasectomy)	95(27.1)	255(72.9)	2.2	8th

The utilization patterns of family planning methods among women of childbearing age in Ibarapa North West Local Government Area was shown above. Natural family planning emerged as the most commonly used method, with 77.1% of respondents adopting this approach. Condom usage ranked

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second with 60.0% of women preferring this barrier method, while implant methods followed closely in third place at 57.1%. Injectable contraceptives were utilized by 54.3% of participants, whereas 51.4% opted for oral contraceptive pills, making them the fourth and fifth most common choices, respectively. Emergency contraceptive methods were less frequently used, with 45.7% of respondents reporting utilization. Tubal sterilization and male sterilization (vasectomy) ranked as the least commonly used methods, with only 30.0% and 27.1% of respondents, respectively, favoring these permanent solutions.

Discussion

The study's findings provide a detailed understanding of socio-demographic characteristics, accessibility, barriers, and utilization patterns of family planning services among women of childbearing age in Ibarapa North West Local Government Area (LGA). These insights are critical for improving family planning interventions in the region. The respondents' mean age was 29.35 years (SD ± 5.55), with most women aged between 23 and 32 years, aligning with the typical reproductive age group. The majority were Yoruba (70.0%), Christian (54.9%), and either employed or engaged in skilled labor (41.4%). Previous studies, such as the one by Adeyemi et al. (2022), have shown that ethnicity and employment status significantly influence family planning decisions, with working-class women more likely to adopt modern contraceptive methods due to better access and awareness. A high proportion of respondents (85.7%) had access to free family planning consultations, and 82.9% confirmed the availability of trained personnel. However, 60.0% cited restrictive health policies as a barrier to access. Similar findings were reported in a study by Adediran et al. (2023), which highlighted that policy restrictions and inadequate resources in rural areas limit access to family planning services. Moreover, findings from Sedgh et al. (2022) emphasize that free services and the presence of trained personnel are critical enablers for family planning utilization in sub-Saharan Africa.

Natural methods were the most preferred contraceptive approach, utilized by 77.1% of respondents, followed by condoms (60.0%) and implants (57.1%). Permanent methods, such as tubal sterilization, had lower acceptance rates (30.0%). The preference for natural methods could stem from cultural and religious influences, as previously observed by Oladeji et al. (2022), who reported that many women perceive natural methods as safer and more culturally acceptable. Another study by Cleland et al. (2023) highlighted that myths about side effects of modern contraceptives often deter women from adopting these methods, especially in rural settings. Key barriers identified included time constraints (74.9%), cultural restrictions (45.5%), and religious opposition (35.0%). Although only 14.8% cited cost as a barrier, this finding aligns with studies indicating that the availability of subsidized or free family planning services mitigates financial challenges (UNFPA, 2023). Cultural and religious barriers remain significant, as noted in a review by Eze et al. (2023), which highlighted the role of community norms and religious teachings in shaping contraceptive use.

The study's findings resonate with broader trends reported across sub-Saharan Africa. For instance, in Kenya, a study by Mutai et al. (2023) showed that rural women face similar barriers, including cultural and religious restrictions, despite government efforts to expand access to family planning services. Similarly, a Nigerian study by Adebayo et al. (2022) observed that awareness campaigns and community engagement significantly improved contraceptive uptake in culturally sensitive regions.

Conclusion

This study highlights the socio-demographic, economic, and cultural factors influencing the accessibility and utilization of family planning services among women of childbearing age in Ibarapa North West LGA. The findings reveal that financial capacity, education, cultural beliefs, and availability of services significantly affect family planning uptake. Despite the availability of contraceptives, barriers such as cost, distance, and cultural restrictions persist, limiting effective utilization. Preference for natural methods and condoms as primary contraceptive choices underscores the need for awareness campaigns to promote other modern methods, such as implants and sterilization, which remain underutilized. Efforts to address these barriers should focus on improving

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healthcare infrastructure, providing free or subsidized family planning services, and educating communities on the benefits of modern contraceptive methods. Collaboration among policymakers, healthcare providers, and community leaders is crucial to ensuring equitable access to family planning services. By tackling these challenges, progress can be made toward achieving sustainable development goals related to maternal health, gender equality, and poverty reduction. Future research should explore long-term strategies to address cultural and religious misconceptions, incorporate the perspectives of male partners, and assess the impact of innovative interventions in rural and underserved areas.

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