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Family Planning and Its Associated Side Effects Among Women Attending Maternity Centers in Akure, Nigeria

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ABSTRACT

This study aimed to assess family planning and the associated risk factors among women attending maternity centers in Akure metropolis. Four maternity centers (Basic Health Center Familusi (Zone 5), Basic Health Centre Oke-Aro, Basic Health Centre Orita Obele and Comprehensive Health Centre Arakale) were randomly selected to participate in the study. Quantitative methods, which include the use of questionnaires were utilized to collect data for the study. The data was coded, entered and analyzed using the SPSS software program. The results showed that majority of the participants are between the ages 31-35 years of age. It was further observed that religion played a vital role in determining the child spacing in marriages. Higher side effect of family planning was noted among people practicing different family planning methods. The side effects include excessive weight gain as complained by 43 participants, 24 participants complained of vomiting whenever they take the drug and 42 complained of excessive heavy flow during their menstruation. These showed that most of the respondent believed that child control methods have side effects and this might be an important reason why most people in the community avoid the methods. To further increase awareness and improve mother to child care in the study area, government and religious leaders should be encouraged to educate the people on child spacing and family planning.

Keywords: Family planning, Contraceptives, Maternal care, Risk

1. INTRODUCTION

Family planning involves comprehensive medical or social activity which enables individuals, including minors, to determine freely the number and spacing of their children and to select the means by which this may be achieved. This may involve consideration of the number of children a woman wishes to have, including the choice to have no children, as well as the age at which she wishes to have them. These matters are influenced by external factors such as marital situation, career considerations, financial position, and any disabilities that may affect their ability to have children and raise them. If sexually active, family planning may involve the use of contraception and other techniques to control the timing of reproduction (1). Other techniques commonly used include sex education, prevention and management of sexually transmitted infections, pre-conception counseling and infertility management. It must be emphasized that family planning prevent conception and does not promote abortion.

Family planning is sometimes used as a synonym for access to and the use of contraception. However, it often involves methods and practices in addition to contraception. Additionally, there are many who might wish to use contraception but are not, necessarily, planning a family (e.g., unmarried adolescents, young married couples delaying childbearing while building a career); family planning has become a catch-all phrase for much of the work undertaken in this realm. Contemporary notions of family planning, however, tend to place a woman and her childbearing decisions at the center of the discussion, as notions of women's empowerment and reproductive autonomy have gained traction in many parts of the world. It is most usually applied to a female-male couple who wish to limit the number of children they have and/or to control the timing of pregnancy (also known as *spacing children*). In 2006, the US Centers for Disease Control (CDC) issued a recommendation, encouraging men and women to formulate a reproductive life plan, to help them in avoiding unintended pregnancies and to improve the health of women and reduce adverse pregnancy outcomes (2).

Raising a child requires significant amounts of resources: time, social, financial, and environmental (3). Adequate family planning can help assure that resources are available. The purpose of family planning is to make sure that any couple, man or woman who has a child has the resources that are needed in order to complete this goal. With these resources a couple, man or women can explore the options of natural birth, surrogacy, artificial insemination or adoption. In the other case, if the person does not wish to have a child at the specific time, they can invest the resources that are needed to prevent pregnancy, such as birth control, contraceptives, or physical protection and prevention. It must be noted that society has no impact in support or against conceiving a child. However, the decision to have or have not a child, it is the prerogative of individuals (4).

The term birth control is sometimes used as a synonym to family planning, but its connotation is more on preventing pregnancies and limiting the family size than on planning families. Contraception generally refers to the devices or medications used for reducing the likelihood of the fertilization of an ovum by a spermatozoon (5). The contraceptive effect can be obtained through temporary or permanent means. Temporary methods include: periodic abstinence during the fertile period; coitus interruptus (withdrawal); the naturally occurring periods of infertility (e.g., during breast-feeding and postpartum amenorrhea); use of reproductive hormones (e.g., oral pills and long-acting injections and implants); placement of a device in the uterus (e.g., copper-bearing and hormone-releasing intrauterine devices); interposing a barrier that prevents the ascension of the sperm into the upper female genital tract

(e.g., condoms, diaphragms and spermicides). Permanent method of contraception includes male and female sterilization (vasectomy and tubectomy) respectively (5). A number of contraceptive methods are available to prevent unwanted pregnancy. There are natural methods and various chemical-based methods, each with particular advantages and disadvantages. Behavioral methods to avoid pregnancy involve include the withdrawal and calendar-based methods, which have little upfront cost and are readily available. Long-acting reversible contraceptive methods, such as intrauterine device (IUD) and implant are highly effective and convenient, requiring little user action, but do come with risks. When cost of failure is included, IUDs and vasectomy are much less costly than other methods. In addition to providing birth control, male and/or female condoms protect against sexually transmitted diseases (STD). Condoms may be used alone, or in addition to other methods, as backup or to prevent STD. Surgical methods (tubal ligation, vasectomy) provide long-term contraception for those who have completed their families (6).

Despite the progress made in ensuring access to modern contraceptive methods in the recent time, women have continued to report an unmet need for family planning in the developing countries. While numerous women across the developing world would like to space or limit the number of their children, non-use of contraceptives is substantially high among them despite their sexual exposure and an expressed intention to avoid pregnancy. Unmet need for contraception is high in most parts of the developing world as a result of low contraceptive-use. An estimated 105.2 million married women had an unmet need for family planning in the developing world and, recently, the figure has increased to over 200 million (7).

The public health relevance of family planning is enormous. In the absence of family planning, the level of childbearing will be high resulting in a greater demand for obstetric and infant/child health services. In such situations maternal morbidity and mortality will also be high. Shorter spacing between births, because of non-use of family planning methods, is linked with increased risk of fetal death, low birth-weight, prematurity and infant and child mortality. It is estimated that about one million of the 11 million deaths of children younger than age five years could be averted annually if there were no inter-birth intervals of less than two years (8). Therefore, the study aimed to evaluate the risk factors associated with different family planning methods available in maternity centers in Akure metropolis.

2. MATERIALS AND METHODS

2. 1. Description of the Study Area

The study, was carried out in selected maternity centers in Akure metropolis of Ondo State (Figure 1). The unique location of Akure as a traversing point from all parts of the State makes it a special place in terms of the social, economic, cultural and political life of the state. Because of its central location, the Metropolis serves as an urban destination accommodating a high migrant population comprising people from almost all the ethnic groups and regions in the country.

Akure is the State capital of Ondo State. Ondo State borders Ekiti State to the north, Kogi State to the northeast, Edo State to the east, Delta State to the southeast, Ogun State to the southwest and Osun State to the northwest (Figure 1) with 18 Local Government Area (9). Until recently cocoa used to be the major source of wealth for the state but this has been replaced by petroleum which is prospected in Ilaje and Ese Odo local government areas.

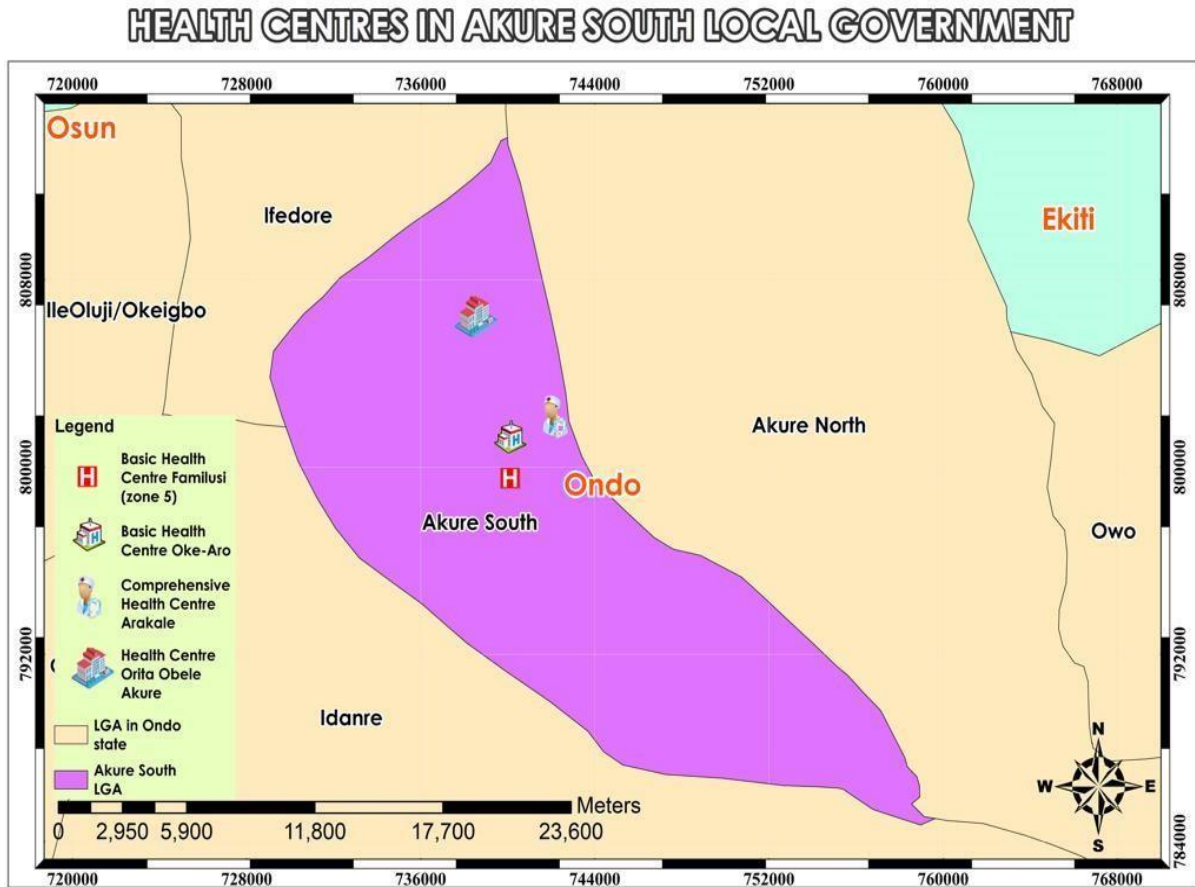


Figure 1. Map of Ondo State Showing the Sampling Sites (Maternity Centers).

2. 2. Study Design and Participants

This study employed the cross-sectional research design with a descriptive approach to examine the risk factors among women attending maternity centers in Akure metropolis of Ondo State. A cross-sectional research design is usually for studies that require detailed information about a phenomenon within a limited time span.

The target population for this study was 500 females attending maternity in Akure who were 18 years or above and majorly married as at the time of the study, in view of the fact that, the Nigerian constitution gives legal backing to people who are 18 years as matured and can decide for themselves. The maternity centers considered for this study include: Comprehensive Health Centre Arakale, Basic Health Centre Oke-Aro, Basic Health Center Familusi (Zone 5) and Basic Health Centre Orita Obele in Akure Metropolis.

2. 3. Informed Consent and Data Collection

Ethical clearance was obtained from Ondo State Ministry of Health and the maternity centers in Akure. Likewise, informed consents of the subjects were sought before obtaining relevant information from them. Data for this study were collected from the subjects using well-

structured questionnaires. The subjects who could not read the questionnaire were guided by the researcher.

2. 4. Statistical Analysis

The data collected from the field survey was entered, processed and analyzed using the SPSS (version 23) software program. The pre-coding of the questionnaire facilitated and eased the data coding process using the SPSS. The data was further generated into frequency tables which aided in the analysis. The study employed both descriptive and inferential statistical tools in the software (SPSS). The descriptive tool categorized the patient’s knowledge on family planning.

3. RESULTS

The results showed that majority of the respondents interviewed fell within the range of 31-35 years at Basic Health Centre Familusi (27.2%), Basic Health Centre Oke-Aro (34.4%), Basic Health Centre Orita Obele Akure (27.8%) and Comprehensive Health Centre Arakale (25.6%). The least age group of respondents were between the ages of 16-20 years and 41 years and above. Overall, majority of the respondents who participated in the study were mostly young adults who constitute the youth according to Nigeria’s definition of youth as persons between the ages 15-30years.

The age of the respondents helped to differentiate between the different categories of respondents. The study noted that youth are the one practicing family planning most in the study 144 area (Table 1).

Table 1. Age Distribution of the Respondents Across the Health Centers in Akure.

Age (years)	BHCF N (%)	BHCOA N (%)	BHCOO N (%)	CHCAA N (%)	TOTAL
16-20	10(8.0)	8(6.4)	10(8.0)	12(9.6)	40
21-25	16(12.8)	20(16.0)	24(19.0)	14(11.2)	74
26-30	26(20.8)	22(17.6)	33(26.2)	42(33.6)	123
31-35	34(27.2)	43(34.4)	35(27.8)	32(25.6)	144
36-40	29(23.2)	24(19.2)	15(11.9)	14(11.2)	82
41 and above	10(8.0)	8(6.0)	8(6.3)	11(8.8)	37
Total	125(100.0)	125(100.0)	125(100.0)	125(100.0)	500

Keys: BHCF = Basic Health Centre Familusi (Zone 5); BHCOA = Basic Health Centre Oke-Aro; BHCOO = Basic Health Centre Orita Obele in Akure Metropolis; CHCA = Comprehensive Health Centre Arakale.

The results further showed that most participants that participated in the study were married women. The marital composition of the participants include: 22.4% for the single women, 66.4% 152 for the married, 8.4% for the divorced and 2.8% for the widow. The married women were evenly 153 distributed among the maternity centers, 68.8%, 68.8%, 65.1% and 63.2% at Basic Health Centre 154 Familusi Zone 5, Basic Health Centre Oke-Aro, Basic Health Centre Orital Obele and Comprehensive Health Centre Arakale respectively (Table 2).

Table 2. Marital Status of the Respondents Across the Health Centers in Akure

Marital Status	BHCF N (%)	BHCOA N (%)	BHCOO N (%)	CHCA N (%)	TOTAL (%)
Single	31(24.8)	18(14.4)	22(17.5)	41(32.8)	112 (22.4)
Married	85(68.8)	86(68.8)	82(65.1)	79(63.2)	332 (66.4)
Divorced	6(4.0)	16(12.8)	16(12.7)	4(3.2)	42 (8.4)
Widow	3(2.4)	5(4.0)	5(4.0)	1(0.8)	14 (2.8)
Total	125(100.0)	125(100.0)	125(100.0)	125(100.0)	500

Keys: BHCF = Basic Health Centre Familusi (Zone 5); BHCOA = Basic Health Centre Oke-Aro; BHCOO = Basic Health Centre Orita Obele in Akure Metropolis; CHCA = Comprehensive Health Centre Arakale

Table 3 results on the educational status of respondents showed that majority of the respondents were secondary school holders. For instance, in Basic Health Centre Familusi, 40% (n= 50) of the respondents attended only secondary school education, 47.2 % (n=59) in Basic Health Centre Oke-Aro, attended secondary school education, 55.6% (n=70) in Basic Health Centre Orita

Obele attended secondary school education and 51.2% (n=64) in Comprehensive Health Centre Arakale attended secondary school education (Table 3). One’s educational level determines how knowledgeable the person is regarding how the person approaches life and how he or she practices family planning.

Table 3. Education Status of the Respondents Across the Health Centers in Akure

Educational Qualification	BHCF N (%)	BHCOA N (%)	BHCOO N (%)	CHCA N (%)	TOTAL
Primary	42(33.6)	25(20.0)	21(16.7)	19(15.2)	107
Secondary	50(40.0)	59(47.2)	70(55.6)	42(33.6)	221

Post Secondary	33(26.4)	41(32.8)	34(17.0)	64(51.2)	172
Total	125(100.0)	125(100.0)	125(100.0)	125(100.0)	500

Keys: BHCF = Basic Health Centre Familusi (Zone 5); BHCOA = Basic Health Centre Oke-Aro; BHCOO = Basic Health Centre Orita Obele in Akure Metropolis; CHCA = Comprehensive Health Centre Arakale

The results showed that the most dominant religion among the respondents is Christianity, with 67 (53.6%) at Basic Health Centre Familusi (Zone 5), 51 (40.8%) at Basic Health Centre OkeAro, 62 (49.2%) at Basic Health Centre Orita Obele and 93 (74.4%) at Comprehensive Health Centre Arakale. Islamic religion followed closely with 46 (36.8%), 50 (40.0%), 43 (34.1%) and 28 (22.4%) respectively. Traditional religion was noted to be the least practice religion in the study area (Table 4).

Table 4. Frequency Distribution of Religion Status of the Respondents

Religion	BHCFZONE N (%)	BHCOA N (%)	BHCOOAS N (%)	CHCAAOS N (%)	TOTAL
Christianity	67(53.6)	51(40.8)	62(49.2)	93(74.4)	273
Islam	46(36.8)	50(40.0)	43(34.1)	28(22.4)	167
Traditional	9(7.2)	24(19.2)	19(15.1)	4(3.2)	56
Others	3(2.4)	0(0.00)	1(0.8)	0(0.00)	4
Total	125(100.0)	125(100.0)	125(100.0)	125(100.0)	500

Keys: BHCF = Basic Health Centre Familusi (Zone 5); BHCOA = Basic Health Centre Oke-Aro; BHCOO = Basic Health Centre Orita Obele in Akure Metropolis; CHCA = Comprehensive Health Centre Arakale

The results on the tribe of the respondents interviewed in the four Health Centre in Akure as presented in Table 5 showed that 78 (56.0%) at Basic Health Center Familusi, 87 (69.6%) at Basic Health Centre Oke-Aro 73 (58.4%) at Basic Health Centre Orita Obele and 76 (60.8%) at Comprehensive Health Centre Arakale are Yorubas. Hausa tribe is the least common tribe in the study area with 7.2% (n=16) in Basic Health centres Familusi zone 5, 5.6% (n=7) in Basic Health Centre Oke-Aro, 8.8% (n=11) in Basic Health Center Orita Obele and 6.4% (n=8) in Comprehensive Health Centre Arakale. In contrary, two respondents were found to belongs to Idoma and Tiv tribe in Basic Health Centres in Akure.

This shows that Yoruba is the dominant tribe in the southwest of Nigeria in which Akure the study area is located.

Table 5. Frequency Distribution of Tribe of the Respondents

Tribe	BHCF N (%)	BHCOA N (%)	BHCOO N (%)	CHCA N (%)	TOTAL
Yoruba	78(56.0)	87(69.6)	73(58.4)	76(60.8)	314
Ibo	31(19.2)	29(23.2)	41(32.8)	41(32.8)	142
Hausa	16(7.2)	7(5.6)	11(8.8)	8(6.4)	42
Other	0(0.0)	2(1.6)	0(0.0)	0(0.0)	2
Total	125(100.0)	125(100.0)	125(100.0)	125(100.0)	500

Keys: BHCF = Basic Health Centre Familusi (Zone 5); BHCOA = Basic Health Centre Oke-Aro; BHCOO = Basic Health Centre Orita Obele in Akure Metropolis; CHCA = Comprehensive Health Centre Arakale.

The results further showed that majority of the participants in the study are traders who engaged in buying and selling of consumables such food, drinks and fruit. However, the least occupation observed in the study area is farming (Table 6).

Table 6. Occupation of the Respondents in the Basic Health Centres in Akure

Occupation	BHCF N (%)	BHCOA N (%)	BHCOO N (%)	CHCA N (%)	TOTAL
Student	25(20.0)	6(4.8)	11(8.8)	16(12.8)	58
Trader	46(36.8)	51(40.8)	48(38.4)	35(28.0)	180
Civil Servant	28(22.4)	40(32.0)	33(26.4)	46(36.8)	147
Artisans	20(16.0)	28(22.4)	32(25.6)	10(4.48)	90
Farmer	6(4.8)	0(0.00)	1(0.8)	18(0.8)	25
Total	125(100.0)	125(100.0)	125(100.0)	125(100.0)	500

Keys: BHCF = Basic Health Centre Familusi (Zone 5); BHCOA = Basic Health Centre Oke-Aro; BHCOO = Basic Health Centre Orita Obele in Akure Metropolis; CHCA = Comprehensive Health Centre Arakale

The results as presented in Table 7 showed different methods of family planning practiced in Basic Health Centers in Akure. The results showed that condom was the most Family Planning method used among the respondents in Basic Health Center Familusi (32.8%), Basic

Health Center Oke-Aro (41.6%) and Basic Health Center Orita-Obele (32%). Meanwhile, Copper T was the most popular method among the respondents in Comprehensive Health Centers Arakale (19.2%). In contrast, withdrawal methods were the least family planning methods used in Basic Health Center Oke-Aro (2.4%), Orita-Obele (4.8%) and Comprehensive Health Center Arakale (6.4%). The use of contraception was also relatively high among the respondents. For instance, 20.8%, 23.2%, 48.8% and 28% preferred contraceptive to other methods in Familusi, Oke-Aro, Orita Obele and Arakale respectively (Table 7).

Table 7. Family Planning Methods Practiced Among Respondent in Akure

Method Used	BHCF N (%)	BHCOA N (%)	BHCOO N (%)	CHCA N (%)	TOTAL
Condom	41(32.8)	52(41.6)	40(32.0)	16(12.8)	149
Injection	11(8.8)	16(12.8)	18(14.4)	8(6.4)	53
Injection	11(8.8)	16(12.8)	18(14.4)	8(6.4)	53
Contraception	26(20.8)	29(23.2)	36(28.8)	35(28.0)	126
Withdraw	21(16.8)	3(2.4)	6(4.8)	8(6.4)	38
Implant	9(7.2)	11(8.8)	13(10.4)	34(27.2)	67
Copper T	17(13.6)	14(11.2)	12(9.6)	24(19.2)	67
Total	125(100.0)	125(100.0)	125(100.0)	125(100.0)	500

Keys: BHCF = Basic Health Centre Familusi (Zone 5); BHCOA = Basic Health Centre Oke-Aro; BHCOO = Basic Health Centre Orita Obele in Akure Metropolis; CHCA = Comprehensive Health Centre Arakale

Results in Table 8 showed the period at which the participants have been using their preferred family planning. Fifty-five percent of the participants claimed to have been using withdrawal method for 1-3 years, 34.8% claimed to be using pills for 4-6 years, 9.2% participants claimed to have been using diaphragm for 7-9 years, 0.8% claimed to have been using contraception for 10-12 years and 0.2% claimed to have been using condoms for 13 years and above (Table 8).

Table 8. Duration of Practicing Family Planning Methods in Akure

Family Planning Methods	Years	BHCF N (%)	BHCOA N (%)	BHCOO N (%)	CHCA N (%)	TOTAL (%)
Withdrawal	1-3	61(56.8)	72(57.6)	70(56.0)	72(57.6)	275 (55)

Pills	4-6	39(39.2)	48(38.4)	46(36.8)	41(32.8)	174 (34.8)
Diaphragm	7-9	25(4.0)	5(4.0)	6(4.8)	10(8.0)	46 (9.2)
Contraception	10-12	0.(0.0)	0.(0.0)	2(1.6)	2(1.6)	4 (0.8)
Condoms	13 above	0.(0.0)	0.(0.0)	1(0.8)	0.(0.0)	1 (0.2)
Total		125(100)	125(100)	125(100)	125(100)	500

Keys: BHCF = Basic Health Centre Familusi (Zone 5); BHCOA = Basic Health Centre Oke-Aro; BHCOO = Basic Health Centre Orita Obele in Akure Metropolis; CHCA = Comprehensive Health Centre Arakale

The interactions with the participants attending the maternity centers on the side effects associated with their preferred family planning showed that 279 (55.8%) participants explained 239 that they face various side effects in the course of using their preferred family planning method. However, 221 (44.2%) participants said they never experienced any side effect from their preferred family planning methods. The most complained side effect was pot belly (12.6%) resulting from the use of pills for birth control followed by excessive fatness resulted from the use of injection (8.6%) and heavy flow during menstrual cycle as complained by 8.4% of the participants. Also, 1.8% of the participants complained that copper T and oral method gave them constant headache while 4.8% of the participants complained that pills made them to vomit regularly. However, 44.2 % said they have never experienced any side effects on their preferred birth control (Table 9).

Table 9. Respondents’ Complaints about the Family Planning Methods

Side Effect/ Respondents Complaints	BHCF N (%)	BHCOA N (%)	BHCOO N (%)	CHCA N (%)	TOTAL (%)
Injection makes me Fat	10	4	3	26	43 (8.6)
Copper T Makes Me Fat	15	9	0	0	24(4.8)
Constant Headache Due to Copper T and Oral Methods	0	0	0	9	9(1.8)
Pot Belly Due To Implant	21	11	0	31	63(12.6)
Pills make me Fat	0	3	25	0	42(8.4)
Pills make me slim	0	8	0	0	8(1.6)
Contraceptive makes me have heavy Flow	8	9	25	0	42(8.4)

Implant makes me Gain Weight	13	13	2	0	28(5.6)
Pills make me vomit	0	10	14	0	24(4.8)
No Challenges	58	58	56	49	221 (44.2)
Total	125(100.0)	125(100.0)	125(100.0)	125(100.0)	500(100.0)

Keys: BHCF = Basic Health Centre Familusi (Zone 5); BHCOA = Basic Health Centre Oke-Aro; BHCOO = Basic Health Centre Orita Obele in Akure Metropolis; CHCA = Comprehensive Health Centre Arakale

4. DISCUSSION

Age at the time of marriage plays an important role on a family and country’s fertility rate even if there are no differences in completed fertility by age at marriage. This is because early marriage means early child bearing and it means reduced generation length and more women able to have children at any time. This increases the crude birth rate which has a positive impact on population growth as stated by (10).

The results of this research show that the respondents between 31-35 years have the highest frequency. According to Negash and Asmamaw (11), median age at first-birth increase with level of education. Women with non-education have their first birth years earlier than women with secondary education and post-secondary education.

Education is considered to be one of the most important social economic factors having an indirect influence on birth interval length through its impact on one or more of the bio-behavior variables as reported by Yohannes et al. (12). The result of above demographic on education status shows higher record of secondary school holder.

This study also observed occupation as one of the demographic tools in determining child planning and management. Demographic on the occupation by the respondents revealed higher result from the trader respondents. The finding shows that business people (traders) have the highest frequency, this can be traced to the fact that most of the traders are almost busy with their business which prompt them to practice family planning. This is in agreement with the finding of Nazmul (13), civil-servants and business class adopt family planning more vigorously than other sectors like apprentice, farming, allied activities and laborers. The results from this study further affirmed that most people now practice family planning.

This finding agrees with the report of Iyoke (14), who reported that given the restrictive abortion law in place in Nigeria, effort at reversing the trend towards high rate of unwanted pregnancy, unsafe abortion and Human Immune Deficiency Virus infection among young people relies upon increase the uptake of contraceptive in particular the more effective modern methods. Also, according to African Population Study by Jacob (15), injectable contraceptives increased about six-fold from 7 to 42%. According to African Population Study by Jacob (15), between 1986, and 2008 the percentage of the married women increase to 37%, while in Malawi only 2% of the married women uses modern contraceptives injections as their current method in 1992, but by 2010, that percentage had increased to 61%.

The results of this study further shows that religion plays a vital role in determine the child spacing in marriages. According to Bhatt et al. (16) who identified barriers to child

spacing to include: religion, cultural factors lack of awareness, opposition to uses by partner or family member. Demographic on religion of the respondent revealed that, higher number of the respondent are Christians, Islam followed immediately, this shows that Christianity has the highest frequency of family planning method. According to (17), he enumerated religion, ethnic background, education level as part of decision considered in marriage per children. Also, Arousell and Calborn (18) stated that religious believer or observer might choose to avoid certain methods of family planning such as control pills in an effort to live their lives according to the teachings of their religion. The findings of (19, 20) stated that, the general agreement among women, husbands, mother-in-law and health services providers that Islam and Christianity both encourage a resting period for the health of the mother and lastborn child. Christianity encourages spacing but does not specify time. Islam however, clearly specifies breastfeeding for two years.

Side effect of the family planning shows higher risk among people practicing family planning. These side effect include fat, pot belly, slim, heavy flow during period, swollen face, ugly, appetites, bleeding, weight gain, visual problems and smelling. These challenges had also been reported by Iyoke (13). The author reported similar side effects among the respondents in Northern Africa.

5. CONCLUSIONS

Based on the research objectives and findings of this study, the following conclusions were made: First, women practicing family planning in Akure Metropolis of Ondo State have adequate knowledge on child spacing. The most used child spacing method is the use of condom and contraception while the least practice family planning method is the withdrawal method. It was also noted that age, religion, level of education, family type, age at the time of marriage, and occupation have significant influence on knowledge of child spacing method adopted.

Lastly, fat, pot belly, slim, heavy flow during period, swollen face, ugly, appetites, bleeding, weight gain, visual problems and smelling are the risk factors associated to family planning. It is therefore, recommended that further campaign and awareness should be intensified among the reproductive females. This campaign should be extended to religious houses and traditional leaders to encourage their followers to embrace family planning programs. Also, government should put sustainable measures in place to encourage family stability so that parents can play their role in proper upbringing of their children.

Biography

Dr Afolabi Olajide Joseph is a reader in the Parasitology and Public Health Unit of the Department of Biology, Federal University of Technology Akure, Nigeria.

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