International Journal of TROPICAL DISEASE & Health
3(3): 267-282, 2013

SCIENCEDOMAIN *international*
www.sciencedomain.org

Barriers to Contraceptive Use among Married Young Adults in Nigeria: A Qualitative Study

A. Ankomah[1*], J. Anyanti[2], S. Adebayo[3] and A. Giwa[4]

[1]Department of Population, Family & Reproductive Health, School of Public Health, University of Ghana, Legon, Accra, Ghana.
[2]Society for Family Health, Abuja, Nigeria.
[3]The National Agency for Food and Drug Administration and Control, Abuja, Nigeria.
[4]Geography Department, University of Sheffield, Sheffield, United Kingdom.

Authors' contributions

The work was carried out in a collaborative effort. Authors AA, JA, and SA designed the study, wrote the study protocol and collected the data. Author AG managed the literature search and wrote the literature review. Transcripts, coding and analysis were done independently by authors AA, JA, and SA. First draft was put together by authors AA, JA, and SA. Review and editing was done by author AG. All authors read and approved the final manuscript.

Research Article

Received 20th April 2013
Accepted 27th June 2013
Published 21st July 2013

ABSTRACT

Aims: Nigeria's contraceptive prevalence is one of the lowest in sub-Saharan Africa. The majority of married women in Nigeria is not currently using contraceptives and has no intention of doing so in the near future. This study was aimed at exploring the key cultural and societal perceptions, beliefs and practices that impede the uptake of contraceptives among young married Nigerians.
Study Design: Focus group discussions (FGDs); qualitative.
Place and Duration of Study: The study took place in thirteen locations across Nigeria's six geo-political zones between July 2010 and September 2010.
Methodology: This is a qualitative study based on 30 focus group discussions held across 13 states in Nigeria's six geo-political zones. Thirteen cities and towns were purposively selected to reflect the main ethnic and geographical variations in Nigeria. Focus groups were stratified, after initial screening, into four main groups: males, females

**Corresponding author: Email: aankomah@ug.edu.gh;*

currently using contraceptives, females not currently using contraception but with no unmet need; and females with unmet need. Local 'mobilizers' were enlisted to help in the recruitment. Trained FGD moderators and note takers used a semi-structured FGD guide to hold discussions in English or local languages.
Results: Compared with women, men have poorer knowledge of family planning. Women currently using family planning do so for two main reasons. The first is for economic reasons at the family level and the second is for health reasons. The greatest impediment to women's contraceptive use is lack of support from husbands and other significant others as well as the absence of inter-spousal communication. Real and perceived fear of side effects is a major barrier. Rumours, myths and misinformation about contraceptives often have a strong negative impact on use.
Conclusion: The study confirms that even among young couples, inter-spousal communication is poor and contraceptive use in Nigeria is unlikely to improve without addressing men's apparent lack of interest and involvement in family planning.

Keywords: Contraceptives; focus groups; Nigeria; family planning; married women.

1. INTRODUCTION

Nigeria's fertility rate has remained high: from 6.0 children per woman in 1990 it recorded only a minimal drop to 5.7 in 2008 [1]. Similarly, modern contraceptive prevalence has been around 10% (11% in 2008) for the past decade [1]. In 1988, the Nigeria government introduced the first explicit population policy for development, unity, progress and self-reliance [2]. In 2004, the government revised the population policy aimed at ensuring and contributing to long-term sustainable development in Nigeria [3]. Most researchers link the ineffectiveness of the population policy to the inability of the government and programmers to take into account the cultural and social context in which individual fertility decisions and behaviour takes place in Nigeria [4]. For example, the policy targeted women's fertility behaviour, while disregarding male reproductive motivation and ignoring the influence of patriarchal structures on women's fertility. In so doing the policy overlooked the fact that women perceived their reproductive lives in the context of a male-dominated society [5]. Both policy attempts failed to address fundamental cultural impediments of behaviour change towards smaller family norms, and explain why Nigeria's contraceptive prevalence has not changed over the past decade.

The high level of awareness about contraception but very low level of use have been established in studies in Nigeria [6,7]. There are several obstacles to contraceptive use in Nigeria. Studies in Nigeria and elsewhere in sub-Saharan Africa have shown that major obstacles to the adoption of modern contraceptive behaviour include myths and misinformation or rumours, and unconfirmed information passed within social networks [8-10].

Another key obstacle to contraceptive use is the difficulty discussing family planning with significant others especially spouse(s), friends, religious leaders, and other key individuals in a person's life [11-15]. The influence of spouses, friends, parents, and religious leaders on contraceptive use have been documented elsewhere in sub-Saharan [11,16]. Communication about family planning is critical. Inter-spousal communication is a key issue that affects the sustained use of family planning in Nigeria [16,17]. Several studies suggest a strong positive effect of spousal communication on contraceptive use [18-24].

Relatives and friends mainly act as a key source of contraceptive information, indicating that many women have access to incorrect contraceptive information [25]. Other issues that affect the use of family planning services include the overall cost and availability of contraceptive commodities, transportation and provider fees for contraceptives and health care services (even when they are subsidized by the government), fear of side effects, spousal approval, culture and religion [26,27]. In a study among Muslim women attending two gynaecology and antenatal clinics in Zaria, Kaduna state [28], the major reason for unmet need for contraception was the fear of side effects of contraceptives. Other reasons included fear of husband's reaction, lack of funds and desire to have more children. The fear of side effects is a reflection of the quality of contraceptive information received by women attending those clinics. A previous study on weight changes in clients on hormonal contraceptives in Zaria suggested that weight gain (a major side effect of hormonal contraceptives) occurred in 65.2 percent of clients after the first year of using hormonal contraception [25].

The demand for family planning is low in Nigeria. The 2008 Nigeria Demographic and Health Survey reported that the majority of married Nigerian women have no intention of ever using modern contraceptives [1]. Examining barriers to contraception within marriage is therefore of critical importance. This study thus examined the various barriers that have impeded contraceptive use in Nigeria with special reference to married persons aged 20-34 years who, by size, constitute a significant number of Nigeria's 140 million persons. Specifically this paper seeks to explore the religious, cultural, and other barriers at the family level that can act as impediments to contraceptive use and assess the perceptions of young adults towards contraception. The cultural system and elements of societal support from family, peers and other community and religious leaders (or lack of it) for family planning were examined, including perceived health concerns and side effects.

2. MATERIALS AND METHODS

This qualitative study was based on the findings from 30 focus group discussions conducted among married young adults (males and females) spread across 13 of Nigeria's 36 federating states. Although the sampling was purposive, to ensure diversity the study took place in 13 sites with at least two in each of Nigeria's six geo-political zones. The large number of focus groups was to reflect Nigeria's diversity in terms of population, beliefs and contraceptive behaviour.

2.1 Recruitment of Study Participants

The 13 cities and towns were purposively selected to reflect the main ethnic and geographical differentials across Nigeria's six geo-political divisions. Each locality, purposively selected, was stratified into two or three divisions. In localities where rural participants were recruited, a rural locality close to the city was purposively selected. For each of the constituent divisions, the political wards were listed. Three wards were selected and grouped together. A focus group was organised for each 'cluster' of three wards. The total number of FGDs is shown in Table 1. Based on the local knowledge of the authors and FGD moderators, the appropriate community leaders were contacted and permission sought to undertake the study. After 'clearance and approval' the research team member with appropriate knowledge of the community identified and recruited 'ward mobilizers' (one male and one female). With their substantial local knowledge of the community, and based on the briefing of the research team, they identified homes where potential study participants lived.

Home visits were made by the 'ward mobilizers' and the appropriate member of the research team. During this visit the moderator spoke exclusively with the potential participants in confidence and using screening questions ascertained their qualification for the study. Voluntary participation was emphasized. Three groups of married women aged 20-34 were to be recruited if after screening they fell into any of the following groups: married women currently using modern contraceptives, married women currently not using contraceptives, and have no intention of doing so in the next two years (i.e. with no unmet need); and those who are not currently using modern contraceptives but who have intention to do so in the next two years (i.e. with unmet need). Those who qualified and agreed to participate were recruited. Not more than one participant was selected in any house. Male participants were recruited in a similar way but 'screened' only to confirm their age and marital status. Care was taken to ensure that male participants were not partners of women already recruited. Male participants were recruited whether or not they were using contraceptives.

2.2 Focus Group Moderation

The study locations and detailed composition of focus groups are presented in Table 1. Each focus group ranged from eight to ten participants in order to make for varied, interesting and sustained discussions. The discussions were held in appropriate venues suggested by participants. To ensure quality data, moderators and note takers were trained by the authors on all aspects of moderating FGDs. The FGD guide was pretested in a locality outside the study sites as part of the training. There were three research teams each headed by one of the co-authors covering the north, east and west of Nigeria. All the researchers, except one, spoke at least one of the languages used for the FGD moderation and all have considerable experience in focus group data collection and analysis. FGDs were tape recorded with the consent of participants. Some of the FGD topics discussed included the following: What family planning is; rationale and benefits of family planning; who should use family planning; traditional beliefs about family planning and contraceptives; the influence of significant others in contraceptive decision-making; and family communication about family planning. Others included reasons for non-use; misconceptions including method-specific concerns; fears of side effects; and access to family planning products and services.

Given the sensitive nature of the dialogue, it was considered necessary to ensure male moderators discuss with men and female moderators with females [29,30]. For each focus group, a trained moderator was assisted by a notetaker to facilitate the session. All discussions were held in either the local languages or in Pidgin English. Each discussion lasted for about 90 minutes after which refreshments were provided to participants. No financial or other incentives were offered to participants although travel expenses, where applicable, were reimbursed. Participation in the study was voluntary, and individual verbal consent was sought. In addition confidentiality was assured. The entire proceedings were tape recorded with the permission of discussants. Recorded sessions were fully transcribed and translated into English.

Table 1. Composition of FGD Groups

		Married females												Married males					
		Users of FP				Non-Users of FP (no intention to use)				Non-users with intention to use				No of FGDs				No FGDs	Total FGDs
	Age Group	20-24		25-34		20-24		25-34		20-24		25-34			20-24		25-34		
	Location	R[1]	U[2]	R	U	R	U	R	U	R	U	R	U		R	U	R	U	
	NORTH																		
1	Kano		1		1									2		1		1	3
2	Katsina					1				1				2					2
3	Maiduguri				1		1							2			1	1	3
4	Gombe							1				1		2					2
5	Makurdi										1		1	2		1		1	3
6	Okene					1						1		2					2
	SOUTH																		
7	Lagos		1				1							2				1	3
8	Ondo			1			1							2					2
9	Oshogbo						1			1				2					2
10	P/Harcourt		1										1	2					2
11	Calabar											1		1					1
12	Enugu		1				1							2		1		1	3
13	Benin			1										1			1	1	2

R=Urban; U=Rural

2.3 Analysis

All transcripts were read independently by three of the authors. Coding of the data was done manually. The codes were then "grouped together under higher order headings" [31]. Consequently, on a higher logical level of abstraction, codes, subcategories, categories, and themes were created [31]. The themes identified related to key barriers to family planning, perceptions about contraceptives, reasons for use or non-use of contraceptives as well as key suggestions to increase contraceptive uptake. Both manifest and latent content analyses were employed in the interpretation of data. Qualitative analysis may focus on manifest or latent content [32]. Manifest analysis describes the visible and the obvious while latent content analysis involves an interpretation of the underlying and inferred meaning of texts [32,33]. Latent analysis allows for in-depth interpretation and systematic and thorough evaluation to assess the presence or absence of particular idea or theory [32,33]. We employed the independent corroborative technique of latent content analysis. The initial analysis involved independent interpretation and documentation by each of the three first-named authors. The research team met several times to discuss the individual interpretations, address discrepancies in interpretation and other issues that required clarity. Quotes that best described the categories and were frequently mentioned were chosen, but in some instances, minority contrasting views were also reported.

3. RESULTS

3.1 Knowledge and Behaviour: Facts and Fiction

Users of modern contraceptives could easily mention various types of modern family planning methods such as condom, Injectables and the pill. Most of the married women had heard of contraceptive methods during routine sessions about family planning at antenatal clinics. Men, on their part, knew mainly about condoms and the withdrawal method, and felt the other methods were for older couples who needed no more children. Most of the men were misinformed about family planning. Some held totally wrong knowledge about family planning. For example, to some of the men, there is no difference between condoms and withdrawal and that both have the same efficacy apparently because in both methods the 'man's release is prevented from entering the woman'. Some women too had very limited knowledge, and argued that since condoms are artificial and withdrawal natural, and both have similar efficacy, they argued strongly for withdrawal:

They are similar (condom and withdrawal). When using condom since the release will not enter your womb so that when he is about to, he releases outside you. That is the method our (Islamic) religion supports... (Female, non-user of contraceptives, 20-24 years, rural dweller).

Most of the participants had never seen condoms before. The knowledge level among female non-users of contraceptives was extremely poor. Apart from condoms, few female non-users of contraceptives from northern Nigeria could mention the name of any modern contraceptive apart from breastfeeding. The most popular method known to this group was breastfeeding: *"Sometimes breast feeding is an effective method of family planning. When I am breast feeding I don't take in. As long as I am breast feeding I don't get pregnant".* Still some men held on to some practices with no proven contraceptive effect including the belief that if a woman douches immediately after sex she is unlikely to get pregnant. Some men

also held the misconception that vasectomy as a method is carried out by '*removing the man's scrotum*'.

Most participants mentioned an array of folk/traditional methods of contraception including those with no possible contraceptive effect such as the wearing of traditional beads or leather tied around the waist during sexual intercourse. As expected, non-users of contraceptives knew more of the traditional methods. They not only knew more about these methods but also strongly attested to their efficacy even though they have never used them. One of such practices is taking a deep breath immediately after sexual intercourse: *"For my family; after me and my husband meet if I don't want to get pregnant. I breathe and the entire thing* [sperm] *will come out".* Another version is the misconception that after sex a woman can start *"jumping up and down so that the sperm would come out"*.

3.2 Rationale for Family Planning

There was evidence that a few of the participants were satisfied contraceptive users. The reason why they use family planning methods varied. Economic reasons were cited as a major reason for family planning as it allows them to have the number of children they can adequately cater for. A participant noted:

If you space, you do have the opportunity to put your children in good private schools instead of government school so that they can get a good education. (Female contraceptive user age, 20-24 years, urban dweller).

For some participants, contraceptive use helps to improve the health of the child:

If you space the children it would be easier to give them healthy food and they will be satisfied and healthy but if the children are too many, you end up spending on medicine to cure their illness rather than giving them good food. (Female contraceptive user age 20-24 years, urban dweller).

For others, contraceptives were used to help improve the health of the mother:

I did it because I want to have rest for my body; If I have too many children, I won't be able to have rest and it will be problem over and over again until I die". (Female contraceptive user, age 25-35, rural dweller).

For some of the women it was for aesthetic reasons: to look young and beautiful; to "remain slim and desirable to your husband" as well as having enough time to give the husband needed attention". A female participant explained further:

If you . . . have many children, you won't have time for the husband, your personal cleanliness; talk less of that of the children and your home. You won't be able to pay attention to him so he can go out and leave you with the kids and look for a young lady outside (Female contraceptive user age 20-24 years, urban dweller).

3.3 Real or Perceived Side Effects as a Barrier

Most of the women said that the main reason for non-use was fear of side effects. A woman said: "*Personally I feel that all the modern contraceptives have their side effects*", another

said "*I have ten children but because of side effects I am afraid to use it* [contraceptive method]".

Spotting and excessive bleeding was reported. This was a key impediment to contraceptive use.

My elder sister took some (contraceptive pill) *when she got married. But she bleeds every time, her menses always exceeds one week; her period does not want to stop. I want to use* (contraceptives) *but I am afraid. The bleeding is too much. (*Female, age 25-34, not using contraceptives but desiring to, rural dweller*).*

A few believed that contraceptives can kill through excessive bleeding: *"I don't like it [modern family planning] so I am not willing to do it… some people will do it they will die (from excessive bleeding) while some will get another sickness from it.* (Female, age 20-24, not using contraceptives, rural dweller).

While some of the side effects are valid and well known, it was found that both users and non-users held on to half-truths, misconceptions and outright conspiracy theories regarding modern contraceptives. There are some who do not use contraceptives because it 'causes cancer'; 'it causes barrenness in a woman'; 'it gives headache'; or 'it causes complications during delivery'.

On barrenness, a participant mentioned a case:

*"I know someone who used injections and has been unable to give birth for four years. She had to go to teaching hospital and her womb was operated on…" (*Female non-user of contraceptives age 20-24 years, rural dweller).

On cancer, a female participant made reference to 'studies done in European countries' which she claims support her view that injectables cause breast cancer. The cancer, it was claimed, was the result of accumulated menstrual flow arising from amenorrhoea. It was erroneously believed that for women who do not menstruate monthly, the waste products that the menstrual fluid is supposed to get rid of can accumulate and lead to "*diseases*". Similarly, despite the lack of empirical evidence, the famous rumour of '*a baby coming out from the mother's womb holding the coil'* still made the rounds in many of the focus groups. Some men also believed the IUCD can be pushed down during sexual intercourse and get dislodged in the woman's abdomen. Some men were of the view that IUCD can "kill your penis" or cause injury during sex. Others believed all methods are irreversible and the fear of an inability to get pregnant after method stoppage was frightening to most participants.

The link between some contraceptive methods and amenorrhea was a major talking point and a source of several misconceptions and a great barrier to contraceptive use. If a woman is unable to menstruate, some strongly argued, she "will become fat" because her menses is "hiding somewhere in her body" and it will make her abdomen protrude outwards. A participant stated:

If a woman should have two children, the woman's belly will be protruding immediately she does family planning... the blood that is not coming out as menstruation will be hiding somewhere" (Female non-user of contraceptives age 20-24 years, urban dweller).

3.4 Societal Perceptions of Family Planning as a Barrier

In many traditional settings, young women who use contraceptives are perceived as promiscuous. Some participants, both male and female, hold the view that if a woman uses family planning it means "she is loose woman, a prostitute". This arises from the perception that if a woman has a method that will prevent her from getting pregnant then she may be liable 'to do anything she likes outside her matrimonial home as it will have no consequence'. This is particularly so if there is a wide age differential between husband and wife as stated by the following male participant:

When young men marry young girls, when you get to hospital they introduce FP, the woman can go out with other men and you will not know. May be the man of 28 years married the girl of 20 years and from there they will have two children and were asked to do the FP, the woman can mess up outside with another man. (Male age 25-35, rural dweller).

This study also investigated the extent to which religion impedes the uptake of modern family planning methods. Majority of the participants from the Muslim north feel that family planning is against the tenets of Islam, which enjoins all to go and multiply. Others believe that you should not plan the family size as you cannot tell which child will be the one in future who will lift the family up or be somebody great. In their view, children are an act of God and as such any attempt at tampering with the process is seen as offensive to God as shown by a participant:

Islam does not support FP because you have no right to specify the number of children you want. God would even deprive you from having them and then we will see what you will do (Male, age 20-24, rural dweller).

However, there was no consensus. Others, particularly female participants, argued that Islam does permit family planning based on health rationale. One female participant cited a radio programme anchored by a Muslim religious leader that motivated her to use contraceptives:

I started family planning because I heard on a radio programme by an Imam that Islam agrees because a man could have an opinion as to the number of children he wants to give birth to, some want many while some don't like. He said that Islam allows you to say for instance that you do like to give birth to five children. So that is family planning. (Female, age 20-24, user of contraceptives, urban dweller).

3.5 The role of Significant others in Family Planning

Use of contraception was found be strongly influenced by the level of support or lack of it from persons within an individual's social network. Some of the women currently using contraceptives mentioned that it was their friends who introduced them to family planning, by explaining how to use them or in some instances, actually took them to the family planning clinic.

It was my friend. She asked if I was doing anything. She meant contraceptives. She was not happy I was taking chances. She warned me. The following week she asked me to accompany her to the clinic. There I got some pills. (Female, age 25-34 user of contraceptives, urban dweller).

Other participants stated that, for them, it was neighbours and not friends. They argued that their friends usually do not 'interfere' in such private areas. But some neighbours can. They cited neighbours as more helpful in the area of family planning than friends as they were likely to observe the daily challenges a mother may face as a result of excessive childbearing. But they pointed out that neighbours do so sometimes after they have gossiped about you in the community. A participant said that after a neighbour saw how she was struggling to cater for her children she advised her to use family planning:

The neighbours; they are likely to gossip about you and when they always see you when you are pregnant, they even wonder if you are weaning the baby correctly… But she was kind enough to call me and say I should do something about my frequent deliveries. (Female, user of contraceptives, age 25-34 years, rural dweller).

On the whole, it was agreed that neighbours were more likely to influence one to use family planning than friends.

The critical role mothers-in-law play in contraceptive decision-making in many traditional African societies is legendary. Participants, particularly from southern Nigeria, perceived mothers- in-law as being at best non-supportive and at worst overtly anti-family planning. Most participants described them as controlling their sons and encouraging them against the use of contraceptives because it will offer 'licence for women to be loose'. A female participant who desired to use family planning was unsure because of the attitudes of mother-in-laws in her community:

"Some mother in-laws feel that if the wife of their son should do family planning she will be promiscuous and she can bring disease to her son (Female, non-user of contraceptives but desire to, age 20-24 rural dweller).

For some women, it was not the mother-in-law but their own mothers who were asking them to discontinue the use of contraceptives. The mothers think that having more children ensures marital stability: *My mother is presently worrying me now that I should have more children now to please my husband* (Female, user of contraceptives, age 25-34; rural dweller).

3.6 Men as Barriers

This study revealed that most women see men as the single most enduring impediment to the use of family planning. According to most of them, regarding reproductive health, men are selfish and have little interest in what happens to the women and children: *"Men are selfish and like to stay away and put the burden on you".* This apparent lack of concern by men is seen by women as a major barrier to the use of family planning methods. A female participant from northern Nigeria, desirous to use contraceptives, but unable to do so recounted her experience:

*There are people who go from house to house on (*family planning*) enlightenment campaigns. They have been to our house three times. They discussed* (family planning) *with my husband but he did not agree. He thinks it is nonsense…and he said no matter how many children he has, God will provide.* (Female, non-user of contraceptives but desires to, age 25-34 years, rural dweller).

Among the participants, particularly from the Muslim north, most men will concede to family planning only when the woman's life is in danger. The women catalogued several instances of support of men for such 'therapeutic' family planning:

It's when he sees you are fainting and dying and they are giving you his blood...In my family they are irritated by family planning ….When I gave birth to the baby I suffered a lot in the hospital so they told my husband so he said I should visit the family planning clinic because of the suffering I was undergoing ...if not for the suffering I faced, my husband would not agree for me to do family planning (Female, user of contraceptives, age 25-34 years, urban dweller).

Some of the women mentioned that whether or not one uses contraceptives puts the woman in a dilemma:

*If you are using family planning the men will say it gives women liberty or license to be promiscuous, if you do not, and get pregnant, they again complain that they are not getting attention from you because of the pregnancy, and this gives them the opportunity to go out and look for other women (*Female, non-user of contraceptives but desiring to, age 25-34, urban dweller).

In both scenarios men are the winners. Those who allowed their wives to use contraceptives would blame the women in the likely event they experienced side effects of contraception. However, there were exceptions, and some women narrated about husbands who supported family planning. In their cases it was the men who insisted that their wives used family planning.

After my first child…My husband used to fight me about that (frequent deliveries*), and that I need to do something about it. So a nurse now counselled me about family planning so that I started using it (*Female, user of contraceptives, age 20-24, rural dweller).

A key result of female powerlessness in decision-making is the covert use of modern family planning methods, particularly when a husband bluntly opposes his wife's intentions. A fairly large number of the men were of the opinion that "if a woman uses family planning without permission she would be asked to leave the house". In spite of the risk associated with being 'caught' using contraceptives without approval, there was evidence that some women use contraceptives without the knowledge of their husbands:

I had a clash with my husband in January this year; it is all about family planning and having more children....He has so far not mentioned anything about it... so I had to do it without his knowledge, since he has no understanding of family planning (Female, user of contraceptives, age 20-24 years, urban dweller).

3.7 Inter-spousal Communication

We explored during the focus group discussions whether or not partners discuss family planning and other reproductive health issues. Participants pointed out that one of the main reasons for non-use of family planning are the lack of communication between spouses, except where is it is related to female infertility or when there are complications during pregnancy or childbirth. Many mentioned that men were often not ready to discuss family planning. A female participant eager to use family planning but getting no support from her husband confirmed:

He may not even give you his attention or may even become upset when you bring up the topic of family planning (Female, non-user of contraceptives but desire to, age 25-34, urban dweller).

While a few men, mainly from the north of the country, were of the opinion that the issue of family planning should not be broached at all within the family, most male and female participants agreed that the use of contraceptives should be a joint decision between husband and wife. Despite this, it was found that the men find it difficult to talk about family planning. As a result most women are in a dilemma, as husbands are unwilling or unable to discuss family planning.

3.8 Availability and Accessibility

Sustained contraceptive usage may be difficult to achieve if people perceive contraceptives as unavailable, unaffordable and difficult to access. There was evidence that family planning products, except condoms, were considered as 'now becoming expensive'. The IUD was mentioned as the most expensive method. Some felt this will prevent some women from accessing family planning methods.

All their prices are expensive, you see the tablets (the pill) *used to be cheap but now in the chemist it is expensive…Actually there are those who want to do it but because it's gone up they can't, but if it would be cheaper, more people could afford it because money is hard to come by nowadays (*Female, user of contraceptives, age 25-34 years, urban dweller).

Accessibility to most clinic-based products particularly in the rural north was mentioned as a problem. In the north, those in the rural areas complained of the problems with having to travel to state capitals to obtain such methods. In some areas, the participants reported that they had to travel through a distances of 20 to 50 km (from where they were living) to get the right quality of services.

4. DISCUSSION

The study revealed several reasons why married women use contraceptives. It is important to note that the economic rationale and the health rationale were the two underlying reasons for using family planning. Women using modern FP referred to the peace of mind that the use of FP gives them. In their perception, when children are spaced, the health of mother and children is enhanced and they are able to cater well for the children. On health, participants noted that Family Planning gives to the woman enough time to be able to recover after her pregnancies before resuming child bearing. Otherwise many women would not be able to cope with the obstetric complexities resulting from childbirth. This finding is important as it offers a platform for family planning programme interventions.

Most of the women could discuss the contraceptive effects of breastfeeding. Given that lactational amenorrhoea method (LAM) is cheap and easy to practice and is acceptable to all religious groups, the promotion of LAM could be increased. On the whole, misconceptions still abound, as has been found in several studies in Nigeria [8,34]. Many women also use traditional folk methods that have no proven efficacy. These include taking in deep breaths after coitus to expel semen or jumping up and down. Family planning service providers and programme planers should design messages to address these wrongly-held views and behaviours. . Most non-users of modern contraceptives rely on breastfeeding as the main contraceptive technique. Given that breastfeeding is rarely exclusive, and the contraceptive

effect of exclusive breastfeeding reduces with time, it appears that most lactating mothers are not fully protected from pregnancy after six months of delivery.

This was an indication that neighbours are more likely to influence family planning matters than friends, who may be too careful and often non-committal when discussing sensitive issues such as in family planning. This could be explored and used in communicating family planning messages. It was also found that spouses hardly discuss family planning matters. This confirms studies in northern Nigeria that support the important role men and religion play on the uptake of contraceptive services in the region [35,36]. The promotion of inter-spousal communication will be important to improving contraceptive prevalence.

For most non users of contraceptives, the fear of side effects was the main reason for non-use as they worry that the methods are irreversible., or that specific methods such as the Injectables cause weight gain, protrusion of the abdomen, believed to be the result of the accumulation of menstrual fluid as the monthly menstrual cycle, which is perceived as being cleansing to the womb does not occur. Consequently most women complained about the possibility of amenorrhea as a side effect. Most of the women felt that the monthly discharge of 'dirty blood' during menstruation was a sign of life, of womanhood; and lack of it demeaned the sense of being feminine. Consequently some women saw the heavy bleeding as a 'better' side effect than experiencing no bleeding at all. This confirms the findings of a recent review of literature on contraceptive practices in Nigeria [37].

Although this study provides data on barriers of contraceptive use, as a qualitative study with potential biases resulting from selection issues, the results of the study are not representative and therefore not generalizable to all married women age 20-34 in Nigeria. Furthermore, the qualitative data could be subject to multiple interpretations.

5. CONCLUSION

The study explored barriers to contraceptive use in various communities spread throughout Nigeria. Findings revealed that while participants were informed about many modern methods available, they also firmly believed in some traditional methods which they claimed were effective. The results from the study show that men's negative attitude is a major reason why their wives fail to practice family planning even when the women are motivated to do so. Some men believed that family planning gives women the liberty or license to be promiscuous. However, majority of the participants agreed that men cannot be ignored, thus once again drawing attention to the need for programmes with high male involvement content. There was evidence of very little communication between spouses on fertility regulation.

It was observed that family planning decisions are not the preserve of couples alone but by significant others who are persons within an individual's sphere whose views are most likely to affect the attitude and behaviour of the individual. The general view was that most mother in-laws are negatively disposed to family planning while neighbours weld more influence than friends. Therefore, in settings where the extended family system is still very relevant, it is crucial to include persons within the couple's sphere of influence.

On a positive note, the fact that among users the rationale for family planning includes economic (ability to provide good education to few children), health of mother and health of children as well as aesthetic factors (being slim and looking beautiful) is an encouraging sign that that can be used by programmers to emphasize the reasons why family planning is

essential. It is important to note that none of the participants mentioned the demographic rationale for family planning at the macro level: to reduce number of people in the country to help in economic development. This suggests that to motivate couples to use contraceptives, family planning interventions should concentrate on the benefits of family planning at the family and not at the state or national level.

CONSENT

Informed verbal consent was sought and received from all participants of the study. No written consent was sought because of the low literacy levels in some of the communities. Confidentiality was assured and maintained. In some rural and highly religious communities, permission was sought from community leaders.

ETHICAL APPROVAL

The study was approved by the Research and Evaluation Department of the Society for Family Health, Nigeria.

ACKNOWLEDGEMENTS

This study was supported by funds from the Department for International Development (DFID) and the United States Agency for International Development (USAID). However, the two bodies were not involved in any way whatsoever in the design, data collection, analysis and interpretation of data.

COMPETING INTERESTS

The authors have declared that no competing interests exist.

REFERENCES

1. National Population Commission & ORC Macro. Nigeria Demographic and Health Survey 2008. National Population Commission, Nigeria & ORC/Macro, Calverton, MD; 2009.
2. Federal Republic of Nigeria. National Policy on Population for Development, Unity, Progress, and Self-Reliance. Federal Ministry of Health/Department of Population Activities. Lagos; 1988.
3. Federal Government of Nigeria. National Policy on Population for Sustainable Development. Federal Government of Nigeria, Abuja; 2004.
4. Isiugo-Abanihe UC. The socio-cultural context of high fertility among Igbo women. International Sociology.1994;9(2):237-258.
5. Obono O. Cultural diversity and population policy in Nigeria. Popul Dev Rev. 2003;(29)1:103-111.
6. Obisesan KA, Adeyemo AA, Fakokunde FA. Awareness and use of family planning methods among married women in Nigeria. E Afri Med J. 1998;75:135-138.
7. Okonofua FE, Odimegwu C, Ajabor H, Daru PH, Johnson A. Assessing the prevalence and determinants of unwanted pregnancy and induced abortion in Nigeria. Stud Fam Plann. 1999;(30)1:67-77.

8. Otoide OV, Oransaye F, Okonofua FE. Why Nigerian adolescents seek abortion rather than contraception: evidence from focus group discussions. Int Fam Plan Persp. 2001;(27)2:77-81.
9. Ankomah A, Oladosu M, Anyanti J. Myths, misinformation and communication about family planning and contraceptive use in Nigeria. Open Access Journal of Contraception. 2011;2:95-105.
10. Orji OE, Onwudiegwu U. Prevalence and determinants of contraceptive practice in a defined Nigerian population. J Obstet Gynaecol. 2002;22(5):540–543.
11. Rutenberg N, Watkins SC. The buzz outside the clinics: conversations and contraception in Nyanza Province, Kenya. Stud Fam Plann.1997;28(4):290-307.
12. Caldwell CJ, Phillips FJ, Barkat-e-Khuda. The future of family planning programmes. Stud Fam Plann. 2002;33(1):1-10.
13. Debpuur C, Phillips FJ, Jackson FE, Nazzar A, Ngom P, Binka NF. The impact of the Navrongo project on contraceptive knowledge and use, reproductive preferences, and fertility. Stud Fam Plann. 2002;33(1):141–64.
14. Okwor EU, Olaseha IO. Married men's perception about spousal use of modern contraceptives: a qualitative study in Ibadan Northwest Local Government area, Southwest Nigeria. Int Q Community Health Edu. 2009;30(3):223-238.
15. Odimegwu OC. Family planning attitudes and use in Nigeria: A factor analysis. Int Fam Plan Persp. 1999;25(2):86-91.
16. Feyisetan BJ. Spousal communication and contraceptive use among the Yoruba of Nigeria. Popul Res Policy Rev. 2000;19(1):29-45.
17. Ogunjuyigbe PO. Spousal communication, changes in patterns attitudes and contraceptive use among the Yorubas of Southwest Nigeria. Journal of Social Sciences. 2002;6(1):59-64.
18. Bawah A. Spousal communication and family planning behaviour in Navrongo: A longitudinal assessment. Stud Fam Plann. 2002;33(2):185-194.
19. Oladosu M. Couples' Decision Making and Reproductive Outcomes in Uganda. Dissertation submitted in partial fulfilment for a PhD degree, Pennsylvania State University, PA, USA; 1999.
20. Katz RK, West GC, Doumbia F, Kane F. Increasing access to family planning services in rural Mali through community-based distribution. Int Fam Plan Persp. 1998;24(3):104-110.
21. Oheneba-Sakyi Y, Takyi KB. Effects of couples' characteristics on contraceptive use in sub-Saharan Africa: the Ghanaian example. J Biosoc Sci. 1997;(29):33-49.
22. Tawiah OE. Factors affecting contraceptive use in Ghana. J Biosoc Sci. 1997;(29):141-149.
23. Agyei AKW, Migadde M. Demographic and sociocultural factors influencing contraceptive use in Uganda. J Biosoc Sci. 1995;27:47-60.
24. Orji EO, Adegbenro CA, Akinniranye BI, Ogunbayo GO, Oyebadejo AE. Spousal communication on family planning as a safe motherhood option in Sub-Saharan African communities. Journal of Chinese Clinical Medicine. 2007;2(6):328-335.
25. Sule S, Umar H, Madugu N. Knowledge and use of modern contraceptives among Muslim women in Zaria, Nigeria. The Journal of IMANA. 2006;38(1):10-16.
26. Casterline J, Sinding S. Unmet need for family planning in developing countries and implications for population policy. Popul Dev Rev. 2000;6(4):691–723.
27. Oye-Adeniran, BA, Adewole IF, Odeyemi KA, Ekanem, EE Umoh AV. Contraception prevalence among young women in Nigeria, J Obstet Gynaecol. 2005;(25):182–185.
28. Sule S, Shittu O. Weight Changes in Clients on Hormonal Contraceptives in Zaria, Nigeria. Af J Reprod Health. 2005;9(2):92-100.

29. Ankomah A. Condom use in sexual exchange relationships among young single adults in Ghana. AIDS Educ Prev. 1998;10(4):303-316.
30. Axelord MD.10 essentials for good qualitative research. Marketing News. 1975;(8):10-11.
31. Burnard P. A method of analyzing interview transcripts in qualitative research. Nurse Educ Today. 1991;11(6):461–466.
32. Graneheim UH, Lundman B. Qualitative content analyis in nursing research: concepts, procedures and measures to achieve trustworthiness. Nurse Educ Today. 2004;24(2):105–112.
33. Kondracki NL, Wellman NS, Amundson DR. Content analysis: review of methods and their applications in nutrition education. J Nutr Educ Behav. 2002;34(4):224–230.
34. Okonofua F, Hammed A, Nzeribe E. et al. Perceptions of policy makers in Nigeria towards unsafe abortion and maternal mortality. Int Perspect Sex Reprod Health. 2009;35(4):194-202.
35. Avong HN. Perception of, and attitudes toward, the Nigerian Federal population policy, family planning program and family planning in Kaduna State, Nigeria. Afr J Reprod Health. 2000;4(1):66-76.
36. Tsui S, Williamson NE. Child spacing and Family planning attitudes of young men and women in selected areas of North West Nigeria. 2008. United States Agency for International Development. (USAID). Available online at: http://pdf.usaid.gov/pdf_docs/PNADL911.pdf. Accessed on the 10th of June, 2010.
37. Monjok E, Smesny A, Ekabua JE, Essien J. Contraceptive practices in Nigeria: Literature review and recommendation for future policy decisions. Open Access Journal of Contraception. 2010;(1):9-22.

Peer-review history:
The peer review history for this paper can be accessed here:
http://www.sciencedomain.org/review-history.php?iid=228&id=19&aid=1714