Family Size Preference and Associated Factors Among Women Using Antenatal Care Services in Kaduna Metropolis, Nigeria

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Abstract

The family size preference of people holds significant implications for population management strategies, informed family planning choices, and focused healthcare interventions aimed at achieving better health outcomes. This study investigates the family size preferences (FSP) of women attending antenatal care (ANC) services in Kaduna metropolis, Nigeria, while also identifying the factors that contribute to shaping their preferences. Data were collected through a self-administered structured questionnaire from 386 married women who were undergoing antenatal care in selected hospitals, chosen through cluster sampling. Descriptive statistics, the Chi-Square test, and multiple regression analysis were employed to analyze the data. A substantial proportion of women expressed a preference for having 3 to 4 children. Notably, factors such as age, age at marriage, and religious affiliation emerged as robust predictors of family size preference. The study findings indicate that younger women, those marrying at earlier ages, and adherents of the Islamic faith tend to exhibit a preference for larger family sizes. This study sheds light on the pivotal factors that influence family planning decisions among women, underscoring the significance of demographic considerations in the design of effective programs. The study offers valuable guidance for policymakers and healthcare practitioners, enabling the development of targeted interventions tailored to the specific needs of women in Kaduna thus enhancing family planning practices and more adept population management strategies.

Keywords: Family Size, Family Size Preference, Antenatal Care, Desired Family Size

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INTRODUCTION

The desired number of children a woman wishes to have in her lifetime entails her family size preference (FSP) (Thomson, 2011). While women bear the physiological and psychosocial burden of childbearing in a family (Buckley, 2015), little attention has been paid to their preferences regarding the number of children they want have received little attention, particularly in African societies like Nigeria, where male-dominated cultures often favor large families (Otite, 1991). In Nigeria, men often dictate family decisions, which causes women's fertility choices to be overlooked (Isiugo-Abanihe, 1994). The societal expectations in northern Nigeria strongly link childbearing to sociocultural and religious obligations, placing pressure on women to procreate unconditionally, without considering the socioeconomic and health consequences (Isiugo-Abanihe, 1994). This can lead to health complications for women as a result of excessive childbearing which can result in pelvic organ prolapse, which can further contribute to maternal and child mortality (WHO, 2019). Moreover, it can cause obstetric complications such as preterm births, low birth weight and delivery injuries (Halilu *et al.*, 2018). The continual stress and burden of excessive childbearing may lead to mental health problems like postpartum depression and anxiety (Schetter & Tanner, 2012). Additionally, large families can strain limited resources, affecting the socioeconomic well-being of women (Odusina *et al.,* 2017).

Giving women the ability to decide the number of children they want is critical because it allows them to plan for their well-being and that of their children, ultimately enhancing their health and general well-being (Alfred *et al.,* 2017). However, achieving personal preferences about family size is difficult for women in developing countries like Nigeria. Disparities in actual and intended fertility rates show that women's preferences are not fully realized, leading to unwanted fertility (Bankole, 1995; Ibisomi, 2007). Dibaba & Mitike (2016) discovered that women prefer smaller family sizes than men in an Ethiopian society. Despite this, the extent to which women's preferences trump their husbands' desires remains insufficiently explored in accessible literature on family size preference (FSP) in Kaduna state. Studies have suggested that husbands often wield significant decision-making power (Eshete and Adissu, 2017). For instance, in a community in Jos, the majority of women regarded their husbands as having the final say on family size preference (Kahansim *et al.,* 2013).

This paper aims to address the knowledge gap by focusing on women attending Antenatal Care (ANC) in Kaduna metropolis, as they are actively involved in childbearing and can provide valuable insights into their family size preferences. ANC attendees are generally more aware of reproductive issues and are likely to express their preferences openly. The aim of the study is to establish the family size preference of women using ANC in Kaduna metropolis with the specific objective of establishing their current family size, identifying their family size preferences, and examining the factors influencing these preferences.
The hypotheses tested to validate the aim of the study are that some sociodemographic and economic characteristics (such as age at first marriage, religious beliefs and educational attainment) of women are significantly associated with their family size preference.

MATERIALS AND METHOD

Study Area
Kaduna metropolis is located between Latitudes 10° 20' – 10° 40' North and Longitudes 7° 15' – 7° 35' East (See Figure 1). It is the capital and the city centre of Kaduna State. It is approximately 80 kilometres from Zaria to the North and 180 kilometres from Abuja to the South. The metropolis comprises Kaduna North, Kaduna South, some parts of Igabi, and

Chikun LGAs. It has an area of 131 km^2 (81 sq mi). It is located on the high plains of northern Nigeria. The study area has a tropical continental climate type characterised by a well-defined wet and dry season (Ayoade, 1988). The wet season lasts from April through mid-October with a peak in August; while the dry season extends from mid-October of one calendar year to April the next year (Abaje et al., 2016). The dry season is dominated by the northeasterly trade winds (harmattan) mostly experienced between November to February. Rainfall begins in May and lasts till October. The annual average rainfall in Kaduna State is about 1323 mm (Abaje *et al.,* 2015). The rain falls heavily with high intensity and short duration (Abaje *et al.,* 2018). The mean temperature of the area mostly peaked in the month of April. The highest average air temperature is 28.9° C which occurs in April, and the lowest average temperature is 22.9° C which occurs around December through January (Abaje *et al.,* 2016).

Kaduna metropolis has an estimated population of 1,397,033 (Projected from the 2006 Census), out of which 711,298 are males and 685,735 are females. The population of Kaduna metropolis consists of people from different parts of Nigeria and other parts of the world, making it the second most cosmopolitan city in the country (Ndabula *et al.,* 2014). Islam and Christianity are major religions in the area with a few adherents of traditional religions (Udo, 1970). The predominant people in the metropolis include Hausa, Yoruba, Igbo, Gbagyi, Bajju, Fulani, Kataf, Gwong, Tiv, Idoma, Nupe, Igbira, and Igala among others. The cosmopolitan nature of the people in the metropolis makes it more suitable for research this nature.
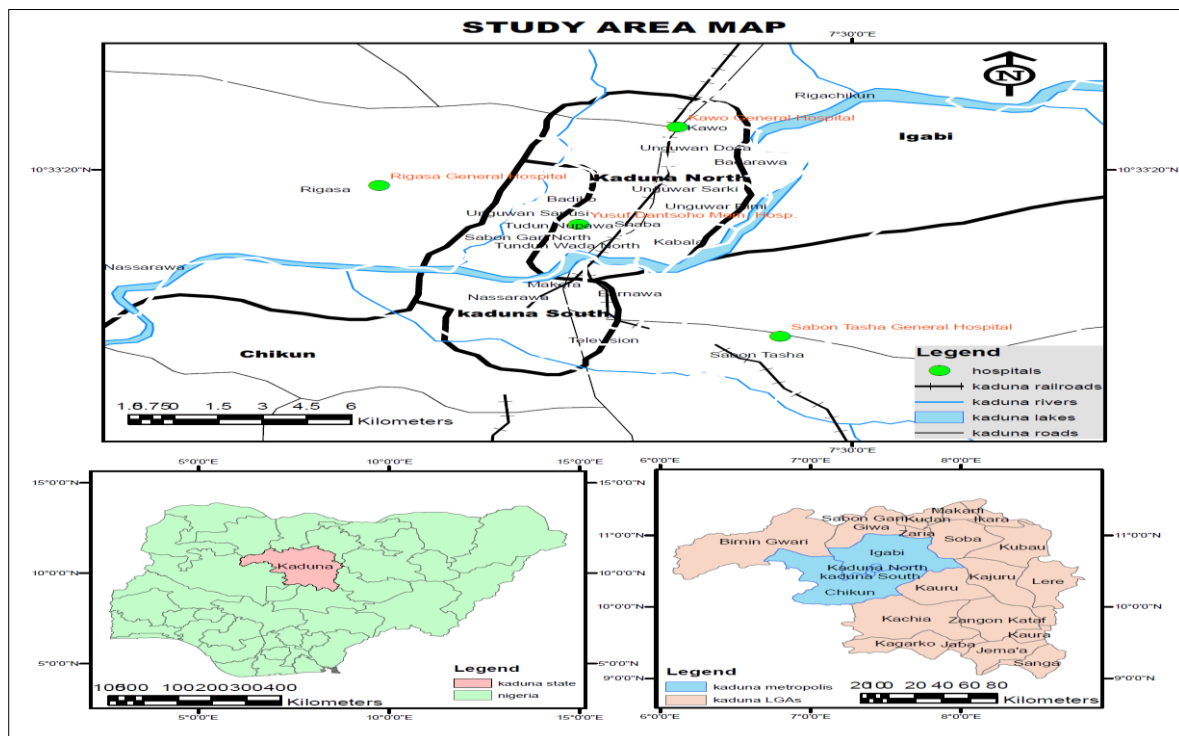

Figure 1: Map of Kaduna Metropolis
Source: Adapted from Administrative Map of Nigeria, 2021

Health facilities and Women's Health
Kaduna metropolis has a very large concentration of health facilities - both public and private. This made people from other parts of the state, troop into the metropolis to seek better health care services. Public healthcare facilities can be categorized into primary, secondary and tertiary. The primary healthcare facilities can be found in most of the wards in the metropolis. Secondary healthcare facilities are in the form of General Hospitals and Specialist Hospitals

which can be found in each of the LGAs that formed the metropolis. There is Kaduna State University Teaching Hospital, which is a tertiary health care facility in the metropolis. Women attend the General Hospitals, and other private hospitals for antenatal care. All the general hospitals and specialist hospitals found in the metropolis have an ANC and gynaecology unit for women. The cosmopolitan nature and awareness in the metropolis result in a high turnout of women who attend hospitals (Oguntunde et al., 2010), which is useful to this research.

METHODOLOGY

Study Design and Settings
This descriptive cross-sectional study was conducted within Kaduna metropolis, which serves as the capital city of Kaduna state. This metropolitan area represents Kaduna North, Kaduna South, as well as portions of the Igabi and Chikun local government areas (LGAs) within Kaduna state. The metropolis has an estimated population of 1,397,033 residents, comprising 711,298 males and 685,735 females. Notably, this diverse population is drawn from various regions of Nigeria and beyond, contributing to its status as the country's second most cosmopolitan city (Ndabula et al., 2014). A significant presence of both public and private healthcare facilities characterizes this metropolitan area. Among the public healthcare resources are four general hospitals, a specialist hospital, and a teaching hospital, complemented by an array of primary health facilities. The public health infrastructure constitutes general hospitals situated within each local government of the metropolis, as well as additional primary and secondary public health facilities. These facilities collectively offer antenatal care (ANC) services to expectant mothers.

Participants
We included women attending their antenatal care on their designated "booking day". Officials of the hospitals categorized the women who visit the ANC section into two – those who attend the unit for the first time (referred to as "new booking"), and those who are already in the care. All the hospitals have selected days for different categories of women according to their level of ANC care. The study employed a multistage sampling technique; the metropolis was divided into four clusters representing the Local Government Areas (LGAs) of the metropolis. One General Hospital was purposely selected from each LGA, chosen due to its accessibility to all individuals regardless of socioeconomic status, religion, or ethno-tribal classifications. Furthermore, women were selected conveniently in the selected hospitals. The monthly records of a six-month period (July to December 2019) were analyzed and a total of 10,717 women were identified. Using Yamane's formula, a sample size of 386 was determined, with each hospital receiving a proportionate share based on the sample size.

Data Collection
A self-administered structured questionnaire was developed according to the study objective and literature. The questionnaire was designed for self-administration, but for non-literate respondents, however, four trained research assistants performed face-to-face interviews with non-literate respondents. Throughout the data collection process, the researchers were available to offer guidance and clarification as needed. The questionnaire was divided into 3 sections: section 'A' addressed the socio-demographic characteristics such as age, religion, age at marriage, education and household income. Section 'B' concerned the current number of children a woman has, and a current number of children a woman has based on gender, while section 'C' asked about number family size preference and the number of family size preferences based on gender as well as perceived factors that influence their family size preference such as income, obstetric health, and children as source of labour, survival of

children, old age security and government population policy. We define current family size as the number of children the women reported to currently have irrespective of the children's gender, while FSP entails the number of children the women desire to have in their lifetime if they are to begin their childbearing.

Data Analysis

Data were extracted in an Excel sheet, cleaned, and imported into IBM's SPSS Statistics Software Package version 25. The current family size of married women in the study area was identified through a frequency distribution analysis. To investigate factors influencing family size preference, cross-tabulation and chi-square tests were employed. Additionally, regression analysis was conducted to assess the impact of associated factors on family size preference, allowing for an examination of the combined effect of independent variables on the dependent variable.

Ethical Consideration

Ethical clearance was obtained from Kaduna State Ministry of Health. This type of research requires such clearance. The clearance was used in the hospitals to gain access to the respondents for all the interviews. The anonymity and confidentiality of the data were ensured. All participants signed a written consent form.

RESULTS AND DISCUSSION
Demographic Characteristics

The sociodemographic characteristics of the respondents consist of their age, religion, age at which the respondents married, education level, occupation and household income.

Table 1: Sociodemographic Characteristics

Age	Frequency	Percentage (%)
15 – 19	18	5.3
20 – 24	55	16.3
25 – 29	77	22.8
30 – 34	79	23.4
35 – 39	66	19.6
40 and above	42	12.5
Total	**337**	**100**
Religion	**Frequency**	**Valid Percent**
Islam	238	70.4
Christianity	99	29.6
Total	**337**	**100.0**
Age Married	**Frequency**	**Percentage (%)**
15 – 19	8	2.4
20 – 24	97	28.8
25 – 29	117	34.7
30 – 34	95	28.2
35 – 39	18	5.3
40 and above	1	0.3
Total	**337**	**100**
Education level	**Frequency**	**Percentage (%)**
No Formal Education	19	5.7
Primary	29	8.6
Secondary	148	43.7
Tertiary	141	42.0
Total	**337**	**100**

HH Monthly Income	Frequency	Percentage (%)
less than 10,000	74	22.0
10,000 - 19,000	21	6.3
20,000 - 29,000	57	17.0
30,000 - 39,000	84	24.7
40,000 and above	101	30.0
Total	**337**	**100**

Source: Author's Field Work, 2021

Age categories of respondents show that women between the age group of 30–34 years were more (23.9%), followed by the age group of 25–29 years with 23.3% and 40 years and above have the lowest distribution. In total, 98.2% of the respondents are within the age bracket of 15–49 years. Measure of central tendency shows that the mean age of the women is 30.6 with the mode being 30 years old. The religion of the respondents shows that Islam is the dominant religion among them with 70.4% and Christianity has 29.6%. The distribution of age married shows that 34.7% of the respondents were aged between 25 and 29 followed by 20-24 and 30-34 with 28.8% and 28.2% respectively (Table 1). Only 2.4% got married as early as 15-19 years old, while 5.6% married late above 35 years. The mean age at which the respondents got married is 22 years while the mode is 20 years. The youngest age the respondents got married was 14 and the oldest was 35. From the result, there is an indication that many women are marrying late in recent years compared to the past. The claim that women in northern Nigeria marry early may not be entirely valid or at least with reduced intensity in Kaduna metropolis especially among those attending ANC services. The fact that only 2.4% married as teenagers means that some efforts at delaying marriage are paying off. Interestingly, those who married after 35 years are even more than teenagers. This means that many of the women are getting socioeconomically and psychologically matured before getting married and are likely to be able to make important family size and family planning decisions with their spouses.

The formal educational achievement of the respondents indicated that about 44% have attained secondary education followed by 42% who attained tertiary level of education. The primary level is the lowest level of education attained by the women with 8.6% while only 5.7% had no formal education.

Among the women, 30.1% reported having a household income of ₦40,000 and above, while 24.7% earn ₦30,000 to 39,000 per month, and 22% earn less than ₦10,000 in their household (Table 3.1). About 24% earn between ₦10,000 to 29,000. It is not surprising that the majority of the women reported a household income of ₦40,000 and above. This is due to the fact that the husbands provide for the family and given the economic situation, earning ₦40,000 for an entire household is not uncommon. The mean household income is ₦20,000 to ₦29,000, which places the majority in the middle income earner category of the reported incomes.

Current Family Size

In order to know the current family size of women in the study area, the number of their living children needs to be established since it is the measure of family size of a household. The number of children the women reported to currently have irrespective of the children's gender, constitute their current family size. The majority of the respondents reported having 1 to 2 children (44.4%), while 27.2% reported having 3 to 4 children.

Table 2: Current Family Size

Child(ren)	Frequency	Percentage
0	9	2.6
1 – 2	150	44.4
3 – 4	92	27.2
5 – 6	44	13.1
7 – 8	25	7.5
9 and above	17	5.2
Total	**337**	**100.0**

Source: Author's Field Work, 2021

The reason for the women having 1 to 2 children as their current family size may be connected to the fact that most of them are at their early stage of childbearing given their short duration of marriage. Also, the study area being cosmopolitan where people are more aware of the burden of having large family sizes may be a reason. The level of education and the socioeconomic exposure of the women as well as the age they first got married can also be related to the current family size. Okolo & Okolo (2013), also found out that the majority of women at the time of their study had a "current family size" of 3 to 4 children.

About 21% of the respondents have a family size of between 5 to 8 children, while the remaining 4% have 9 children and above. Only 2.6% reported having no children as of the time of the survey. These are likely to be those attending ANC services as newly booked. However the story may be slightly different if samples are drawn from the entire women population outside those attending ANC services. Those attending ANC services are equally representative hence the result is a valid reflection of Kaduna metropolis.

The mean family size of the respondents is 2. This can also be related to the duration of marriage of the women as most of them have been married for less than 5 years as shown in table 2. The maximum number of children the women reported is 12. This may be the few older women among the sample especially those above 40 years of age who probably married at a relatively young age.

Current Family Size (based on Gender of Children)
Current family size consists of both gender of living children a woman has, therefore identifying the gender of the children of the respondents is a detailed way of explaining the current family size of the women. Table 3 shows the existing number of living boys and girls which sums up the family size of the women. The current family size is in the 1-2 category with 67% and 68% for boys and girls respectively. This shows almost equal size in the 1-2 family size category for both boys and girls. Another 19% reported 3-4 for both boys and girls. The minimum number of boys and girls is 2, while the maximum shows a greater number of boys (10) than girls (7).

Table 3: Current Family Size based on gender

Family Size	Boys		Girls	
	Frequency	%	Frequency	%
0	20	6.0	18	5.3
1-2	226	67.1	229	67.9
3-4	64	19.0	66	19.6
5-6	19	5.6	23	6.7
7-8	2	0.5	2	0.5
9-10	6	1.9	0	0.0
Total	337	100	337	100

Central tendency:
Source: Author's Field Work, 2021

It is expected that as family size increases, there is a likelihood for bias in sex especially for boys. Since the majority of the women are at the early stage of childbearing, gender bias may be uncommon as shown in Table 3 where the mean gender for both is 2. The bias for boys may be best understood when the current family size is large in relation to the duration of marriage of the women. In terms of percentage, boys constitute 50.8% of the FS and girls have 49.2. Interestingly, the result of this study regarding family size is similar to the National Population Census of 2006 data where 50.5% are male and 49.5% are female in Kaduna state.

Family Size Preference
Family size preference is central to this study and it is the variable that explains the FSP of women in the study area. The number of children the women desire to have in their lifetime if they are to begin their childbearing is what FSP entails. To sort out the numeric value of FSP of the women, a hypothetical question was asked: "Let's suppose you just got married, how many children would you prefer to have over your entire lifetime." This type of question gives the respondent a clear picture of the numeric answer required to establish their FSP. Table 4 shows the FSP of the women with close to 47% preferring 3-4 children, followed by 33.5% who preferred 5-6 children. About 14% have a preference of 7 and above with only 1.2% having a preference of 11-12, which is similar to the finding of Adiri et al. (2016) where women were found to have a preference of as many as 12 children in their study. Only 5% of the women prefer 1-2 children, which may not be unconnected with the fact that the study area is in the metropolis, as some people may be more conscious of the FSP in relation to certain factors, which were as well identified in this research.

Table 4: Family Size Preference

Family Size Preference	Frequency	Percentage
1-2	17	5.0
3-4	158	46.9
5-6	113	33.5
7-8	32	9.5
9-10	13	3.9
11-12	4	1.2
Total	337	100.0

Source: Author's Field Work, 2021

The mean number of children preferred by the women is 4.6 while the mode is 4 children. This is also in line with the findings of Okolo and Okolo (2013) where the model number of

children women desire is 4. This study also corroborates that of Amente *et al.* (2017) where the average number of children married women desire in their study is 4.09. Therefore, the finding of this study regarding FSP shows that the women in the study area are not interested in large family sizes. This is contrary to other locations in the state such as Zaria where Abubakar (2012) found out that respondents have a desire to have 7 children and above. On a second look, 2012 and 2021 are almost a decade and the reality of socioeconomic challenges has perhaps changed the preference for small family size as enunciated in the National Population Policy.

Family size preference (based on Gender of Children)
Family size preference is the number of children a woman wants to have in her lifetime from both genders. When a preference is established, gender comes into play as women who have a particular numeric preference would further have a preference for a particular gender or a combination of both genders as is usually the case. The FSP for boys and girls is shown in Table 5, wherein the preference category of 1-2, about 76% of the respondents preferred boys while 66.3% preferred girls. In the 3-4 FSP category, 26.9% of the women preferred girls while 17.5% wanted boys. In the 5-6 FSP, 6.9% wanted girls while 6.2 wanted boys. The preference for boys is more when the FSP is low, while girls are slightly preferred when the FSP is high. This indicates that the bias for the preference of boys is associated more with women who prefer smaller family sizes.

Table 5: Family Size Preference based on gender

FSP	Boys		Girls	
	Frequency	Percentage	Frequency	Percentage
1-2	255	75.7	223	66.3
3-4	59	17.5	91	26.9
5-6	21	6.2	23	6.9
7 and above	2	0.6	0	0
	337	**100**	**337**	**100**

Source: Author's Field Work, 2021

This may be as a result of the general belief that boys carry the family name and are more likely to be economically successful than girls and therefore, in low preference, it is safer for them to prefer boys than girls. In the case of women who have higher preference in the 3-4 and 5-6 categories, they tend to desire more girls than boys. In general, the FSP for both boys and girls in the study area is almost equal in terms of measure of central tendency, as the mean FSP for both boys and girls are 2.3 children, with the mode being 2 for both, and the minimum and maximum for both are 1 and 7 respectively.

Associated Factors Influencing Family Size Preference
General factors that influence FSP include income, obstetric health, children as a source of labour, survival of children, old age security and government population policy. Table 6 shows the identified general factors that influence FSP in the study area. Income has the highest percentage of 32.8%. It is a major factor that influences FSP as the respondents affirm that income is the major factor, they consider limiting their number of children by using FP. This is in line with the study of Otumo (2000) who also found income to be a major factor that influences FSP. Obstetric health (21.2%) is another reason why some of the women would want to limit their childbearing, as some of the women consider childbirth to be stressful. Some of the respondents affirmed that they tend to give birth more as they are not sure who will survive till adulthood (20%). This is a major factor that influences family size, especially

in developing countries like Nigeria where the healthcare is not adequate. Old age security (13%) is also a factor, as the women want to make sure they have children they can take care of when they are old, which influences FSP and it is in line with the findings of Okolo and Okolo (2013) as well as Odimegwu et al. (2018) where they reported old age security to be among the major factors that influence large family size preference in Africa.

Table 6: General Factors influencing Family Size Preference

Factors	Frequency	Percentage
Income	112	32.8
Obstetric Health	71	21.2
Source of Labour	34	10.1
Survival of Children	68	20.3
Old Age Security	44	13.1
Gov't. Pop. Policy	8	2.4
Total	**337**	**100**

Source: Author's Field Work, 2021

Some of the women consider children as a source of labour (10%) - to help them in their various domestic chores, occupational and livelihood endeavours or to work in other avenues that will sustain the family. Only a few of the respondents have FSP in conformity with the government population policy. This indicates a low level of awareness as regards Nigeria's population policy by women.

Test of Hypothesis
Hypotheses tested were to identify the association between some sociodemographic variables (such as age at first marriage, religion and educational level) and family size preference of the respondents.

Table 7: Selected Sociodemographic Factors that Influence Family Size Preference

Age Married	Mean FSP	X^2, P=value
15 – 19	5.8	X^2 = 22.005,
20 – 24	5.1	p = .015
25 – 29	5.0	
30 – 34	4.5	
35 – 39	3.7	
40 and above	3.0	
Religion	**Mean FSP**	
Islam	5.1	X^2 = 11.730,
Christianity	4.1	p < .003
Education level	**FSP**	
No Formal Education	5.7	X^2 = 77.437,
Primary	5.3	p = <.001
Secondary	4.8	
Tertiary	4.6	

Source: Author's Field Work, 2021

Age Married and FSP
The age at which a woman marries tends to affect her family size preference which is pertinent to her fecundity since women who marry at an early age are likely to have higher FSP than women who marry late. Women who got married at the age of 15-19 tend to have the highest mean FSP of 5.8, while women who got married between the ages of 40-44 have the lowest

mean FSP of 3.0 (Table 6). Those between the ages of 20 to 29 years have a mean of 5. It is clear that as the age increases so does the desired number of children decreases. Women between the ages 30 to 34 have a mean FSP of 4.5 followed by those between the ages 35-39 who have a mean of 3.7. Statistical analysis in the form of Chi-Square (X^2 = 22.005, df = 10, p = .015) indicates a significant relationship between age married and FSP. Therefore, it is clear that women who got married at younger ages tend to prefer more children than women who got married at older ages.

Religion and FSP
Respondents who are adherents of religion and FSP, women who followed Islamic religion (70%) have a mean FSP of 5.1, while those who are Christians have a mean FSP of 4.1. This clearly shows that Muslim women tend to prefer larger family sizes than their Christian counterparts. This may be due to the Islamic perspective that children are gifts from God and therefore should be accepted all the time (Ibisomi, 2011). The result of Chi-Square (X^2 = 11.730, df = 2, p = .003) shows a significant relationship between religion and FSP of the women. This is in line with the findings of Okolo and Okolo (2013), where they also found religion to influence FSP in their study area.

Education and FSP
Education influences the perspective of women regarding fertility, as women who are educated are most likely to prefer smaller family sizes, while it is common for uneducated women to prefer large family sizes or not even have an opinion regarding their family size choices. Table 6 shows that women with no formal education have a mean FSP of 5.7 which is higher than those with tertiary education who have 4.6. It is expected, as women who are not educated are most likely not to have personal opinions regarding FSP. This corroborates the findings of Ibisom (2011), that women with no formal education seem to have higher fertility in Nigeria. Those who only attained primary education tend to have a mean FSP of 5.3 which is only slightly lower than those with no formal education. While those with secondary school have a 4.8 mean FSP, which is lower than those with primary education. The hypothesis was tested using Chi-Square (X^2 = 77.437, df = 33, p = < .001) and it shows a significant relationship between education and FSP of women in Kaduna metropolis. This relationship according to Ibisom (2011) places education as a factor that has a strong influence on FSP. This result may be contrary if men are involved in the study, as stated by Nelson (2008), that Nigerian men love children, and they are always ready to have more children irrespective of their educational background.

CONCLUSION
This study has shed light on the family size preference of women as well as the important factors influencing it in the study area. The findings indicate a preference for smaller family sizes, with most women having a family size preference of 3 to 4 children, irrespective of the gender of the child. Income, obstetric health, child survival, age at marriage, religion, and education were identified as major influencing factors of family size preference. The study underscores the significance of considering sociocultural, religious, and economic factors in family planning programs as they are the influencing factors of family size preference. Targeted interventions that align with women's preferences are essential to promote improved family planning and reproductive health outcomes.

By emphasizing the importance of formal education beyond the secondary level and delaying marriage, as well as ensuring maternal health and old age social protection, we can continue

to observe a reduction in family size preference among women in Kaduna metropolis. These insights provide valuable guidance for policymakers and health practitioners to develop effective family planning strategies that match the needs and desires of women in the study area. Understanding these factors will be crucial in fostering a more sustainable and healthier demographic atmosphere in Kaduna metropolis

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