



## **Factors Limiting Modern Contraceptive Use in Zing Local Government Area of Taraba State, Nigeria**

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### **Authors' contributions**

*This work was carried out in collaboration between both authors. Both authors read and approved the final manuscript.*

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### **ABSTRACT**

This study was set out to find out factors influencing contraceptive use among women in Zing Local Government Area of Taraba State, Nigeria. The study was triggered by the fact that despite various interventions and awareness on the need to use contraceptives, the usage is still very low in Nigeria, most especially the Northern Nigeria which Zing Local Government Area of Taraba State is inclusive. The broad aim of the study was to investigate the factors influencing contraceptive use among women in Zing Local Government of Taraba State, however, the specific objectives were: to find out socio-economic factors, cultural factors, and religious factors influencing contraceptives among women in Zing L.G.A. Taraba. A review of the related literature was based on the objectives of the study. The data were collected mainly through questionnaires, while official documentation and observations were employed as supplementary tools. The data were analyzed via the Statistical Package for Social Sciences (SPSS). The study finds out that contraceptive use is against religious teachings and not approved by religion furthermore cultural factors that influence contraceptives are demand for children, partners' decisions, contraceptives limits population infertility, myths, and misinformation. Other reasons for the disapproval of contraceptives include serious side effects, and there is no need for it since they are legally married and children are gifts from God. The study however recommended that Public enlightenment on contraception should start from antenatal clinics, religious leaders should be involved as change agents for shaping norms and influencing Behaviours related to family planning and contraceptives as well as the need for stakeholders in the state to find ways of increasing the use of family planning services by making it attractive to the women through incentives, especially among those living in the rural areas of the state.

*Keywords: Contraceptives; women; cultural; religious factors.*

## 1. INTRODUCTION

Contraceptives are devices, drugs, or methods for preventing pregnancy, either by preventing the fertilization of the female egg by the male sperm or by preventing implantation of the fertilized egg [1]. Contraception stands as the morally most acceptable form of fertility control that possibly attracts less criticism when compared to that which depends on the destruction of embryos (Mason et al. 2013) cited in [2]. Contraception use however has to do with deliberate employment of a technique or device to prevent conception.

Modern contraceptive has been generally recognized as one of the most cost-effective approaches to improve reproductive health and promote socio-economic development worldwide. In addition to preventing unintended pregnancies and thus reducing the risk of illegal abortions and maternal mortality, the control of fertility permitted by modern contraceptives also makes a major contribution to women's access to opportunities for education and empowerment [3]. Contraceptive has many health benefits, such as avoiding unplanned pregnancy, ensuring optimal birth spacing, reducing maternal and infant mortality, and improving the lives of women and children in general [4] equally, Like all medications, contraceptives can have side effects. The most common side effects are spotting or bleeding between periods (this is more common with progestin- only pills), sore breasts, nausea, or headache [5].

Worldwide, in 2019, 49 per cent of all women in the reproductive age range (15-49 years) were using some form of contraception, an increase from 42 per cent in 1990. Although use of modern contraception in 2019 was lower in sub-Saharan Africa compared to other regions, a number of countries in this region have seen a significant increase in recent years [6].

Demographic factors influencing contraceptive use may include age, family size, distance from a health care facility and education level. Additionally, contraceptive is influenced by women's norms and perceptions. Women may face cultural or religious pressures against using contraceptive, often rooted in beliefs that contraceptive leads to unfaithfulness or interferes with goals of procreation. Side effects of contraceptive, either experienced or anticipated,

have been identified as a common reason that women either choose not to start or discontinue contraceptives. Side effects include menstrual changes (heavier bleeding, amenorrhea or oligomenorrhea), changes in weight, headaches, dizziness, nausea, and cardiovascular impacts. In addition, women may harbor fears of long-term effects of contraceptive use, such as infertility and childbirth complications. A 2014 systematic review found a significant proportion of women attributed their unmet need for family planning to a fear of side effects: 28% in Africa, 23% in Asia, and 35% in Latin America and the Caribbean (WHO, 2018). A fear of side effects may occur when a woman or someone she knows has experienced side effects with a method, or when rumors or overestimations or rare complications are considered factual (Schrumpp et al., 2020).

Despite the many supplies and demand-side interventions aimed at increasing contraceptive uptake, the modern contraceptive prevalence rate (mCPR) has remained very low in Nigeria. Nigeria's mCPR is one of the lowest globally, currently estimated at 9.8%. In comparison, the mCPRs of other sub-Saharan African countries, such as Rwanda and Malawi, are much higher (45% and 62%, respectively). The health and socioeconomic benefits of contraceptive have been well-documented. These benefits include improved quality of life, increased well-being of families and communities, improved maternal and newborn health outcomes, reduced poverty, increased female education, and additional non-contraceptive health benefits of hormonal methods [7].

The use of modern contraceptive methods translates into the prevention of unwanted pregnancy and subsequent abortions. Unfortunately contraceptive is still low in the North Eastern Nigeria. If contraceptive in the population increases among Nigerian men and women who are sexually active, there will be a significant reduction in unwanted pregnancies and abortions leading to reduced maternal mortality. In Nigeria, reasons for non-use of contraceptives have included fear of side effects, partner objection, and religious conflicts, with the fear of side effects largely fueled by misinformation. The effects of contraceptives on women's health are becoming more evident and the side effects of the use of hormonal contraceptives are enormous, such as rashes, loss of libido, discoloration of the skin

(melasma/chloasma), changes in weight or appetite, nausea, vomiting, migraines, mood changes (including depression), aggravation of varicose veins, gastrointestinal symptoms (pain, cramps, bloating), spotting, vaginitis (yeast infection), vitamin deficiencies, water retention, vision impairment, liver malfunction. Furthermore, numerous studies show increased risk of cancer and increased risk of blood clots resulting from the use of hormonal contraceptives [7,4,8,9].

The North Eastern states has one of the lowest contraceptive where about 83.4% of women currently married or in union not using any form of contraceptive (National Bureau of Statistics (NBS) and United Nations Children's Fund (UNICEF), 2018). Furthermore, according to same report, about 93.3% of the married women or in union are not using any form of contraceptive in Taraba State. In a similar development, according to NDHS, 2018, only 8%-13% of women currently married or in union do use any form of contraceptive. The Despite the fact that official data or statistics on contraceptive in Zing local government seems to be unavailable at the moment, it is against this background that this study is set to investigate factors influencing the use of contraceptives among couples, in Zing Local Government, to understand the general trend.

### 1.1 Objectives

1. Examine the socio-economic factors influencing contraceptives among couples in Zing L.G.A. Taraba State.
2. Examine the cultural factors influencing contraceptive in Zing L.G.A. of Taraba State
3. What are the religious factors influencing contraceptive in Zing L.G.A. of Taraba State?

## 2. METHODOLOGY

This study adopted a survey design because it is community-based. The study was conducted in the households of selected communities in Zing L.G.A. The study was conducted in Zing Local Government Area of Taraba State, Nigeria.

### 2.1 Study Area

Zing Local Government Area is located in Taraba State, in the northeastern part of Nigeria. It is situated in the northern part of the State, in

the northern senatorial district of Taraba State. Zing township is located about sixty-two (62) kilometers in the north of Jalingo metropolis, the State Capital. As at January 2021, 58 health facilities from zing local government were listed in the directory of health facility in Taraba State. By ownership 53 are public health facilities while 2 % are private health facilities. By types of the total 58 health facilities in the local government 57 are primary health care facilities spread across the wards and one secondary health facility i.e. the general hospital located at the local government headquarters with no single tertiary health facility. However family planning services is obtainable only in the Health maternity centers which are located one in each ward and the General hospital in Zing.

### 2.2 Study Population

The population for the study was made up of couples and those that ever married within childbearing age (Women aged 15-49 years). This population and the age bracket was chosen because 15-49 years is demographically considered as the childbearing age that is age group that women can conceive and perhaps give birth.

### 2.3 Sample Size Estimation

In determining the sample size, the Taro Yamane's, formula (2001) was applied to determine the sample size.

The Taro Yamane's Formula state thus:

$$n = \frac{N}{1 + N(e)^2}$$

Where n = Sample size

N = Total Population

1 = Statistical Constant

e = the assume error of margin or level of significance which is taken as 0.05 i.e. 95% confidence level.

In calculating the sample size, the result is as follows:

Zing local government has a population of 127,363

$$n = \frac{127,363}{1 + 127,363 (0.05)^2}$$

$$n = \frac{22948000}{127,364 \times 0.0025}$$

$$n = \frac{127,363}{318.4}$$

$$n = 400$$

A multistage sampling technique was applied to select 400 respondents for the study. Zing Local Government Area is made up of ten (10) wards which include Zing A, Zing A2, Zing B, Kakulu, Bitako, Lamma, Dingding, Bubong, Monkin A, Monkin B and Yakoko ward respectively. First stage included selection of four wards from the 10 wards using simple random sampling (SRS) by balloting. The wards were basically divided into Zing south and Zing metropolis, three (3) wards were selected from Zing south because they constitute largely rural areas characterized by inadequate infrastructure, illiteracy and poverty while one (1) ward was selected from Zing metropolis which is a semi-urban area.

The second stage was the selection of four (4) settlements from each of the 3 selected wards using simple random sampling by balloting where twenty five (25) respondents will be selected. Finally, the selection of households was carried out by a systematic random sampling technique after conducting a household census that provided a sampling frame. The final selection of study participants was done at the household level. In each selected household, an eligible respondent that give informed consent was selected. In households with more than one eligible respondent, only one participant was selected by balloting which was done in the presence of all of them.

## 2.4 Instruments of Data Collection

The major instrument for collecting data for this study was the questionnaire. The questionnaire which is a structured schedule and which is essentially a quantitative instrument was the most suitable for obtaining data from a representative sample of people which could be used to describe or analyze a larger population.

## 2.5 Data Analysis

The data from the questionnaire was processed with the help of the Statistical Package for the Social Sciences (SPSS). Frequency distribution tables and descriptive statistics like percentages, graphs, and charts were used to describe the characteristics in the study.

## 2.6 Ethical Considerations

The study abide by the principles governing human subject research. Ethical approval would be sought from the Federal Medical Center, Jalingo ethical review board. The principles of confidentiality, beneficence, non-maleficence, and voluntariness were dutifully observed in the course of the study.

## 3. PRESENTATION OF RESULTS

**Table 1. Age of Respondents**

| Age          | Frequency  | Percentage   |
|--------------|------------|--------------|
| 15-19        | 39         | 10.6         |
| 20-24        | 48         | 13.0         |
| 25-29        | 69         | 18.7         |
| 30-34        | 72         | 19.5         |
| 35-39        | 57         | 15.4         |
| 40-45        | 45         | 12.2         |
| 45-49        | 39         | 10.6         |
| <b>Total</b> | <b>369</b> | <b>100.0</b> |

*Source: Field Work 2021*

Table 1 shows the age distribution of the respondents. The table indicates that 10.6% of the respondents are within the age category of 15-19 years, 13.0% falls within 20-24 years while 18.7% are within the age category of 25-29 years. Furthermore the majority of the respondents that is 19.5% are within the age category of 30-34 years, 15.4% within the age category of 35-39 years, 12.2% within the age category of 40-45% while 10.6% are within the age category of 45-49 years. This implies that majority of the respondents are within the age bracket of 30-34 years.

The marital status of the respondents above shows that overwhelming majority which constitute 79.4% of the respondents are married, 7.6% are single, 3.0% are Divorced, 5.7% are separated while 4.4% are widows. This indicates that majority of the respondents are married.

The distribution by level of education according to Table 3 shows that 5.1% had no any form of formal education, 3.0% had Islamic education, 19.3% had first school leaving certificate, majority of the respondents which constitute 36.9% had secondary certificate, 26.3% had Ordinary Diploma (OND) or Nigerian Certificate in Education (NCE), 8.4% had Higher National Diploma or Bachelor of Science Degree (B.sc), while 1.1% had Master of Science Degree (M.sc). This implies that majority of the

respondents have secondary certificate as their highest educational qualification. This explains one of the reasons why Zing as a local government area is regarded as one of the low educational area in the state.

**Table 2. Marital Status of Respondents**

| Marital status | Frequency  | Percentage   |
|----------------|------------|--------------|
| Married        | 293        | 79.4         |
| Single         | 28         | 7.6          |
| Divorced       | 11         | 3.0          |
| Separated      | 21         | 5.7          |
| Widowed        | 16         | 4.4          |
| <b>Total</b>   | <b>369</b> | <b>100.0</b> |

Source: Field Work 2021

**Table 3. Educational level of respondents**

| Educational Qualification | Frequency  | Percentage   |
|---------------------------|------------|--------------|
| No formal Education       | 19         | 5.1          |
| Islamiyya School          | 11         | 3.0          |
| Primary Education         | 71         | 19.3         |
| Secondary Education       | 136        | 36.9         |
| OND/NCE                   | 97         | 26.3         |
| B.sc/HND                  | 31         | 8.4          |
| M.sc                      | 4          | 1.1          |
| <b>Total</b>              | <b>369</b> | <b>100.0</b> |

Source: Field Work 2021

The distribution by level of education according to Table 3 shows that 5.1% had no any form of formal education, 3.0% had Islamic education, 19.3% had first school leaving certificate, majority of the respondents which constitute 36.9% had secondary certificate, 26.3% had Ordinary Diploma (OND) or Nigerian Certificate in Education (NCE), 8.4% had Higher National Diploma or Bachelor of Science Degree (B.sc), while 1.1% had Master of Science Degree (M.sc). This implies that majority of the respondents have secondary certificate as their highest educational qualification. This explains one of the reasons why Zing as a local government area is regarded as one of the low educational area in the state.

**Table 4. Nature of Employment of Respondents**

| Nature of Employment | Frequency  | Percentage   |
|----------------------|------------|--------------|
| Student              | 68         | 18.4         |
| Apprentice           | 24         | 6.6          |
| Farming              | 149        | 40.4         |
| Civil servant        | 44         | 11.9         |
| Business/Trading     | 31         | 8.4          |
| Artisan              | 53         | 14.4         |
| <b>Total</b>         | <b>369</b> | <b>100.0</b> |

Source: Field Work 2021

The distribution of respondents on the nature of employment equally revealed that 18.4% are students, 6.6% are apprentice, and 40.4% are farmers. Similarly 11.9% are civil servant, 8.4% are business men or women and traders while 14.4% are artisan. This indicates that majority of the respondents are farmers.

**Table 5. Average monthly income of respondents**

| Average Monthly Income | Frequency  | Percentage   |
|------------------------|------------|--------------|
| Below 10,000           | 60         | 16.3         |
| 10,100-20,000          | 154        | 41.7         |
| 20,100-30,000          | 94         | 25.5         |
| 30,100-40,000          | 28         | 7.6          |
| 50,100 and above       | 33         | 8.9          |
| <b>Total</b>           | <b>369</b> | <b>100.0</b> |

Source: Field Work 2021

The income distribution of the respondents revealed that 16.3% reported income of below 10,000 naira, 41.7 % had income of 10,100-20,000 naira, 25.5% had income of 20,100-30,000 naira, and 7.6% reported income of 30,100-40,000 naira, while 8.9% reported income of 50,100 and above. By implication majority of the respondents have income of 10,100-20,000. This can be attributed to the fact that Zing is an agrarian area where most of the farmers farm only at subsistence level and don't have much to sell and get income moreover only few are civil servants with stable source of income.

### 3.1 Socio-Economic Factors Influencing Contraceptives among Couples in Zing L.G.A. Taraba State

Table 6 shows the distribution of respondents on socio-economic factors influencing contraceptive. According to the table 34.5% of the respondents agreed and strongly agreed that high cost of contraceptive is a factor influencing contraceptives, 17.9% were neutral while 47.7% disagreed. This implies that high cost of contraceptives is not a factor influencing contraceptives. 28.2% of also agreed that poverty is a factor influencing contraceptives, 13% were neutral while 58.8% disagreed that poverty is a factor influencing contraceptives. This implies that poverty is not a factor influencing contraceptive. On whether distance to contraceptive service centers and providers is a factor influencing contraceptive, 49.3% agreed, 10.5% were neutral while 40.2% of the respondents disagreed. This implies that

distance to contraceptive is a factor influencing the use of contraceptives. 51% of the respondents also agreed that unavailability of contraceptive services and centers is a factor influencing the use of contraceptives, 7.6% were neutral while 41.5% disagreed. This implies that unavailability of contraceptive services and centers is also a factor influencing the use of contraceptive.

Furthermore 58.3% of respondents agreed that fear of contraceptive side effects is a factor influencing contraceptives, 13.6% were neutral while 28.1% disagreed. This implies that fear of contraceptive side effects is a factor influencing contraceptive. Similarly, 59.9% of the respondents agreed, 10.8% were neutral while 29.3% disagreed that level of efficacy is also a factor influencing contraceptive. Similarly, 58.4% of the respondents that Lack of informed choice is a factor influencing contraceptives, 7.3% were neutral while 38.8% disagreed. This implies that Lack of informed choice is a factor influencing the use of contraceptives.

### **3.2 Cultural Factors Influencing Contraceptives**

Table 7 shows the distribution of respondents' cultural factors that influence contraceptives. According to the table, 59.6% of the respondents agreed that demand for children is a cultural factor influencing contraceptives while 40.4% disagreed, this implies that demand for children is a cultural factor influencing contraceptives. 54.5% of the respondents also agreed that contraceptives is against their culture while 45.6% disagreed, this implies that contraceptives is against the culture and do influence contraceptives. Furthermore 65.3% of the respondents agreed that partners decision is a cultural factor influencing contraceptives while 34.7% disagreed, this also implies that partners' decision is a cultural factor influencing contraceptives. Similarly 73.4% of the respondents also agree that contraceptives limits population while 26.6% disagreed, this also implies that limiting population is a cultural factor influencing contraceptives. Also 54.2% agreed that infertility is also a cultural factor influencing contraceptives while 45.8% disagreed. Equally 24.4% of the respondents agreed that contraceptives is a taboo while 75.6% disagreed on it as a taboo. This implies that contraceptive is not a taboo and is not also a cultural factor affecting contraceptives.

### **3.3 Religious Factors Influencing Contraceptive**

Table 8 shows the distribution of respondents on whether their religion supports contraceptive or not, according to the table, 7.6% of the respondents said yes to contraceptives being supported by their religion, 50.4% said no to contraceptives being supported by their religion while 42% do not know whether it is supported by their religion or not. This implies that contraceptives is not supported by the respondents' religion.

Table 9 shows the distribution of respondents on religious factors influencing contraceptives. According to the table, 60.4% of the respondents agreed that Contraceptive is against the commandment of God, 11.1% were neutral while 28.5% disagreed. This implies that contraceptive is against the commandment of God. 62.1% of the respondents also agreed that Contraceptive is against their traditional and religious belief, 9.8% were neutral while 28.7% disagreed. Similarly, 57.8% also agreed that Contraceptive is a sin agreed, 7.3% were neutral while 35% disagreed. On whether Contraceptive is not allowed according to their religious leaders 59.9% agreed, 7.3% were neutral while 31.5% disagreed. 67.8% also agreed that contraceptive is good, though it's against their religion, 12.5% were neutral while 19.8% disagreed.

## **4. DISCUSSION OF FINDINGS**

The study also found out that contraceptives is against religious teaching and do not approve the use of contraceptive. Reasons for the disapproval of includes a serious side effect, they are legally married, and children are gift from God, they are Catholics and is against their catholic belief and religion. This finding was also discovered in Studies among students in tertiary institutions in south-western Nigeria where it was revealed that people develop negative attitudes towards contraceptives for several reasons. These include insufficient information, fear of side effects, the experience of contraceptive failure, the perceived tedious routine involved with methods such as the oral pill, and societal disapproval of contraception among young and unmarried youths (Salako et al, 2006 and Ugoji, 2008). Related studies in this region by Omo-Aghoja et al, (2009) and Abiodun and Balogun, (2009) reveal that the majority of their respondents (53.1% and 77.5% respectively)

**Table 6. Distribution of respondent on socio-economic factors influencing contraceptive**

| <b>Socio-economic factors</b>                           | <b>Strongly agreed</b> | <b>Agreed</b> | <b>Neutral</b> | <b>Strongly Disagreed</b> | <b>Disagreed</b> | <b>Total</b> |
|---|------------------------|---------------|----------------|---------------------------|------------------|--------------|
| High cost of contraceptive                              | 54(14.7%)              | 73(19.8%)     | 66(17.9%)      | 95(25.7%)                 | 81(22.0%)        | 369(100%)    |
| Poverty   | 49(13.3%)              | 55(14.9%)     | 48(13.0)       | 146(39.7)                 | 71(19.2%)        | 369(100%)    |
| Distance to contraceptive service centers and providers | 90(24.4%)              | 92(24.9%)     | 39(10.5%)      | 83(22.5%)                 | 65(17.7%)        | 369(100%)    |
| Unavailability of contraceptive services and centers    | 91(24.7%)              | 97(26.3%)     | 28(7.6%)       | 73(19.8%)                 | 80(21.7%)        | 369(100%)    |
| Fear of contraceptive side effects                      | 102(27.6%)             | 113(30.7)     | 50(13.6%)      | 51(13.8%)                 | 53(14.4%)        | 369(100%)    |
| level of efficacy                                       | 99 (26.8%)             | 112(33.1%)    | 40(10.8)       | 58(15.7%)                 | 50(13.7%)        | 369(100%)    |
| Lack of informed choice                                 | 88(23.8)               | 111(30.1%)    | 27(7.3%)       | 71(19.3)                  | 72(19.5%)        | 369(100%)    |

Source: Field work 2021

**Table 7. Distribution of respondents on cultural factors that influence contraceptive**

| <b>S/No</b> | <b>Cultural Factors</b>  | <b>Yes</b> | <b>No</b>  | <b>Total</b> |
|-------------|--------------------------|------------|------------|--------------|
| a           | Demand for children      | 220(59.6%) | 149(40.4%) | 369(100%)    |
| b           | Against my culture       | 201(54.5%) | 167(45.6%) | 369(100%)    |
| c           | Partner's decision       | 242(65.3%) | 127(34.7%) | 369(100%)    |
| d           | It limits population     | 271(73.4%) | 98(26.6%)  | 369(100%)    |
| e           | It can cause infertility | 200(54.2%) | 169(45.8%) | 369(100%)    |
| f           | It's a Taboo             | 90(24.4%)  | 279(75.6%) | 369(100%)    |

Source: Field Work 2021

**Table 8. Distribution of respondents on whether their religion supports contraceptive or not**

| <b>Response</b> | <b>Frequency</b> | <b>Percentage</b> |
|-----------------|------------------|-------------------|
| Yes             | 28               | 7.6               |
| No              | 186              | 50.4              |
| Don't Know      | 155              | 42.0              |
| Total           | 369              | 100.0             |

Source Field work, 2021

**Table 9. Distribution of respondents on religious factors influencing contraceptives**

| <b>Response</b>   | <b>Strongly Agreed</b> | <b>Agreed</b> | <b>Neutral</b> | <b>Strongly disagreed</b> | <b>Disagreed</b> | <b>Total</b> |
|---|------------------------|---------------|----------------|---------------------------|------------------|--------------|
| Contraceptive is against the commandment of God                 | 52(14.1%)              | 171(46.3%)    | 41(11.1%)      | 30(8.1%)                  | 75(20.4%)        | 369(100%)    |
| Contraceptive is against my traditional and Religious belief    | 50(13.6%)              | 179(48.5%)    | 36(9.8%)       | 35(9.5%)                  | 68(18.7%)        | 369(100%)    |
| Contraceptive is a sin  | 22(6.0%)               | 191(51.8%)    | 27(7.3%)       | 50(13.6%)                 | 79(21.4%)        | 369(100%)    |
| Contraceptive is not allowed according to our religious leaders | 23(6.2%)               | 198(53.7%)    | 32(7.3%)       | 34(9.2%)                  | 82(22.3%)        | 369(100%)    |
| Contraceptive is good, though it's against my religion          | 49(13.3%)              | 201(54.5%)    | 46(12.5%)      | 27(7.3%)                  | 46(12.5%)        | 369(100%)    |

Source Field work, 2021

would not use contraceptives because of its perceived side effects, including health risks, on the individual.

Similarly, A 2009 study on sexuality and contraceptive among female students of tertiary education in Ilorin equally found that due to the special recognition given to mothers and the stigma attached to women without children, women may sometimes not use certain contraceptives because of the fear of infertility resulting from continuous contraceptive [10]. The low prevalence of contraceptive among Nigerian couples is also informed by the negative cultural attitudes hold towards the use of contraceptives by youths which are commonly associated with promiscuity [4].

The findings Cultural factors that influence contraceptives are demand for children, partners decision, contraceptives limits population infertility , myths and misinformation about the effectiveness of contraceptive technology, including its side effects, are a reflection of the quality of contraceptive services available in any society (Campbell et al. 2006). These myths and misinformation operate at the household and community levels to influence what is known about contraceptives. They also act at the point of service provision to influence people's choices of available methods based on preconceived knowledge of contraception.

Given that the fertility rate in Nigeria is relatively high, it is important to understand the factors that drive the household level. Religion and culture have been identified as primary factors that affect women's reproductive agency within the household. These factors operate by influencing the demand for children, particularly with regards to the preference for male children, and controlling women's identity by ascribing status and rewards for high fertility [11].

The study also found out that, contraceptives is not supported by their religion. Religious factors influencing contraceptives includes it is against the commandment of God, it is against their traditional and religious belief, it is a sin, furthermore contraceptive is not allowed according to their religious leaders. This is in agreement with Wolf & Abubakar, [12] who opined that religion is one very influential factor that controls the actions and inaction of a number of individuals. Pinter, Hakim, Seidman, Kubba, Kishen and DiCarlo (2016) also believed that one

of the many factors contributing to preventing women's access and use of contraceptives is religion. This probably is because it (religion) permeates the innermost part of the individual and tries to explain the relationship with God based on certain principles that man must adhere to, which includes matters bordering on sexual relationship and procreation. Religious groups therefore exercise enormous influence on issues of reproduction, and promoting same actively across cultural divide [12].

## 5. CONCLUSION

The study focused on factors influencing contraceptives use among couples in Zing local government area of Taraba state. The study therefore concludes that couple and women of child-bearing age in Zing Local Government Area of Taraba State have low level of contraceptive usage and its methods. Attitude towards contraceptives is poor with cultural, medical, economic and religious factors playing vital roles.

## 6. RECOMMENDATIONS

Based on the findings of the study, the following recommendations are made with the hope that if they are implemented, it will help to increase contraceptive use among couples:

1. Public enlightenment on contraception should start from antenatal clinics. This can be extended to other outpatient clinics which men are part of, so that the information on contraception will spread to as many people as possible.
2. A significant component of any family planning program for Nigeria would have to be concentrated on community health education to reduce misconceptions about the side effects of modern contraceptives, which is the most common reason for nonuse of modern contraceptives in Nigeria.
3. Government should provide more Family Planning clinic to make access to health facilities easier specifically in the rural areas.
4. It is also important to adopt strategies that combine individual education, improvement of services and community outreach/mobilization to inform communities about available services, need for child spacing and to increase acceptability and use of contraceptives



## CONSENT

As per international standards or university standards, respondents' written consent has been collected and preserved by the author(s).

## COMPETING INTERESTS

Authors have declared that no competing interests exist.

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