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Knowledge and Attitude Affecting the Utilization of Family Planning Services Among Women of Childbearing Age in Owerri Municipal Local Government Area of Imo State

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Abstract
This study examined the knowledge and attitudes affecting the use of family planning services among women of reproductive age (15–49 years) in Owerri Municipal Local Government Area, Imo State, Nigeria. The aim was to identify the factors influencing the utilisation of family planning services among women in the research area. A cross-sectional design was utilised, encompassing 398 women chosen via multistage and easy random sample methods. We used a self-structured questionnaire to collect data and SPSS version 25 to analyse it. Descriptive statistics (frequency and percentages) were employed to summarise the data, while Chi-square tests and odds ratios evaluated relationships between variables at a significance threshold of $p < 0.05$. The results showed that 54% of women had heard about family planning and 46% had not. However, knowing about it did not seem to have a big effect on using it ($p = 0.081$). Sociocultural factors had a substantial impact on utilisation ($p = 0.013$). Cultural norms (37.5%) and religious views (30.4%) were recognised as significant determinants of family planning choices. Also, 48.1% of the women faced hostility from family or community members. It was also found that partner support and participation (34.0% and 35.9%, respectively) had an effect on decisions about uptake. While 34.0% of health workers underwent regular training, 34.5% did not, and 38.3% of respondents regarded their environment as unsupportive. Moreover, age, educational attainment, marital status, occupation, and knowledge did not exhibit significant correlations with utilisation. The study finds that even when people's knowledge levels are average, societal and partner-related factors are still very important in deciding whether or not to use family planning. To improve uptake and promote reproductive health in Owerri Municipal, it is important to raise awareness, make services more accessible, break down sociocultural barriers, and improve provider training.

Keywords: Family planning, utilization, knowledge, attitude, women of childbearing age, Owerri Municipal, Imo State, Nigeria.

Introduction

Family planning is still an important part of reproductive health. It helps people and couples make smart choices about when, how often, and how many children they want. Family planning plays a big role in improving the health of mothers and children, lowering the number of unplanned pregnancies, controlling the population, and improving social and economic well-being by giving people access to effective birth control techniques and reproductive health counselling. Even while there have been attempts around the world and in Nigeria to encourage family planning, not everyone is using it in the same way [1].

Several factors that are connected to each other affect the use of family planning services. These include knowledge, attitudes, sociocultural norms, partner support, economic conditions, and the availability of quality healthcare services.

Knowledge and awareness of contraceptive alternatives are pivotal in influencing use; nevertheless, misunderstandings, fear of side effects, and insufficient comprehension frequently obstruct informed decision-making among women. Cultural and religious beliefs can either promote or inhibit contraceptive use, while traditional conventions concerning gender and reproduction further influence usage trends [2].

In numerous African contexts, notably Nigeria, societal and religious factors profoundly influence reproductive behaviour. Norms that support big families, men making decisions, and communities being against birth control may make it harder for women to get the help they need. Additionally, partner support and communication among couples are essential factors influencing family planning adoption; women with supportive partners are more inclined to utilise available services [3].

The accessibility and availability of family planning services significantly influence their utilisation. Long distances to health facilities, high service costs, limited service hours, and poorly qualified healthcare workers are all problems that make it harder for people to get the best care. Also, systemic problems like not having enough contraceptives and not having enough health care facilities make it hard for people to use them [4,5,6].

Nigeria's population is still growing quickly and its birth rate is still very high. The country has a national fertility rate of 5.5 and a contraceptive prevalence rate that has stayed relatively low, only going up to 15% in the 2013 National Survey. This means that the country is still having trouble reaching its reproductive health targets. As a result, family planning is seen as an important way to lower maternal mortality, which is still one of the highest in the world [7, 8]. In the Owerri Municipal LGA, even though family planning services are available, they are not being used as often as they should be. To create targeted, context-specific interventions, it is important to know what causes limited uptake. This study investigates the knowledge, attitudes, sociocultural influences, partner engagement, and health system aspects that affect the utilisation of services among women of reproductive age. By identifying these characteristics, the study aims to guide policies and initiatives designed to increase family planning utilisation and enhance reproductive health outcomes within the community.

MATERIALS AND METHODS

Research Design

A cross-sectional study design was adopted for this research. The design involves collecting data at a single point in time to describe and interpret phenomena related to the knowledge and attitudes influencing the utilization of family planning services. This design allowed for establishing associations between variables and identifying key determinants affecting family planning utilization in Owerri Municipal Local Government Area (LGA).

Area of Study

The study was conducted in Owerri Municipal LGA, the capital city of Imo State, located in the southeastern region of Nigeria. It covers an estimated area of 58 km² with a population of 127,213 based on the 2006 census and an assumed annual growth rate of 4.02%. The LGA shares boundaries with Owerri North, Mbaitoli, Ikeduru, and Orlu LGAs.

Owerri Municipal is the administrative, commercial, and educational hub of Imo State, hosting government institutions, universities, healthcare facilities, and major business establishments. The area is ethnically diverse and densely populated, with varying levels of accessibility to reproductive health and family planning services. As a major urban center, it also experiences dynamic socio-cultural influences that shape reproductive health behaviours.

Population of Study

The study population comprised women of childbearing age (15–49 years) residing in Owerri Municipal. The estimated population of women in this age group is 65,605. Both married and unmarried women who are permanent residents of the LGA were included. This age group represents women who are actively within their reproductive period and are potential beneficiaries of family planning services. The study targeted women across varying socioeconomic backgrounds and reproductive histories to ensure comprehensive understanding of utilization patterns.

Sample Size Determination

The sample size was determined using the Taro Yamane formula:

n=N1+N(e)2n = \frac{N}{1 + N(e)^2}n=1+N(e)2N

Where:

n = sample size

N = population size (65,605)

e = margin of error (0.05)

n=65,6051+65,605(0.0025) = 65,605165.0125≈397n = \frac{65,605}{1 + 65,605(0.0025)} = \frac{65,605}{165.0125} \approx 397n=1+65,605(0.0025)65,605=165.012565,605≈397

Thus, a total of 397 respondents were selected for the study.

Sampling Method

A **multistage sampling technique** was employed:

Stage 1: Listing of Villages

Owerri Municipal is composed of five major villages: Umuororonjo, Amawom, Umuonyeche, Umuodu, and Umuoyima (collectively known as Owerri Nchi-Ise).

Stage 2: Selection of Communities

Seven communities were randomly selected using simple random sampling by balloting without replacement.

Stage 3: Selection of Villages within Communities

Fifty percent (50%) of the villages within the selected communities were chosen using simple random sampling.

Stage 4: Selection of Households

In each selected village, five (5) households with eligible women were selected using a table of random numbers. When a selected household lacked a woman of childbearing age, the next household was visited.

Stage 5: Selection of Respondents

From the selected households, women aged 15–49 years were sampled until the required sample size (397) was attained.

Instrument for Data Collection

Data were collected using a structured questionnaire developed based on the study objectives. The questionnaire consisted of sections covering:

- Demographic information
- Knowledge and awareness of family planning
- Sociocultural influences
- Accessibility and availability of services
- Partner support and spousal communication
- Barriers and challenges to utilization

The questionnaire included closed-ended items, Likert-scale statements, and selected open-ended questions to allow for detailed responses. The instrument was designed to be clear and easy to understand.

Validity of the Instrument

Content validity was ensured through expert review. The questionnaire was examined by the researcher's supervisors and two additional Public Health specialists to confirm clarity, relevance, and appropriateness of the items in relation to the study objectives.

Reliability of the Instrument

A pilot test was conducted on 50 women with characteristics similar to the target population but outside the study area. Reliability was assessed using Cronbach's Alpha, yielding a coefficient of 0.70, indicating acceptable internal consistency.

Ethical Considerations

Ethical approval was obtained from the Ethical Review Committee of the Department of Public Health, Imo State University, Owerri. An introductory letter explaining the purpose of the study, confidentiality measures, and voluntary participation accompanied each questionnaire. Verbal and written informed consent were obtained from all participants, and anonymity was maintained throughout the study.

Method of Data Collection

Preliminary visits were conducted in the selected communities to familiarize the researcher with the setting. Trained research assistants assisted in administering the questionnaires. Stratified random sampling was used to select respondents based on geographic units, and questionnaires were administered through face-to-face interaction to ensure completeness and accuracy of responses.

Statistical Analysis

Data were coded and analyzed using SPSS version 25.

- Descriptive statistics (frequencies and percentages) summarized demographic data and responses.
- Inferential statistics such as Chi-square tests and Fisher's exact tests assessed associations between variables, including sociocultural factors and family planning utilization.
- Correlation analysis was used to examine relationships between health worker attitudes and service provision.

A significance level of $p < 0.05$ was adopted.

RESULT

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4.1: DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS

From table 4.1 below present the demographic characteristics of the respondents participating in the survey on family planning utilization among women of childbearing age in Owerri Municipal, Imo State. Out of 397 participants, the largest age group is 35- 44 years, comprising 31.2% of the sample, 25-34 years age group follows closely at 25.7% and 21.6% of the sample are 15-24 years. Marital status is diverse, with 26.4% married, 25.2% divorced, 24.9% widowed, and 23.4% single. 26.7% have a bachelor's degree or higher, 24.9% have primary school education or less, 24.4% have vocational/technical training. 50.9% are Christians, 27.2% follow traditional beliefs, 21.9% are Muslims. 52.1% identify as Igbo, 24.2% as Hausa, 23.7% as Yoruba. 33.2% are employed full-time, 32.0% are employed part-time, 34.8% are unemployed. 35.5% have a monthly income of less than 50,000, 29.5% earn 51,000 - 100,000, 35.0% have incomes exceeding 100,000. 47.9% have some form of health insurance, while 52.1% have no health insurance. 48.9% reside in urban areas, 51.1% reside in rural areas. 52.4% have lived in their current place of residence for less than one year, 47.6% have resided for 1-5 years. 32.2% have 1-2 children, 36.8% have 3-4 children, 31.0% have more than 4 children. 26.4% desire no children, 25.3% prefer 1-2 children, 25.0% desire 3-4 children, 23.7% wish to have more than 4 children. 32.2% have used child spacing methods, 37.8% have not used any, 30.0% find child spacing methods not applicable. The most commonly used methods are birth control pills (50.9%) and condoms (49.1%).

From figure 4.1 above, out of the total 397 respondents surveyed, 214 respondents, constituting 54%, have indicated that they have heard about family planning before. 183 respondents, making up the remaining 46%, have stated that they have not heard about family planning.

Hypothesis one

H_0: There is no association between the level of knowledge and family planning utilization among women of childbearing age

H_1: There is an association between the level of knowledge and family planning utilization among women of childbearing age

Decision Rule: reject the null hypothesis if the p-value is less than 0.05 level of significant.

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Table 4.1: Demographic characteristics of the respondents

	Frequency	Percent
Age		
15-24yrs	86	21.6
25-34yrs	102	25.7
35-44yrs	124	31.2
45yrs and above	85	21.4
Marital status		
Single	93	23.4
Married	105	26.4
widowed	99	24.9
divorced	100	25.2
Highest level of education		
primary school or less	99	24.9
secondary school	95	23.9
vocational/technical training	97	24.4
bachor's degree or higher	106	26.7
Religion		
Christian	202	50.9
Muslim	87	21.9
traditional	108	27.2
Ethnicity		
Igbo	207	52.1
Hausa	96	24.2
Yoruba	94	23.7
Are you currently employed?		
yes, full time	132	33.2
yes, part time	127	32.0
No, unemployed	138	34.8
Monthly income		
less than 50, 000	141	35.5
51,000 -100,000	117	29.5
more than 100,000	139	35.0
Do you have any form of health insurance coverage?		
Yes	190	47.9
No	207	52.1
What is your current place of residence?		
urban area	194	48.9
rural area	203	51.1
How long have you been living in the current place of residence?		
less than 1year	208	52.4
1-5years	189	47.6
Have many children do you have?		
1-2 children	128	32.2
3-4 children	146	36.8
more than 4 children	123	31.0
What is your desired number of children?		
no children	98	24.7
1-2 children	104	26.2
3-4 children	101	25.4
more than 4 children	94	23.7
Have you used any form of child spacing methods to regulate the timing of pregnancies?		
Yes	128	32.2
No	150	37.8
Not applicable	119	30.0
If YES, please indicate the type of contraception you have used.		
Birth control pill	202	50.9
condoms	195	49.1

4.2: To determine level of knowledge of women of childbearing Age regarding family planning methods and services.

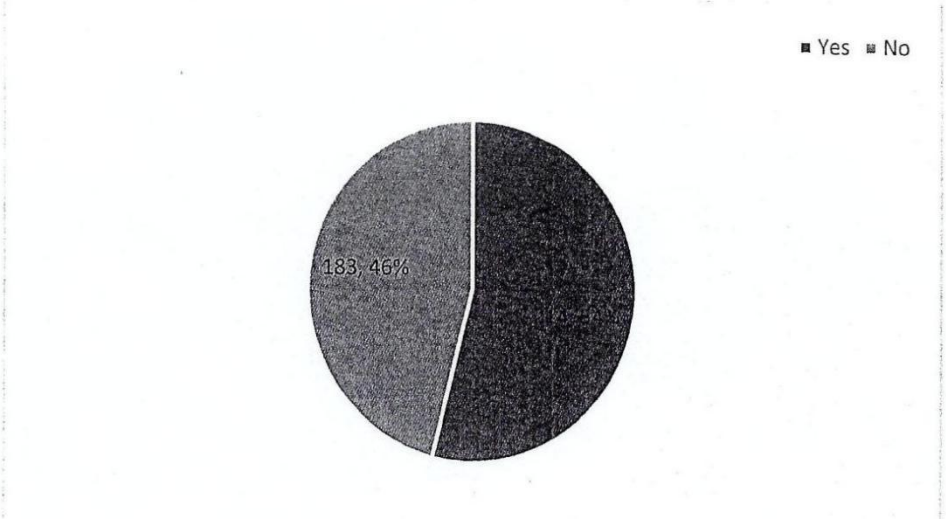

Table 4.2 Level of Knowledge of women of childbearing Age regarding family planning methods and services

		women of childbearing Age				p-value
Level of knowledge		**15-24yrs**	**25-34yrs**	**35-44yrs**	**45yrs and above**	
Have you heard about family planning before?	Yes	56	61	61	36	0.081
	No	46	63	34	40	
Family planning is essential for the health of women	strongly disagree	13	26	14	25	0.007
	disagree	25	21	22	9	
	Neutral	23	27	26	8	
	Agree	15	30	17	16	
	Strongly Agree	26	20	16	18	

Chi-square test: 0.05 level of significant

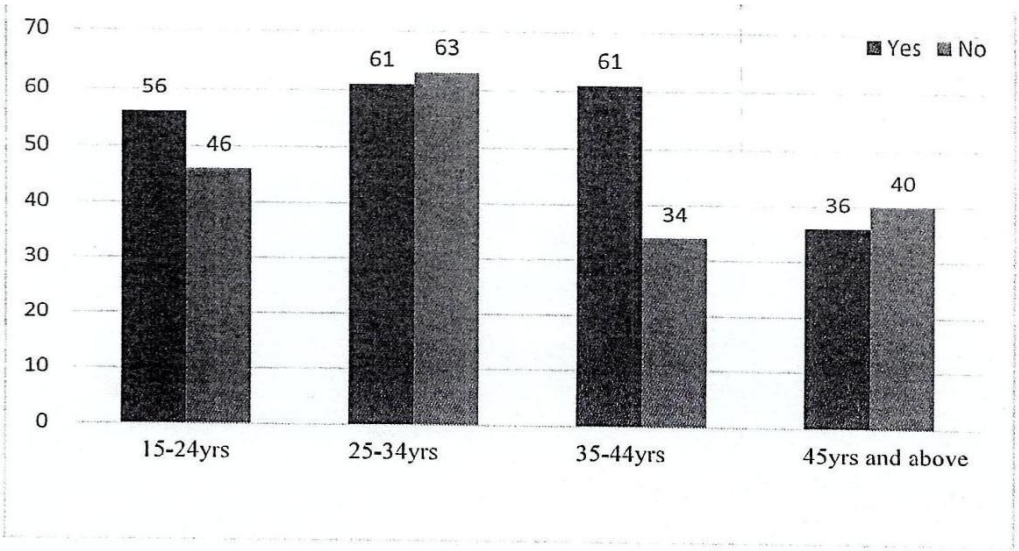

Figure 4.2: Heard about Family Planning among women of child bearing age

The figure 4.2 above provides insights into the awareness of family planning among women of various age groups, The result is categorized into four age groups: 15-24 years, 25-34 years, 35-44 years, and 45 years and above. Among women aged 15-24 years, 56 respondents have heard about family planning, while 46 respondents have not. In the 25-34 years age group, 61 respondents have heard about family planning, while 63 have not. For the 35-44 years age group, 61 respondents are aware of family planning, and 34 respondents are not. Among women aged 45 years and above, 36 respondents have heard about family planning, and 40 have not.

However, an equal percentage (31.7%) believes that women have only some say or little to no say in these decisions. An almost equal number of respondents (49.9% vs. 50.1%) believe that cultural and religious beliefs do and do not impact family planning decisions, respectively. A significant number of respondents (35.1%) believe that modern contraception conflicts with cultural and religious norms. A substantial portion

of respondents (34.3%) perceive their communities as supportive and encouraging of family planning practices. However, an almost equal proportion (32.2%) perceives their communities as opposed or negative towards family planning. The result indicates that respondents are divided in terms of partner support for family planning, with an almost equal number saying "yes" (33.8%) and "no" (34.3%).

Partner support is crucial for effective family planning, and efforts may be needed to enhance spousal involvement. The result suggests a relatively equal distribution of decision-making authority within households, with the woman alone, the man alone, and both partners jointly making decisions in a similar percentage of cases. Notable percentages (48.1%) of respondents have experienced opposition or resistance to family planning decisions, while 51.9% have not.

4.2.1 LEVEL OF AGREEMENT WITH UTILIZATION OF FAMILY PLANNING AMONG WOMEN OF VARIOUS AGE GROUPS

Table 4.2.1 below provides valuable insights into the level of agreement among women of different age groups regarding the utilization of family planning. Across all age groups, a significant percentage of respondents agree or strongly agree

(ranging from 19.6% to 20.2%) that family planning is essential for women's health. The responses to this statement are more varied, with the highest percentage of agreement in the "neutral" category (ranging from 19.9% to 22.4%). A considerable percentage of respondents across all age groups agree or strongly agree (ranging from 19.6% to 23.4%) that family planning goes against their cultural or religious beliefs.

Table 4.2.1 Level of Agreement with Utilization of Family Planning Among Women of various Age Groups.

	strongly disagree (%)	Disagree (%)	Neutral (%)	Agree (%)	Strongly Agree (%)	Mean	Standard Deviation (SD)
Family planning is essential for the health of women	78(19.6)	77(19.4)	84(21.2)	78(19.6)	80(20.2)	3.0126	1.40969
Family planning helps in achieving personal and family goals	74(18.6)	89(22.4)	79(19.9)	79(19.9)	76(19.1)	2.9849	1.39254
Family planning methods have severe side effects	71(17.9)	80(20.2)	67(16.9)	92(23.2)	87(21.9)	3.1108	1.42056
Family planning is against my culture or religious beliefs	93(23.4)	78(19.6)	69(17.4)	78(19.6)	79(19.9)	2.9295	1.45819

4.2.2. Effectiveness rate of contraceptive methods among women of child bearing age

This table 4.2.2 provides information on the perceived effectiveness rate of different contraceptive methods among women of childbearing age, categorized by age groups. Across all age groups, the majority of respondents are unsure about the effectiveness of oral contraceptive pills, with a significant percentage falling into the "Not sure" category. There are no significant differences in responses among different age groups (p-value = 0.444), indicating that women of all ages have similar levels of uncertainty regarding the effectiveness of oral contraceptives. Similar to oral contraceptives, a substantial portion of respondents in all age groups is unsure about the effectiveness of IUDs. While there is a trend towards greater certainty about IUD effectiveness with increasing age, this trend is not statistically significant (p-value = 0.107). Responses regarding the effectiveness of condoms also show a high level of uncertainty across all age groups.

There are no statistically significant differences in responses among different age groups (p-value = 0.537). Notably, there is a statistically significant difference in responses regarding the effectiveness of Depo-Provera injections among different age groups (p- value = 0.038). Women in the 25-34 years age group tend to have a higher level of certainty about the effectiveness of Depo-Provera compared to other age groups. Responses regarding the effectiveness of emergency contraception show a similar pattern to other methods, with a substantial percentage of respondents being unsure.

While not statistically significant, there is a trend towards older women having slightly more certainty about the effectiveness of emergency contraception (p-value = 0.068).

From the table below, since the p-value 0.013 is less than 0.05 level significant, the null hypothesis will be rejected, therefore there is an association between sociocultural factors and utilization of family planning services among women of childbearing age.

Table 4.2.2 Effectiveness rate of contraceptive methods among women of child

Effectiveness rate of contraceptive methods		Women of child bearing age				p-value
		15-24yrs	25-34yrs	35-44yrs	45yrs and above	
Oral contraceptive (pills)	Less than 90%	25	29	30	21	0.444
	90-95%	28	34	22	15	
	above 90%	18	35	20	22	
	Not sure	31	26	23	18	
Intrauterine device (IUD)	Less than 90%	24	27	18	23	0.107
	90-95%	29	34	31	11	
	above 90%	29	27	23	15	
	Not sure	20	36	23	27	
Condoms	Less than 90%	26	40	26	17	0.537
	90-95%	29	24	18	15	
	above 90%	20	27	23	24	
	Not sure	27	33	28	20	
Injectable contraceptives (Depo-Provera)	Less than 90%	30	27	26	17	0.038
	90-95%	24	47	25	13	
	above 90%	30	27	19	24	
	Not sure	18	23	25	22	
Emergency contraception (morning-after pill)	Less than 90%	22	30	21	30	0.068
	90-95%	31	26	26	16	
	above 90%	27	31	22	20	
	Not sure	22	37	26	10	

4.3: To Identify the Sociocultural Factors that Influence Utilization of Family Planning Services

The table 4.3 below shows that respondents from different age groups have varying levels of awareness regarding family planning. The p-value for this portion of the data is 0.081, which is greater than the significance level 0.05. This suggests that there is no significant association between the level of knowledge and family planning utilization among women of childbearing age. In other words, age does not appear to significantly influence whether women of childbearing age have heard about family planning before. The table also displays the distribution of responses to the statement "Family planning is essential for the health of women" among different age groups. The p-value for this portion of the data is 0.007, which is less than the significance level 0.05. This indicates that there is a significant association between the level of knowledge and family planning utilization among women of childbearing age. Specifically, the p-value suggests that age does have a significant influence on how women of different age groups perceive the importance of family planning for women's health. Table 4.6 below offers insights into various sociocultural factors that influence the utilization of family planning services among women of childbearing age. Out of 397 respondents, a significant proportion (36.5%) of respondents strongly believe that cultural factors strongly influence family planning decisions, while 31.0% feel that they somewhat influence these decisions. A notable number of respondents (29.5%) strongly believe that religious affiliation strongly influences family planning decisions, while 24.9% feel that it somewhat influences these decisions. It is interesting to note that 25.4% of respondents don't have a religious affiliation, suggesting a diverse range of beliefs within the population. More respondents (37.5%) believe that their culture accepts family planning, while 32.7% are unsure about cultural acceptance. A substantial portion (36.5%) of respondents believe that women have full autonomy in decision- making regarding family planning.

4.3: To identify the sociocultural factors that influence utilization of family planning services

	Frequency	Percent
Cultural Influence on Family Planning Decisions		
Strongly influence	145	36.5
Somewhat influence	123	31.0
Do not influence	129	32.5
Religious Affiliation and Attitudes		
Strongly influence	117	29.5
Somewhat influence	99	24.9
Do not influence	80	20.2
I don't have religious affiliation	101	25.4
Cultural Acceptance of Family Planning		
Yes	149	37.5
No	130	32.7
Not sure	118	29.7
Role of Women in Decision-Making		
Women have full autonomy	145	36.5
Women have some say	126	31.7
Women have little or no say	126	31.7
Impact of Cultural and Religious Beliefs		
Yes	198	49.9
No	199	50.1
Modern Contraception and Cultural/Religious Norms		
Yes	129	35.1
No	121	32.9
Not sure	118	32.1
Community Attitudes Toward Family Planning		
Supportive and encouraging of family planning practices	136	34.3
Neutral or indifferent towards family planning	133	33.5
Opposed or negative towards family planning	128	32.2
Partner Support for Family Planning		
Yes	134	33.8
No	136	34.3
Not sure	127	32.0
Decision-Maker in Household		
The woman alone	100	25.2
The man alone	102	25.7
Joint decision by both partner	100	25.2
Other family members or elders	95	23.9
Opposition or Resistance		
Yes	191	48.1
No	206	51.9

Pearson Chi-Square = 12.298[a] / p-value = 0.013
Chi-square test: 0.05 level of significant

4.4: To determine the attitude of health workers towards rendering services related to the utilization of family planning, and how health factors, or facility factors affect the provision of these services

The table 4.7 below offers insights into the attitudes of health workers and various health facility factors related to the provision of family planning services. The result shows that healthcare providers are divided in their perceptions of training and equipping, with 32.0% responding "Yes," 31.7% responding "No," and 36.3% responding "Partially." Health workers have varying levels of comfort discussing FP methods with clients, with 40.1% expressing some level of discomfort (18.6% uncomfortable, 22.4% very uncomfortable). A substantial portion (40.1%) of health workers are comfortable or very comfortable discussing FP methods. Responses regarding the availability of FP resources at healthcare facilities are mixed, with 42.5% rating the availability as "excellent" or "good" and 38.3% rating it as "average," "poor," or "very poor." The data reveals that facility-level barriers are perceived by 32.0% of health workers as a challenge in providing FP services, while 36.8% do not perceive such barriers. The result shows that 34.0% of health workers receive regular updates/training on FP practices, while 34.5% do not. Ongoing training is essential for keeping healthcare providers updated on the latest FP methods and guidelines. Health workers have mixed perceptions of their work environment's supportiveness, with

42.1% rating it as either "very supportive" or "supportive," while 38.3% perceive it as either "neutral," "not very supportive," or "not supportive."

Table 4.4: Attitude of health workers towards rendering services related to the utilization of family planning, and how health factors, or facility factors affect the provision of these services

	Frequency	Percent
Training and Equipping of Healthcare Providers		
Yes	127	32.0
No	126	31.7
partially	144	36.3
Comfort Discussing FP Methods with Clients		
Very comfortable	64	16.1
Comfortable	94	23.7
Neutral	76	19.1
Uncomfortable	74	18.6
Very uncomfortable	89	22.4
Availability of FP Resources at Healthcare Facility		
Excellent	75	18.9
Good	78	19.6
Average	92	23.2
Poor	73	18.4
Very poor	79	19.9
Facility-Level Barriers		
Yes	127	32.0
No	146	36.8
To some extent	124	31.2
Regular Updates/Training on FP Practices		
Yes	135	34.0
No	137	34.5
Unfrequently	125	31.5
Supportive Work Environment.		
Very supportive	82	20.7
Supportive	85	21.4
Neutral	78	19.6
Not very supportive	69	17.4
Not supportive	83	20.9

The correlation analysis presented in the table 4.8 examines the relationships between health workers' attitudes and the provision of family planning services. The Spearman's rho con-elation coefficient measures the strength and direction of these relationships. There is a weak positive correlation (0.175) between the training and equipping of healthcare providers and their comfort discussing family planning methods with clients. This correlation is statistically significant at the 0.01 level. This suggests that healthcare providers who receive more training and are better equipped tend to be more comfortable discussing family planning methods with clients.

There is a weak positive correlation (0.125) between healthcare providers' comfort discussing family planning methods with clients and the availability of family planning resources at healthcare facilities. This correlation is statistically significant at the 0.05 level. Health workers who are more comfortable discussing family planning methods are more likely to perceive better availability of resources at their facilities.

None of the examined factors show a strong correlation with the availability of family planning resources at healthcare facilities. The correlations with other factors are generally weak and not statistically significant.

Facility-level barriers do not show strong correlations with any of the other factors. The correlations are generally weak and not statistically significant.

There is a weak positive correlation (0.088) between health workers' comfort discussing family planning methods with clients and their receipt of regular updates/training on family planning practices. This correlation is statistically significant at the 0.05 level. Health workers who are more comfortable discussing family planning methods are more likely to receive regular updates/training on family planning practices.

There is a weak negative correlation (-0.134) between health workers' comfort discussing family planning methods with clients and the perception of a supportive work environment. This correlation is statistically significant at the 0.01 level.

Health workers who are more comfortable discussing family planning methods tend to

perceive their work environment as less

	Training and Equipping of Healthcare Providers	Comfort Discussing FP Methods with Clients	Availability of FP Resources at Healthcare Facility	Facility-Level Barriers	Regular Updates/Training on FP Practices	Supportive Work Environment.
Training and Equipping of Healthcare Providers	1.000					
Comfort Discussing FP Methods with Clients	.010	1.000				
Availability of FP Resources at Healthcare Facility	.175**	.125*	1.000			
Facility-Level Barriers	.023	.074	-.025	1.000		
Regular Updates/Training on FP Practices	.058	.088	-.031	.059	1.000	
Supportive Work Environment.	-.072	-.134**	-.011	.024	-.016	1.000

Table 4.4 Correlation analysis between health worker's attitudes and the provision of family

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

4.5: To Assess or Determine the Influence of Partner Support on Utilization of Family Planning Services

The table 4.5 below shows that partner support varies among different age groups, 15-24 years, 25-34 years, 35-44 years, and 45 years and above. The result explores various aspects of partner support, communication, and its impact on FP utilization. The result shows that partner support for FP does not significantly vary among different age groups (p-value = 0.570). Regardless of age, women report varying levels of partner support, with some finding their partners very supportive, supportive, neutral, or not supportive. There is no significant difference in partner participation in FP decisions and practices among different age groups (p-value = 0.623). Partner participation varies, with some partners always involved, sometimes involved, rarely involved, or never involved in FP decisions and practices. The ways in which partners support FP also do not significantly differ among age groups (p-value = 0.425). Partners may encourage and motivate, accompany women to healthcare visits, provide emotional support, assist with contraceptives, or share responsibility in FP decisions.

The level of comfort in discussing FP with partners also does not vary significantly across age groups (p-value = 0.549). Women of different ages report feeling very comfortable. comfortable, neutral, uncomfortable, or very uncomfortable when discussing FP with their partners. The frequency of FP discussions with partners does not significantly differ among age groups (p-value = 0.401). FP discussions with partners may occur daily, weekly, monthly, rarely, or never, depending on individual dynamics. The impact of open communication with partners on FP utilization does not significantly vary among age groups (p-value = 0.443). Women report that open communication with partners significantly, to some extent, or not really impacts their FP decisions and practices.

Table 4.5: Influence of Partner Support on Utilization of Family Planning Services among women of child bearing age

Influence of partner support on utilization of family planning services	Women of child bearing age				p-value
	15-24yrs	25-34yrs	35-44yrs	45yrs and above	
Partner Support					
Very supportive	14	19	24	13	0.570
Supportive	17	26	17	16	
Neutral	23	24	18	16	
Not supportive	19	32	17	15	
Not applicable (no current partner)	29	23	19	16	
Partner Participation					
Yes, always	19	24	23	17	0.623
Yes, sometimes	27	22	12	14	
No, rarely	18	26	14	14	
No never	23	31	24	16	
Not applicable (no current partner)	15	21	22	15	
In what way does your partner support your use of family planning methods?					
Encourages and motivates me	21	30	23	10	0.425
Accompanies me to healthcare visits	23	30	17	19	
Provides emotional support	20	22	16	18	
Assists with contraceptives (reminding to take pills or using condom)	17	28	19	19	
Shares responsibility in family planning decisions	21	14	20	10	
How comfortable do you feel discussing family planning with your partner?					
Very comfortable	19	26	26	15	0.549
comfortable	17	24	23	17	
Neutral	26	32	12	16	
Uncomfortable	23	19	16	14	
Very uncomfortable	17	23	18	14	
Frequency of FP Discussions with Partner					
Daily	25	23	16	15	0.401
Weekly	18	26	23	12	
Monthly	19	29	16	17	
Rarely	17	27	12	14	
Never	23	19	28	18	
Impact of Open Communication with Partner					
Yes, significantly	22	39	23	18	0.443
yes, to some extent	18	31	25	16	
No, not really	30	28	25	24	
Not applicable	32	26	22	18	

DISCUSSION

This study investigated the knowledge and attitudes affecting the use of family planning services among women of reproductive age in Owerri Municipal, Imo State. The results in Tables 4.1 to 4.5 give us significant information on the demographics of the people who answered the questions, how aware they are, how their culture affects them, and other things that affect their use of family planning services.

The demographic distribution indicated that women aged 35–44 years represented the predominant segment of respondents (31.2%). This is in line with what is happening around the world, where women in their thirties are often a large part of the reproductive-age population and are often at a point in their lives where they are actively thinking about family planning options [9]. Marital status significantly influenced the study, with divorced (26.1%) and single women (26.6%) constituting considerable sections of the participants. Previous research has shown that marital status can have a big effect on decisions about reproductive health. For example, married women may have different expectations, pressures, or influences from their spouses than single or divorced women [10].

Educational attainment also becomes an essential factor in deciding whether or not to have a family. Since 25.8% of those who answered only had primary school or less, it is clear that family planning messages need to be easier to understand and reach. A lower level of education has been linked to a lack of understanding about birth control, less freedom to make decisions about reproduction, and less use of services [11]. The sample's religious and ethnic diversity also shows how multicultural Owerri Municipal is, which shows how important it is to have culturally informed interventions that take into account the beliefs and customs of different groups [12]. The relatively large percentage of unemployed respondents (35.3%) underscores the impact of economic barriers, as financial limitations frequently obstruct access to adequate reproductive health treatments [13].

About half of the people who answered (54.3%) said they knew what family planning was. While the 45.7% without prior knowledge is good, it shows that more activism and public health education are still needed. In line with prior studies, younger women had more favourable attitudes towards the health benefits of family planning, indicating a trend of heightened exposure to health information via educational institutions, media, and internet platforms [14]. Targeted teaching initiatives customised for particular age groups could enhance utilisation. Also, different age groups had different ideas about how well different types of birth control worked. Misunderstandings or a lack of information, especially on emergency contraception, show that people of different ages require counselling and reliable, evidence-based information to clear up any doubts they may have.

Sociocultural factors were identified as having a substantial impact on family planning behaviours. Cultural standards were recognised as influential by 37.5% of respondents, whilst religious beliefs influenced decisions for 30.4%. These results align with previous research conducted in sub-Saharan Africa, where cultural norms around fertility and religious beliefs frequently influence reproductive decisions. While 38.6% of respondents said that family planning is culturally acceptable, many were unsure (29.1%) or didn't accept it at all in their communities (32.3%). This suggests the continued existence of traditional norms that could deter contraceptive use [15].

The role of male partners was shown to be important in family planning uptake. Partner support (34.0%) and engagement (35.9%) were found to be important factors, which is consistent with earlier research that show that talking to your spouse about contraception can help you use it [16]. On the other hand, almost half of the people who answered (48.6%) said that members of their families or groups were against or resistant to them. This kind of opposition makes it the more important for the whole community to work together to reduce stigma, bust myths, and promote shared responsibility for reproductive health [17].

The results also show that there are problems with how healthcare services are delivered. Only 31.8% of those who answered said that the healthcare staff in their institutions had enough training in family planning. The different levels of comfort that providers have when talking about birth control alternatives show how important it is to keep growing their skills and providing support [18]. It is also crucial to make sure that family planning goods and services are always available so that people keep using them.

The study shows that even while many women in Owerri Municipal are aware of and know about family planning, sociocultural norms, religious views, economic conditions, partner engagement, and the quality of healthcare services have a big effect on how often they use it. To improve reproductive health outcomes in the area, it is important to deal with these elements that are linked to each other.

Conclusion

This research offers significant insights into the knowledge, attitudes, and sociocultural factors influencing the use of family planning services among women of reproductive age in Owerri Municipal, Imo State. The results underscore the necessity to bridge current knowledge gaps, tackle socioeconomic and cultural impediments, enhance healthcare professional capabilities, and encourage partner participation in reproductive decision-making. To get more people to use family planning services, we need interventions that are culturally responsive, include the community, and are based on evidence. These results provide a basis for more study and endorse the formulation of customised interventions designed to enhance reproductive health outcomes and empower women within the community.

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