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Factors Influencing Contraceptive Use Among Traders in Boundary Market of Ajeromi Ifelodun, LGA, Lagos State

Uchenna, Ngozi Grace (RN, RM, RPHN, BNSc)
Department of Public/Community Health Nursing,
School of Nursing, Babcock University, Ilishan-Remo, Ogun State

Farotimi, Abosede Adekunbi (RN, Ph.D)
Department of Nursing Science,
Faculty of Clinical Sciences, College of Medicine, University of Lagos

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ABSTRACT: *It is the intentional prevention of conception or impregnation during sexual activity through natural or man-made means. The widely accepted strategy is regulating and controlling fertility through contraception. Contraceptive use has been known to have numerous health benefits in the area of preventing unplanned pregnancies, ensuring optimum spacing between births, reducing maternal and child mortality, and improving the lives of women and children in general. This study is on factors influencing contraceptive use among traders in Boundary market of Ajeromi.Ifelodun. A quantitative research design was used for the study. A calculated sample size of 370 was gotten from the target population of 2645. Questionnaire was used to collect data from only the consented traders. The findings of the study reveals that 9(2.6%) of the respondents representing had poor knowledge of contraceptives, 176(50%), had moderate knowledge while 167(47.4%) had high knowledge of contraceptives. This means. most of the respondents had good knowledge of contraceptives while the perceived factors influencing contraceptive use identified among the traders were partner's disapproval of use of contraceptives, in-frequent sex with spouse, financial implication, fear of side effects, religious inclinations, and cultural beliefs. Also, there was no significant association between socio-demographic characteristics and background knowledge of contraceptives among traders in Boundary market. It is recommended that stakeholders in the health committee of the market should liase with nearby health facility for quarterly outreach program in the market pending the availability of their own health facility.*

KEYWORDS: factors influencing, contraceptives, traders

INTRODUCTION

Contraception is the conscious desire to limit or space birth, it may be traditional or modern. The study of Gbenga-Epebinu and Ogunrinde (2020) on modern contraceptive use in a suburb in Ekiti

reveals contraceptive use has been with us for a while. A study by Ntoimo, et al., (2017) revealed only 27% of Nigerian couples were on contraceptive use at the time of the survey. It is defined generally as intentional prevention of conception or impregnation during sexual activity through man-made means (Hossain, et al., 2018). The world's populations have risen steadily and have grown fast over 7.5 billion. This growth is unevenly distributed, much of the growth occurred in developing countries and Nigeria being one of them with growth rate of 4.7% and approximate 5.8 live births per woman is ranked highest in the world (United Nations 2020). Rapid population growth rate as against scarce resources has been and is presently one of the major problems facing Nigeria and most countries in the world today, as a result attempts are being made globally to create awareness and find ways of combating it. The widely accepted strategy is regulating and controlling fertility through contraception.

Contraceptive use has been known to have numerous health benefits in the area of preventing unplanned pregnancies, ensuring optimum spacing between births, reducing maternal and child mortality, and improving the lives of women and children in general (Stover & Sonneveldt, 2017). Also, the innovative development of safe and effective contraceptive methods is effective in poverty reduction, reduction of maternal and child mortality, prevention of STI, and women empowerment (Ajony, 2015). Majorly, among women and couples' contraceptives it's used to aid healthier pregnancies, help time and space births, and to achieve desired family size. Contraceptives helps regulate pregnancies that occur too early or too late in a woman's life, or that are spaced too closely, which may negatively affect maternal health and increase the risk of prematurity and low birth weight.

According to WHO (2018) among the 1.9 billion Women of Reproductive Age group (15-49 years) worldwide in 2019, 1.1 billion have a need for family planning; of these, 842 million are using contraceptive methods, and 270 million have an unmet need for contraceptive methods. In the United States, there are 61 million U.S. women in their childbearing years (15–44). About 43 million of them (70%) are at risk of unintended pregnancy, that is, they are sexually active and do not want to become pregnant but could become pregnant if they and their partners fail to use a contraceptive method correctly and consistently. Couples who do not use any method of contraception have approximately an 85% chance of experiencing a pregnancy over the course of a year. A much higher proportion of married women and never-married women use a contraceptive method. Even among those at risk of unintended pregnancy, contraceptive use is higher among currently married women than among never-married women (93% vs. 83%). There are associated socio demographic patterns in contraceptive usage. Contraceptive use is common among women of all religious denominations.

In Africa and Nigeria in particular, the subject of contraception is sensitive and controversial and even resentful to some partners, due to the heterogeneity of our culture. In developing countries like Nigeria, one in three women gives birth before the age of 20 and pregnancy-related death during childbirth is two times higher compared to women older than 20 years. Reports from 2015–

2017, 42% of never-married female teenagers aged 15–19 and 38% of never-married male teenagers had had sexual intercourse (NDHS, 2018). Many sub-Saharan African countries still present a high total fertility rate: almost 5·4 births per woman and a low modern contraceptive prevalence rate. Nigeria and Lagos have shown fewer improvements in modern contraceptives. According to Singh, et al. (2017), there was non-utilisation of contraceptives which resulted in 5 million unplanned pregnancies, 1.2 million infant mortalities would have been averted if contraceptive was effectively used. It is same in many studies in Sub-Saharan Africa which reported low level of contraceptive uptake as discussed by Solanke (2017), few of the many reasons for low uptake were women's misconceptions of contraceptive use, use of unproven concoctions, religious beliefs, spousal disapproval among others.

Trends in contraceptive use worldwide by United Nations department of Economic and social affairs population division revealed that because of the unmet needs for family planning which results in mothers not utilizing antenatal care or opting for options leading to high maternal mortality rate (WHO, 2015). Approximately 12% of married or in-union women are estimated to have an unmet need for family planning; the most important way to remove unmet needs for family planning is to use modern contraceptive methods (Sensoy, et al., 2017). It was revealed in NDHS (Nigerian Demographic & Health Survey NDHS 2018) that only few market women in Nigeria are currently on any form of contraceptives, this shows contraceptive use is still low among market women. The use of contraceptives and the pattern of its use may be influenced by numerous factors such as contraceptives, risk perception, fear of side effects, opposition from male partners, health service limitations, and insufficient knowledge to make informed choices, socio-demographic characteristics, and negotiation skills of the persons involved (Balogun et al., 2013; Sultan, 2018). There are some factors affecting the utilisation of modern contraception among couples. Blackstone, et al. (2017) in their work reported low levels of education, women's and partners' disapproval of modern family planning methods, religious beliefs, fear of side effects of modern contraception, women's misconceptions of contraceptive side effects, use of unproven methods or concoctions and infrequent sex are among the reasons for non-use of contraception. Other factors that might influence the pattern of contraceptives use may include partners' preference, African traditional culture settings, and family planning knowledge (Newey, 2020). A study in Bangladesh by Islam et al., (2016) on prevalence and determinants of contraceptive use among employed and unemployed women (16,616 as sample) revealed that the contraceptive use was found higher among employed women (67%) than that of unemployed women. Women's age, education, region, number of living children, and child preference were found to be factors contributing to current use of contraception among employed women likewise women's age, education, husband's education, region, residence, religion, number of living children, ever heard about family planning, and child preference were identified as the significant predictors of contraceptive use among the women.

Sekoni and Oladoyin (2016) concluded that contraceptive use is lowest among young women, reaches a peak among women in their thirties and declines among older women, this is indicative

of a high desire for procreation among younger women. Ismail et al., (2016) explored age gap and its effect on reproductive health in Nigeria, using Ankpa local government area of Kogi state as a unit of analysis, in-depth interview on spousal age gap with married women gave the researcher an opportunity to assess the views of married women, findings were age-gap narrows spousal communication and it has implication on younger bride's ability to communicate well and freely with their husbands, the wider the age gap the more the respect, the closer the age gap the tendency for disrespect .

In developing countries, men are the leader of the households and make most decisions while women are to merely obey, including contraceptive issues (Geleta, et al., 2015; Okigbo, et al., 2015). Okigbo, et al., (2015) posited that the less importance attached to male involvement in family planning choice by couple is neglect of a vital factor. In the study, a two-stage cluster sampling was used in selecting men from Senegal (1613), Nigeria (2311) and Kenya. 58% of the men reported use of modern contraception, 43% in Nigeria, and 27% in Senegal, despite about 80% exposure to Urban Reproductive Health Initiative (URHI) in their respective countries. There was association between men involved in URHI community events in Kenya, likewise men who are exposed to URHI-television programs and religious leaders' voice on family planning but in Nigeria there was no association. Kabangeyi, et al., (2016) in their study on socio-cultural inhibitors to use of modern contraceptives among men and women in rural Uganda using 18 selected focused group discussion and 8 in-depths interviews revealed that socio-cultural expectations and values attached to married women and childbearing are very strong. The themes that emerged were persistence of socio-cultural beliefs and practices promoting birth e.g., polygamy, extending family lineage and replacement of the dead, continued reliance on traditional family planning practices and misconceptions about modern contraception. Their findings in the qualitative study showed access barriers associated with health workers who only promote their preferred and available modern contraceptives, son preference also persists even with and without female education, this is attached to the cultural belief of lineage sustenance.

Sultan (2018) in her submission on the effects of education, poverty and resources in family planning in Uganda that females with basic primary education tend to have fewer healthier children, post-secondary school women use contraceptives more than their illiterate counterparts and that education aids proper understanding of family planning. Trading economics dissected the problems in accessing healthcare in relation to contraceptive prevalence 'as not wanting to go alone, distance to health facility, getting money for treatment, concern that there may not be a family planning provider, getting permission to go for treatment, having to take a transport and knowing where to go for treatment'. Kabangeyi et al., (2016) expatiate further that Christians believe children are the heritage of the Lord so He will take care of them, Muslims believe all the women's eggs must be fertilized, Catholics said it is abominable to interfere with procreation. The use of herbs, concoction, charms tied around the waist, umbilical cord inserted into the vagina, herbs used with mixed sanitary pads, blood from first menstruation after delivery mixed with herbs and placed in the bedroom, all these and more are traditional methods which are cheap and has

been existing for long and most preferable. It was further iterated in the study that polygamy pushed women to gaining their husband's love by having more children and to gain more inheritance. Likewise, a married woman has obligations to bear children frequently so as not to be chased out of matrimony or her bride price retrieved from her family, the community perception also encouraged gender violence.

In a study on attitude on married men and women in Ekiti by Babatunde, et al. (2019), 72.8% of respondents like use of family planning method, 63.6% preferred health center for access to family planning, 27.3% agreed in-laws have major decision on how children are spaced in the family, however it was recorded that their sexual health are affected by poor knowledge of available methods, the religion of married men and the shyness to express appropriately issues relating to sex. Findings of Babatunde, et al., (2019) showed relationship between religion and attitude to family planning, acceptance of sterilization to limit family size was greater among Christians and Muslims than Hindus, these pointed at strength, adherence and attachment of a couple to a particular religion which influence their reproductive behaviour. Individuals get the knowledge of family planning methods then they transcribe their attitudes and positive or negative behaviour for the decision of the method suitable for them. Some studies have mentioned the importance of the role of men in reproductive health and their influence on decision-making and behaviour related to reproduction, though many family planning programs have focused mainly on women. Even though men are increasingly being "involved" in reproductive health programs, their participation still seems to be lean (Sensoy, et al., 2018). Family planning is not only decided by economic factors, but also affected by socio-cultural factors such as fertility preferences or values related to having children.

Studies have identified multiple factors that underlie low contraceptive prevalence in Nigeria; these factors span demand and supply domains. The supply factors associated with low contraceptive prevalence are method mix, provider technical and interpersonal skills, Provider bias, erratic supply of contraceptives and type of facility (Schwandt, et al., 2017). Among the demand factors that have been found to be associated with contraceptive use are socio-demographic and socio-economic characteristics, including age, parity, education, religion, monogamous marriage, urban residence, and household wealth (Odewale, et al., 2016; Sekoni & Oladoyin 2016). A study on five-year plan on contraceptive uptake in Bauchi and Sokoto in 2015 submitted that despite substantial and targeted interventions which are increased number of contraceptives, increased service delivery points especially in rural areas and shifting health workers tasks such as implant insertion to lower tier providers like CHEWS, there was still desire for large families mainly due to economic quintile, religious belief and so many controversies about limiting childbearing however child spacing was generally accepted. Though consent of client's husband was universally required before initiation, it could be in form of verbal approval, consent form, physical presence of husbands in health facility, though few wives came in secret which has led to medico-legal issues, but it can be granted if the health of the woman is at stake (Schwandt, et al., 2015).

Kasa, et al., (2018) concluded that couple-based education or counselling, shared decision making on family planning use, men mobilization as partners to increase awareness and willingness, allowing and supporting their partners to use a family planning method. Ndayigize, et al., (2017) reported that despite available modern contraceptives, uptake of family planning services was as low as 0.6%, the in-depth interview with facility heads and community leaders revealed only 22.4% family planning trained providers, unavailability of the long-acting method of contraception (implants), fear of side effects and disclosure of been on a modern contraceptive method. Mustapha, et al., (2015) discovered that knowledge level of the study participants was low, overall FP use in rural areas (31%), urban (45%), abortion was used clandestinely and as an option for failed contraception, distance to a reproductive health facility in rural areas is mostly longer than in urban and quacks were mostly patronized. The influence of mother-in-law and spousal communication on uptake of family planning was evident, there was lack of health facilities in the rural areas which made private hospitals and quacks to be more patronized, and choice of available methods were limited though lady health worker was available, but the participants reported they are biased and charge more during night visits, so they are not fully trusted (Mustapha, et al., 2015). At the selected province, religious ties made them jettison surgical FP methods like tubal ligation and vasectomy because they believe someone can have more children as much as possible so far there is money, and their reliable and most immediate source of information is verbal.

Provision of modern contraceptive methods is one of the main components of sustainable global development, poverty alleviation, environmentally safe sustainability, increased life expectancy, women empowerment, gender equality, and health promotion including the reduction of maternal morbidity, mortality, and unsafe abortion, and the improvement of child survival through birth spacing (WHO, 2018). More so, the improvement of contraceptive usage is dependent on policies based on data from contraceptives usage and patterns of use. It is on this basis, coupled with personal encounters with people with unintended pregnancy and people struggling with repeated contraction of sexually transmitted infections that drives this study to investigate contraceptive use among traders in boundary market of Ajeromi Ifelodun, LGA, Lagos State.

The main objective of this study is to determine the factors influencing contraceptive use among traders in Boundary market of Ajeromi Ifelodun, LGA, Lagos state. The specific objectives are to:

1. Determine the background knowledge of contraceptives among traders in boundary market Ajeromi Ifelodun, LGA, Lagos state.
2. Investigate the perceived factors influencing contraceptive use among traders in boundary market Ajeromi Ifelodun, LGA, Lagos state.

Research Questions

The following question will guide the study:

1. What is the background knowledge of contraceptives among traders in Boundary market Ajeromi Ifelodun, LGA, Lagos state?

2. What are the perceived factors influencing contraceptive use among traders in Boundary market Ajeromi Ifelodun, LGA, Lagos state?

Hypothesis

The proposed hypothesis will be tested in the study at 0.05 level of significance.

H_o1: There is no significant association between socio-demographic characteristics and background knowledge of contraceptives among traders in Boundary market

METHODOLOGY

The study adopted a quantitative approach. The study used a descriptive survey method. It involved a structured way of gathering characteristics and information on responses. The target population for this study is traders in Boundary market, Ifelodun LGA, Lagos State. The population is 2645. The population of 2645 was obtained from the heads of market. The Cochran formula was used to calculate the sample size which yielded sample size of 370 traders. Stratified and simple random sampling techniques were used to select the 370 traders. Stratified random sampling technique was used to select different segments of the market. The different segments of the market were the strata, they are North South West and East according to the market register. A simple random technique was used to select 370 traders randomly. A structured questionnaire was used to elicit information from the respondents, the questionnaire was developed using study objectives and research questions in line with the literature reviewed. The questionnaire consisted of 3 sections;

Section A: The first part of the questionnaire covered question items on demographic information of the respondents. The questions were on gender, age, educational level, marital status, parity, ethnic group, religion and family type

Section B: This section will elicit information on respondent's knowledge of contraceptives use, examples of modern contraception, the right time to commence modern contraceptives and known benefits. The items are 12. The low level of knowledge of contraceptives will be those who scored less than 50% of the 12 items which ranges from 0 to 5. The moderate level will be those who scored between 50% and 70% of the 12 items and it ranges from 6 to 8. The high levels of knowledge of contraceptives will be those who scored above 70% of the 12 items which ranges from 9 to 12.

Section C: This section will elicit information on respondent's perceived factors influencing contraceptive use. This section consists of 8 items as Strongly Agree will be scored 4 points, Agree will be scored 3 points, Disagree will be scored 2 points while Strongly Disagree 1 point

The instrument was subjected to face and content validity. The items in the questionnaire were presented to experts in the test and measurement, and in the nursing field for review, correction and appraisal after which necessary corrections were made. The internal consistency method was used to determine the reliability of the instrument. The corrected and validated version was

administered on 37 traders (10% of the sample size) in Badagry market which is outside the sample area. The data collected were analysed using Cronbach Alpha. The overall reliability index and reliability index of each section were calculated using Cronbach Alpha, which yielded coefficient value of 0.775. Consent was sought and obtained from the participants (traders) before administering the research instrument. The researcher clarified the intention of the study to the willing participants in order to promote good responses and cooperation. Questionnaires were administered by the researcher on the participants. Data entering, cleaning and coding to spread sheets were done and analysed using Statistical Package for Social Sciences (SPSS) version 28 was used. The quantitative data was analysed through descriptive and inferential statistics. The only hypothesis was analysed using Chi-square at 0.05 level of significance.

RESULTS

Socio-demographic Characteristics of Respondents.

Table 1: Distribution of respondents by socio-demographic characteristics N= 352

Socio-demographic characteristics	Frequency (N= 352)	Percentage
Age		
Below 20 years	18	5.1
21-30 years	119	33.8
31-40 years	114	32.4
41-50 years	71	20.2
Above 50 years	30	8.5
Religion		
Traditional	8	2.3
Islam	164	46.6
Christianity	180	51.1
Gender		
Female	244	69.3
Male	108	30.7
Marital Status		
Single	55	15.6
Married	253	71.9
Separated	29	8.2
Divorced	15	4.3
Educational level		
No Formal Education	17	4.8
Primary	65	18.5
Secondary	209	59.4
Tertiary	61	17.3
Ethnicity		
Yoruba	218	61.9
Hausa	16	4.5
Igbo	67	19.0
Others	51	14.5
Family Type		

Monogamy	294	83.5
Polygamy	58	16.5
Parity		
None	35	9.9
1	117	33.2
2-3	144	40.9
4 and above	56	15.9
Total	**352**	**100.0**

Table 1 indicated that respondents below the age of 20 years were 18(5.1%), those within 21-30 years were 119(33.8%), 31-40 years were 114(32.4%), 41-50 years were 71(20.2%), while above 50 years were 30(8.5%). On religion, 8(2.3%) were traditionalist, 164(46.6%) were Muslims while 180(51.1%) were Christians. On gender, 244(69.3%) were female, while 108(30.7%) were male. On marital status, 55(15.6%) were single, 253(71.9%) were married, 29(8.2%) were separated, while 15(4.3%) were divorced. On educational level, 17(4.8%) had no formal education, 65(18.5%) had primary education, 209(59.4%) had secondary education while 61(17.3%) had tertiary education. On ethnicity, 218(61.9%) were Yoruba, Hausa were 16(4.5%), Igbo were 67(19%), others were 51(14.5%). On family type, 294(83.5%) were monogamous while 58(16.5%) were polygamous. On parity, 35(9.9%) had no children, 117(33.2%) has one child, 144(40.9%) has between 2-3 while 56(15.9%) has 4 and above.

Research Question 1: What is the background knowledge of contraceptives among traders in Boundary market Ajeromi Ifelodun, LGA, Lagos state?

Table 2: Background Knowledge of Contraceptives among Respondents N= 352

S/N	ITEMS	Correct (%)	Incorrect (%)	Mean	S.D.
1.	Modern contraceptives can be commenced at 6 weeks after a woman puts to bed	215 (61.1)	137 (38.9)	0.61	0.49
2.	Modern contraception is a method used to limit or space birth	322 (91.5)	30 (8.5)	0.91	0.28
3.	Modern contraceptive should be done in the health facility	247 (70.2)	105 (29.8)	0.70	0.46
4.	Modern contraceptive limits the number of children people can have	275 (78.1)	77 (21.9)	0.78	0.41
5.	Modern contraceptive leads to marital disharmony	224 (63.6)	128 (36.4)	0.64	0.48
6.	Modern contraceptive reduces unwanted pregnancy	299 (84.9)	53 (15.1)	0.85	0.36
7.	Modern contraceptive reduces mother and child illnesses	263 (74.7)	89 (25.3)	0.75	0.44
8.	Condom usage is not necessary during menstrual period	118 (33.5)	234 (66.5)	0.34	0.47

9.	Condom may break while in use	261 (74.1)	91 (25.9)	0.74	0.44
10.	Emergency contraception is used after a week of unprotected sexual intercourse	237(67.3)	115(32.7)	0.67	0.47
11.	Modern contraceptives should be used based on contraceptive effectiveness	163(46.3)	189(563.7)	0.54	0.50
12.	Modern contraceptives should be used based on self-prescription	145(41.2)	207(58.8)	0.59	0.49

On background knowledge of contraceptives among traders in Boundary market Ajeromi Ifelodun, 189(53.7%) were correct about modern contraceptive should be used based on contraceptive effectiveness, while 163(46.3%) were wrong. Also, 299(84.9%) of the respondents were correct that modern contraceptives prevent unwanted pregnancy while 53(15.1%) were wrong.
To summarize the level of background knowledge of the SOLO classification was used as stated under definition of terms.

Table 3: Summary of level of background knowledge of contraceptives

Level	Frequency	Percent
High	167	47.4
Moderate	176	50.0
Low	9	2.6
Total	**352**	**100.0**

Table 3 summarises the level of background knowledge of contraceptives among traders in Boundary market Ajeromi Ifelodun. From the table, 9 respondents representing 2.6 percent had poor knowledge of contraceptives, 176 respondents representing 50.0 percent had moderate knowledge while 167 respondents representing 47.4 percent had high knowledge of contraceptives. It could be concluded that most of the respondents had good knowledge of contraceptives.
Research Question 2: What are the perceived factors influencing contraceptive use among traders in Boundary market Ajeromi Ifelodun, LGA, Lagos state?

Table 4: Perceived factors influencing contraceptive use among respondents N=352

S/N	ITEMS	SA (%)	A (%)	D (%)	SD (%)	Mean	S.D.
1.	My poor knowledge of contraceptives is a factor influencing my use of contraceptives		13(3.7)	170(48.3)	169(48)	1.56	0.57
2.	My Partner disapproves my use of contraceptives	59(16.8)	161(45.7)	91(25.9)	41(11.6)	2.68	0.89
3.	The fear of side effects of contraceptives is alarming	67(19.0)	108 (30.7)	135(38.4)	42(11.9)	2.57	0.93
4.	My Cultural beliefs negates contraceptive use	104 (29.5)	151 (42.9)	84(23.9)	13(3.7)	2.98	0.83
5.	My religious inclinations disallows about contraceptives	69(19.6)	164 (46.6)	101(28.7)	18(5.1)	2.65	0.77
6.	My accessibility to family planning provider ensures my use of contraceptives	69 (19.6)	164 (46.6)	101(28.7)	18(5.1)	2.81	0.81
7.	The financial implications of contraceptives deter me from visiting the family planning provider	81(23.0)	159 (45.2)	97(27.6)	15(4.3)	2.87	0.81
8.	I don't have frequent sex with my spouse hence no reason for contraception	88(25)	173(49.1)	85(24.1)	6(1.7)	2.97	0.75

Mean cut off=2.5

On perceived factors influencing contraceptive use among respondents, 13(3.7%) agreed poor knowledge of contraceptives is a factor influencing their use of contraceptives, 170(48.3%) disagreed while 169(48%) strongly disagreed. Only 69(19.6%) strongly agreed their accessibility to family planning provider ensures their use of contraceptives, 164(46.6%) agreed, 101(28.7%) disagreed while 18(5.1%) strongly disagreed. Only 88(25%) strongly agreed they don't have frequent sex with their spouse hence no reason for contraception, 173(49.1%) agreed, 85(24.1%) disagreed while 6(1.7%) strongly disagreed.

Based on the mean cut off of 2.5, mean scores of 8 items were greater than the mean cut-off while the mean score of only 1 item was less than the mean cut-off mark. Hence the perceived factors; my partner disapproves my use of contraceptives, they don't have frequent sex with their spouse hence no reason for contraception, the financial implications of contraceptives deter them from visiting the family planning provider, fear of side effects of contraceptives is alarming, their religious inclinations disallows about contraceptives and cultural beliefs negates contraceptive use.

Test of Hypothesis

H_o1: There is no significant association between socio-demographic characteristics and background knowledge of contraceptives among traders in Boundary market

Table 5: Chi-Square Showing the Association between socio-demographic characteristics and background knowledge of contraceptives among traders in Boundary market N = 352

SN	Variable		Background knowledge of contraceptives					
			High (%)	**Moderate (%)**	**Low (%)**	**X^2**	**df**	**P**
1	Age	Less than 20 years	8 (2.3)	9 (2.6)	1 (0.3)	4.083	8	.850
		20-30 years	58 (16.5)	59 (16.8)	2 (0.6)			
		31-40 years	57 (16.2)	55 (15.6)	2 (0.6)			
		41-50 years	31 (8.8)	38 (10.8)	2 (0.6)			
		50 and above	13 (3.7)	15 (4.3)	2 (3.7)			
2	Religion	Traditional	3 (0.9)	5 (1.4)	0 (0.0)	1.321	4	.858
		Islam	82 (23.3)	78 (22.2)	4 (1.1)			
		Christianity	82 (23.3)	93 (26.4)	5 (1.4)			
3	Gender	Female	119 (33.8)	121 (34.4)	4 (1.1)	2.940	2	.230
		Male	48 (13.6)	55 (15.6)	5 (1.4)			
4	Marital Status	Single	22 (6.3)	33 (9.4)	0 (0.0)	7.995	6	.238
		Married	128 (36.4)	118 (33.5)	7 (2.0)			
		Separated	11 (3.1)	16 (10.0)	2 (0.0)			
		Divorced	6 (1.7)	9 (2.6)	0 (0.0)			
5.	Ethnicity	Yoruba	105 (29.8)	108 (30.7)	5 (1.4)	1.758	6	.941
		Hausa	7 (2.0)	8 (2.3)	1(0.3)			
		Igbo	31(8.8)	35 (9.9)	1 (0.3)			
		Others	24 (6.8)	25 (7.1)	2 (0.6)			
6.	Family Type	Monogamy	140 (39.8)	148 (42.0)	6 (1.7)	1.911	2	0.385
		Polygamy	27 (7.7)	28 (8.0)	3 (0.9)			
7.	Educational Level	No Formal Education	9 (2.6)	7 (2.0)	1 (0.3)	1.652	6	0.949
		Primary	32 (9.1)	31 (8.8)	2 (0.6)			
		Secondary	98 (27.8)	106 (30.1)	5 (1.4)			
		Tertiary	28 (8.0)	32 (9.1)	1 (0.3)			

From the table above, none of the socio-demographics variables were related to background knowledge of contraceptives among traders in Boundary market because their p-values were greater than 0.05 level of significance. Therefore, the null hypothesis is not rejected and retained. Hence, there was no significant association between socio-demographic characteristics and background knowledge of contraceptives among traders in Boundary market.

DISCUSSION OF FINDINGS

The findings of the study revealed that most of the respondents had good knowledge of contraceptives. It was revealed that 9 respondents representing 2.6 percent had poor knowledge of contraceptives, 176 respondents representing 50.0 percent had moderate knowledge while 167 respondents representing 47.4 percent had high knowledge of contraceptives. It could be concluded that most of the respondents had good knowledge of contraceptives. In support of this finding, Ethiopian women's knowledge, attitude, and practise were respectively 42.3%, 58.5%, and 50.4%. The reasons implicated were residence far from facility, socio-economic reasons, number of children alive, inadequate knowledge spread across knowing some names of contraceptive but not how to use them (Kasa, et al., 2018). Reasons implicated included number of children alive, inadequate knowledge spread across knowing some names of contraceptive but not how to use them. Studies conducted by Ajony (2015) on usage of contraceptives among 712 women interviewed revealed that majority 701 (98.5%) were familiar with at least one form of birth control and 699 (98.2%) were familiar with at least one technique of contemporary birth control. At the time of the research, there were 614 women who were sexually active and had the potential to get pregnant. Of those women, 424 were using some kind of contraception, giving us a worldwide prevalence of contraception of 69.5%. Of those women, 381 were using a contemporary technique, giving us a prevalence of modern contraception of 62.1%.

It was further revealed that the perceived factors influencing contraceptive use among traders are partner's disapproval and use of contraceptives, in-frequent sex with spouse, financial implication, fear of side effects, religious inclinations, and cultural beliefs. In support of this finding, Giman (2015) used a sample size of 140 married women of reproductive age in Cambodia to conduct research on the knowledge, attitudes, and practises of contemporary family planning among married women of reproductive age in the country. The conclusion drawn from the findings of the study was that respondents who had a high financial level displayed a favourable attitude towards contemporary techniques of family planning. Contraceptive usage was found to be greater among employed women (67%) than that of unemployed women, according to a study that was conducted in Bangladesh by Islam et al., (2016) on prevalence and determinants of contraceptive use among employed and jobless women (16,616 as sample). Women's age, education, husband's education, region, residence, religion, number of living children, ever heard about family planning, and child preference were found to be factors contributing to current use of contraception among employed women. Similarly, women's age, education, number of living children, ever heard about family planning, and child preference were identified as the significant predictors of contraceptive use among the women.

CONCLUSION

Sequel to the findings of this study, it is concluded that most of the respondents had good knowledge of contraceptives while the factors influencing contraceptive use where partner disapproves use of contraceptives, lack of frequent sex with their spouse, financial implications of contraceptives, fear of side effects of contraceptives, religious inclinations and cultural beliefs.

Recommendations

Based on the findings of this study, the following recommendations were made.

1. Health care providers should organize outreaches to increase awareness and counselling about contraceptives and to empower couples on choice to make.
2. Different media such as billboards and posters to dispel myths and misconceptions attached to modern contraceptive should be strategically placed in the market.
3. Stakeholders in the health committee of the market should liase with nearby health facility for quarterly outreach program in the market pending the availability of their own health facility.

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