

Knowledge and Practice of Family Planning by Women of Childbearing Age in Delta State, Nigeria.

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ABSTRACT: *The problem of rising population, caused by high fertility rates, low death rates and aggravated by low contraceptive practice has taken a frightening dimension in most developing nations, including Nigeria, hence different authors have voiced their concerns and advocated ways out of the dilemma as a means of having a better society by the practice of contraception. This study investigates the knowledge and practice of family planning by women of child bearing age in Delta State with a view of knowing the current status of family planning and making relevant policy recommendations to the State. The study adopted a quantitative approach using a descriptive survey design in a cross sectional study using 582 structured questionnaires. The result of the research indicate that the women in this study showed good attitude to family planning and have very high knowledge of family methods (93.2%) which tilted towards condom (91.3%), pills (72.3%), and injectables (64.2%) with relatively low contraceptive prevalence (31.2%), thus indicating a wide gap between knowledge and current usage promoted by expectations of side effects of family planning methods. The conclusion of the study was that women should be educated on the benefits of family planning as well as on more family planning methods by using sources identified in this study as a way of improving population control and enhancing the standard of lives of the women in Delta State and Nigeria.*

KEYWORDS: *Delta State, Family Planning, Knowledge, Practice, Nigeria, Women*

I. INTRODUCTION

One of the global problems of today is the increasing population without commensurate rise in the world resources to care for the numerous needs of the people [1]. Authors in the past, alarmed about the situation have voiced their concerns that, if the population explosion was allowed to continued, a time will come when the world food supply will not be able to keep pace with the growing population [2, 3, 4, 5]. Today, while developed nations have been able to deal with the challenges of rising population, sadly the developing countries, with their high fertility rates and very high population growth rates are still grappling with the problem of uncontrolled population upsurge [6, 7, 8, 9, 10, 11, 12; 13). Explanations have been given for this high population growth to include: high fertility rates, low contraceptive usage, very high birth rate and declining death rate [10, 14, 15, 16, 17] Population growth is equally desirable in some situations because; it is the resource of labour supply for production of goods and services as well as consumption of various products produced within and outside the country [18]. However, due to the effects of increasing population on the socio-economic development in the country in general such as: education, water, transportation, housing and maternal/child health in particular, there is therefore the need to maintain the growth of the population at a level that is desirable and appropriate so as to ensure a balance between population growth and environmental resources - which provides sustainable economic development and improvement on the well being of the people [18, 19].

To strike a balance between population growth and resource usage requires strategies among which is family planning (FP) through the use of contraceptive methods. Family planning is defined as the ability of the individuals and couples to attain their desired number of children and plan the spacing and timing of their births through use of contraceptive methods [20]. Thus, family planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods [18]. While women in developed and industrialised countries used family planning at one time or the others in the course of their lives [21], the situation is different in most developing nations such as Nigeria - where the growth of population had been consistent and the control of birth through the use of family planning using contraceptives have remained extremely low [15, 22, 23, 24, 25, 26, 27, 28]. For example, in Nigeria with a population of over 140 million persons (NPC, 2007), the total fertility rate per woman is 5.5

with a contraceptive prevalence of 15% [29]. With a continuously growing population and low contraceptive prevalence, it is imperative to promote family planning.

According to Sileo [30], the benefits of family planning have become increasingly recognised worldwide, including improved health, economic, and social outcomes for women and families, as well as public health, and environmental benefits at the population-level. From the perspective of Dabral & Malik [31], family planning is design for two major reasons. Firstly, it creates opportunity of having only desired number of children and secondly, family planning brings about the spacing of the desired children. Other specific individual benefits of family planning include prevention of pregnancy related risks and death of women [30], reduction of infant mortality, unsafe abortion, prevention of sexually transmitted infections (STI), prevention of mother to child transmission of HIV [13], prevent adolescents from going out of schools by reducing their pregnancies and enhances the opportunity for girls getting educated [32] and improvement of economic of the family [33]. Studies in the past revealed that awareness/knowledge of family planning was very high at over 75 % [9, 21, 28, 34, 35], with a contraceptive prevalence of 15% [27]. Condom has been reported as the most popular contraceptive method (Nwachukwu & Obasi, 2008). Also, previous studies indicate a positive attitude toward family [9] with media as the dominant source of information on family planning [36, 37].

Despite the knowledge of benefits of family planning and attendance consequences of failure to adopt it as birth control strategy the rate of usage have been found to be low [27, 38,39, 40, 41]. Many factors have been adduced for the low contraceptive prevalence. A greater proportion of the populations of the Nigerians are known to reside in the rural area with attendance low contraceptive prevalence due to their fear of contraceptive and side effects [34, 42, 43]. Culture and traditions play a huge role on how people perceive innovations including family planning in developing nations and their behaviour tend to reflect the expectations of the influential custodians of these traditions [6, 44, 45]. The low usage of family planning also stemmed from lack of general knowledge on family planning [46, 47] and opposition from husbands [28]. Other factors responsible for low contraceptive prevalence have to do with background characteristics such as, education, wealth, parity, religion and place of residence as well as women status (attitudes, subjective norms, and perceived behavioural control) [48, 49 50, 51].

Family planning is important to Delta State and indeed Nigeria in view of rising population and dwindling states and National resources. If Delta State, including Nigeria must deal with the threat posed by the upsurge of population, it becomes imperative to understand the dynamic of the programme of FP in the State by looking at the knowledge and practice of family planning. Hence, this study investigates the knowledge and practice of family planning by women of child bearing age in Delta State with a view of knowing the current status of FP and making relevant policy recommendations to the State.

II. METHODS

A quantitative approach using a descriptive survey design was chosen in a cross sectional study using a structured questionnaire developed after a literature search of relevant materials to the subject of study in order to ensure validity and reliability of the questionnaire [52, 53 54,55].The method adapted here was first used by Olugbenga-Bello [34] in his study of Contraceptive Practices Among Women in Rural Communities in South-Western Nigeria. This study took place in three Local Government Areas (LGAs) in Delta State among women of reproductive age using a multi-stage sampling using. This sampling commenced with the selection of a sample frame of 25 LGAs after which 3 LGAs using simple random sampling method, after the State was divide into three parts based on the existing political Senatorial District with an LGA selected from each using a sample size of about 400 gotten from Taroyamane formula for population. The 400 was increase to 600 questionnaires for the sake of representativeness (582 questionnaires used in analyses due to invalidation of some questionnaires). This was followed by making lists of urban as well as rural communities of each LGA. Three communities were selected from each LGA – two rural and one urban community, randomly selected from each of the lists to make up 9 communities in the study. In the rural communities, numbers were given to all the houses in the communities and only the houses with even numbers were selected. In urban communities, a street was selected and the houses in even number in the street included. The next stage involved the interview using self administration of questionnaires to women of age 15 -49(child bearing age) who consented to be part of the study. The questionnaire which was also adapted from the work of Olugbenga-Bello [34], consisted of information about the respondent's age, education, occupation, marital status, residence, ethnic groups; religion, income level, definition of family planning, knowledge about family planning methods, attitude to family planning, prevalence of family planning methods, adverse effects, ever use and current use of family planning methods and source of information.

Data analysis/ Ethical consideration

The data were analysed using Statistical Products and Service Solutions (SPSS) software IBM version 21. Analysis was done using percentages and cross tabulations. The survey protocol were reviewed and approved by the Ethical Review Committee of Centre for Population and Environmental Development. At all levels, participants were briefed on the study objectives and their consent was received verbally before

administering any of the research protocols. In addition, all the participants were informed of their rights to withdraw their participation in the study at any stage. The participants were also assured of their anonymity during and after the study [56].

III. RESULTS

Table 1 indicates that the respondents were almost equally divided between rural and urban residences. A greater proportion of them (54.4%) were in the age bracket of 20 to 34 years, followed by 35 years and above and 19 years or less with 27.8% and 17.8% respectively. Majority of them (72.2%) were married, followed by 11.8% and 10.9% of them who are cohabiting and single respectively. The respondents were from Ijaw (31.2%), Urhobo (30.2%) and Igbo (29.4%) since the study was carried out in three major ethnic groups of Urhobo, Ijaw and Igbo. The respondents were more from Pentecostal churches (43.5%) and Protestant (38.3%) with 27.3%, 25.7%, 20.5%, and 16.5% of who are farmers, traders, self employed and civil servants respectively. Majority of them (40.3%) completed secondary, 24.4% completed primary education, and 18.2% completed one form of tertiary institution or the others with 17.1% who never attended any formal institution of learning. The income level of 27.8% of the respondents ranged from 1000 naira (\$3) to 5,000 naira (\$13); 25.2% for respondents with income level of 6000 naira (\$16) to 10,000 naira (\$27); 17.8% for income range of 11,000 naira (\$29) to 15,000 naira (\$40) and 15.9% for income range of 16,000 naira (\$43) to 20,000 naira (\$53). Only 13.3% of the respondents fell within the income bracket of earning above 20,000 naira (\$53). A closer look at the table revealed respondents who were young women with mostly secondary and primary education, very poor income level who were mostly farmers, traders and self employed.

Table 1: Socio-Demographic Characteristics of the Study Population(n=582)

Variable	No	%
Residence		
Rural	286	49.1
Urban	296	50.9
Age (Years)		
19 or less	104	17.8
20-34	316	54.4
35 and above	162	27.8
Marital Status		
Single	63	10.9
Married	420	72.2
Cohabitation	69	11.8
Divorced	9	1.5
Widowed	7	1.2
Separated	14	2.4
Ethnic Groups		
Urhobo	176	30.2
Ijaw	182	31.2
Igbo	171	29.4
Others	54	9.2
Religion		
Catholic	78	13.4
Protestant	223	38.3
Pentecostal	252	43.5
Others	28	4.8
Occupation		
Farming	162	27.8
Housewife	16	2.8
Self employed	119	20.5
Trading	150	25.7
Tailoring	20	3.5
Civil Servant	96	16.5
Others	19	3.2
Highest Level of Education		
Primary	142	24.4

Secondary	234	40.3
Tertiary	106	18.2
Never attended any	100	17.1
Income Level		
1000-5000	161	27.8
6000-10,000	147	25.2
11,000-15,000	104	17.8
16,000-20,000	93	15.9
Above 20,000	77	13.3

Information obtained regarding respondents knowledge of FP, in Table 2 showed that 37.7% of them believed that family planning means limiting the family size, 34.6% are of the opinion that family planning is about child spacing. To others, family planning is about prevention of unwanted pregnancy and prevention of STIs as 21.2% and 6.5% respectively indicated such in the studied area. However, more persons believed in the rural areas (42%) than in the urban centres (33.4%) that family planning limit family size. Regarding FP as a child spacing option, women in the rural areas (36%) than urban communities (33.2%) believed that, FP is defined as a child spacing mechanism. More respondents in the urban areas see FP as means of preventing unwanted pregnancy (24.3%) and prevention of STIs (9.1%) compared to rural areas where 17.8% and 4.2% respectively were of the opinion that FP means preventing unwanted pregnancy and preventing STIs.

On respondents' knowledge in the area of various method of family planning by which a couple could delay or avoid pregnancy, as Table 2 also indicates, revealed a very high knowledge in the studied area since 93.2% of the respondents knew at least one or more methods. The most commonly recognised methods were the male condom (91.3%), followed by pills and injectables with 72.3% and 64.2% respectively. The least popular methods were female sterilisation (9.3%) and Male Sterilisation (23.2%). The respondents in the urban areas knew of at least one method (97.3%) than their rural counterparts. More respondents knew of male condom (94.7%), pills (79%), injectables (69.5%) and rhythm (66.3) methods in the urban areas compared to rural respondents. Just like their urban counterpart, the most widely recognised family planning methods in the rural areas were male condom (87.9%), Pills (65.6%) and injectable (58.9%). However, the fourth most recognised FP method in the rural communities was withdrawal method (37.8%) unlike in the urban areas where it was rhythm method with 66.3%.

It was also evident in Table 2 that most respondents got information about family planning from Health personnel (36.7%), friends/relatives (28.4%), electronic media (24.1%) and not surprising, printed media was the least source of information (10.8%) on FP in the studied area. However, more persons in the rural areas got their information from health personnel and friends/relative with 44.8% and 37.4% compared to urban dwellers that have the proportion of 28.6% and 19.4% for the same sources. The electronic media was the most popular source of information in the urban areas with 37.4%.

As Table 2 equally revealed, majority of the respondents did not know of the side effect of using family planning since a very high proportion (74.1%) so indicated. However, it was curious that more persons in the urban areas (75.3%) did not know side effects compared to those in rural dwelling with 72.9%. Regarding who should decide on the use of family planning in the studied area, 40.4% believed this should be done by both partners while 32.4% and 27.2% respectively were of the opinion that the task should be done by the husband and wife alone. Nevertheless, more urban dwellers agreed that it should be the job of both partners (46.3%) compared to their rural communities with 34.5%. More rural dwellers were of the opinion that the husband as well as the wife alone should decide on family planning with 35.8% and 29.7% respectively.

Table 2: Respondents' Knowledge of Family Planning (FP) in the studied area, rural and urban locations

Variable	Studied Area (N=582)		Rural (N=286)		Urban (N=296)	
	N	%	N	%	N	%
Definition of Family Planning						
Prevention of unwanted pregnancy	123	21.2	51	17.8	72	24.3
Child spacing	201	34.6	103	36.0	98	33.2
Limit family size	219	37.7	120	42.0	99	33.4
Prevention of STIs	39	6.5	12	4.2	27	9.1
Contraceptive Methods (Multiple response)N582						
Any method	542	93.2	255	89.1	287	97.3
Rhythm	281	48.3	87	30.3	194	66.3
Withdrawal	266	45.7	108	37.8	158	53.6
Male Sterilisation	135	23.2	54	18.9	81	27.5
Condom (Male)	531	91.3	251	87.9	280	94.7
Female Sterilisation	54	9.3	8	2.8	46	15.8
IUD	199	34.2	62	21.7	137	46.7
Emergency Contraceptive	139	23.9	27	9.4	112	38.4
Injectables	374	64.2	168	58.9	206	69.5
Pills	421	72.3	188	65.6	233	79.0
Diaphragm	159	27.4	51	17.9	108	36.9
Condom (Female)	215	36.9	66	23.2	149	50.6
Sources of Information						
Health Personnel	214	36.7	128	44.8	86	28.6
Friends/Relatives	165	28.4	107	37.4	58	19.4
Printed Media(Postal and Handbills)	63	10.8	20	7.0	43	14.6
Electronic Media	140	24.1	31	10.8	109	37.4
Knowledge of Side – effect						
Non	431	74.1	208	72.9	223	75.3
Weight gain	20	3.4	11	3.8	9	3.0
Weight Loss	12	2.1	7	2.5	5	1.7
Condom burst/spillage	8	1.3	4	1.5	3	1.1
Extra Marital Affairs	13	2.3	7	2.5	6	2.1
Amenorrhea	19	3.3	9	3.3	10	3.3
Secondary Infertility	19	3.3	10	3.5	9	3.1
Heavy Menses	32	5.4	14	4.9	18	5.9
Irregular Menses	28	4.8	16	5.1	13	4.5
Decider of Family Planning Method						
Husband alone	189	32.4	102	35.8	86	29.0
Wife alone	158	27.2	85	29.7	73	24.7
Both wife and husband	235	40.4	99	34.5	137	46.3

In order to gauge the attitude of respondents to family planning in this study, the likert scale of strongly agreed and agreed were merged as agreed while strongly disagreed and disagreed were equally merged as disagreed. From Table 3, most of the respondents were highly in support of the national policy of 4 children per family (71.9%), 50.2% were of the opinion that husbands should be involved in family planning decision and 48.3% agreed that FP encourages promiscuity. However, 78.9% and 78.5% totally disagreed that FP is against their culture and only female should use family planning respectively. Also, 58.8% did not agree that family planning diminishes sexual pleasure. Lastly as high as 44.9% believed that FP is not for only literate but more respondents (55.1%) were of the view that this was the case.

Table 3: Attitude to Family Planning in the Studied Area

Variable	Strongly Agree I		Agree		I don't know		Disagree		Strongly Disagree	
	N	%	N	%	N	%	N	%	N	%
It is against culture and religion	20	3.4	23	4.0	80	13.7	139	23.9	320	55.0
Only females should use contraceptives	41	7.0	51	8.8	33	5.7	121	20.7	336	57.8
It encourages promiscuity	137	23.5	144	24.8	162	27.8	78	13.4	61	10.5
Diminishes sexual pleasure	57	9.7	85	14.6	98	16.9	174	29.9	168	28.9
It is only for the literate	121	20.8	79	13.7	120	20.6	121	20.7	141	24.2
Husbands should be involved in family planning decision	154	26.5	138	23.7	91	15.7	110	18.9	89	15.2
Support national policy of 4 children per family	235	40.3	184	31.6	72	12.4	44	7.6	47	8.1

Table 4 provides the responses of respondents to ever use and prevalence of family planning. From the table, a preponderant of women (78.4%) who took part in the study revealed that they have used FP at one time

or the other. However, a greater proportion of the respondents in the urban communities (94.3%) used FP methods than their counterpart in the rural locations with 78.4%. The most common family planning methods ever used by respondents were injectables (42.3%), male condom (20.4%) and pills (18.3%) in the studied area. In the urban communities, the most common FP methods ever used were injectables (42.7%), male condom (19.5%) and pills with 18.5%. Compared to rural areas, while the proportion of FP methods ever used for injectables and pills in urban centre was higher than those of rural areas with 41.9% and 18.1%, the proportion of ever used of male condom in rural areas was slightly higher (21.3%) than urban areas where it was 19.5%.

The family planning prevalence in the studied area was 31.2%. The figure differs between rural dwellings and urban communities with greater proportion (46.4%) of the current users of family planning methods coming from urban settings compared to 16% in rural communities. The family planning methods mostly prevalent in the studied area were injectables (9.3%) and pills (5.5%). The FP methods that were mostly prevalent in rural area were pills (4.1%) with injectables (14.5%) being the most prevalent in urban dwelling. Respondents' main reason adduced for the choice of FP methods in the studied area were little or no side effects (27.9%), affordability and availability (25.9%) and suitability and reliability (25.6%). Approximately 26% however have no reasons or considerations for making such choices. A good proportion of the respondents (47.9%) who were not currently using any method have no reason for their action but 23.5% believed it was as a result of side effects, 16.9% were of the opinion that their decision was based on disapproval from their husbands or boy friend's and as a result of personal desires to have children (11.7%) . There existed only slight different between rural communities and urban areas in term of the reason for not currently using FP. Most FP users have been doing this for 1-5 years (52.3%) and 6-10 years (30.3%).

Table 4: The Use and Prevalence of Family Planning (FP) in the Studied Area, Rural and Urban Locations

Variable	Studied Area (N=582)		Rural (N=286)		Urban (N=296)	
	No	%	No	%	No	%
Ever used of Family Planning						
Yes	456	78.4	179	62.5	277	94.3
No	126	21.6	107	37.5	17	5.7
Family Planning Methods ever used (Studied Area = 456) (Rural=179) Urban: N=277						
Foam	0	0.0	0	0.0	0	0.0
Withdrawal	5	1.2	3	1.5	3	0.9
Implants	37	8.1	14	7.7	19	8.5
Diaphragm	3	0.7	2	1.2	1	0.2
Condom (Male)	93	20.4	38	21.3	54	19.5
Condom (Female)	2	0.3	1	0.1	1	0.5
IUD	11	2.4	4	2.0	8	2.8
Emergency Contraceptive	29	6.3	11	6.2	18	6.4
Injectables	193	42.3	75	41.9	118	42.7
Pills	83	18.3	32	18.1	51	18.5
Male Sterilisation	0	0.0	0	0	0	0.0
Female Sterilisation	0	0.0	0	0	0	0.0
Currently used contraceptive methods (Studied Area = 456) (Rural=179) Urban: N=277						
Foam	0	0.0	0	0.0	0	0.0
Withdrawal	5	1.0	4	2.0	0	0.0
Implants	12	2.6	0	0.0	14	5.2
Diaphragm	15	3.3	4	2.0	13	4.6
Condom (Male)	17	3.7	4	2.0	15	5.4
Condom (Female)	0	0.0	0	0.0	0	0.0
IUD	16	3.4	3	1.4	15	5.4
Emergency Contraceptive	10	2.1	0	0.0	12	4.2
Injectables	42	9.3	7	4.1	40	14.5
Pills	25	5.5	8	4.5	18	6.5
Male Sterilisation	0	0.0	0	0.0	0	0.0
Female Sterilisation	1	0.3	0	0.0	2	0.6
Not currently using any method	313	68.8	150	84.0	148	53.6
Main Reasons for choice of FP Methods (Studied Area = 456) (Rural=179) Urban: N=277						
No Reason	117	25.6	54	30.0	59	21.2
Little or no side effects	127	27.9	46	25.9	83	29.9
Suitable and reliable	94	20.6	33	18.4	63	22.8
Affordable/Available	118	25.9	46	25.7	72	26.1

Main Reason for not currently using any method (n = 313)						
No Reason	149	47.9	86	48.3	132	47.5
Husband's/boy friend's disapproval	37	11.7	21	11.7	32	11.7
Side Effects	74	23.5	41	22.6	68	24.4
Desire for more children	53	16.9	31	17.4	45	16.4
Duration of Contraceptive use(in years) (Studied Area = 456) (Rural=179)						
Urban: N=277						
1-5	238	52.3	113	62.9	116	41.7
6-10	138	30.3	59	33.0	76	27.6
11-15	41	8.9	4	2.1	43	15.7
16-20	20	4.3	2	1.1	21	7.5
21-25	19	4.2	1	0.9	21	7.5

IV. DISCUSSION

The focus of this study is to investigate the knowledge and practice of family planning by women of child bearing age in Delta State with a view of knowing the current status of FP and making relevant policy recommendations to the government of Delta State as well as other relevant stakeholders. Many studies have carried out inquiries with regard to family planning especially in areas of knowledge, attitude and practice. This study revealed a very high knowledge of family planning methods as 93.2% of the respondents have knowledge of at least one method of family planning method; with respondents in urban centres having more knowledge (97.3%) than those in rural communities (89.1%). Thus, the finding from this study is in line with similar research works in the past. For example, studies such as Barrett & Buckley [21]; Moronkola et al. [47]; Nwachukwu & Obasi [9]; Obisesan,[28] and Olugbenga-Bello, et al.[34]; reported awareness/knowledge of family planning methods that were well over 75 %. Other studies that reported very high awareness or knowledge of family planning methods were: Tuladhar and Marahatta [35] whose finding put the proportion of awareness of family planning methods at 93%, Zafar, et al. [57] which reported 94% awareness in Pakistan and Renjhen et al. [58] whose research found out awareness level of family planning methods at 94.2% in Sikkim. Olugbenga-Bello, et al. [34] in their study in South Western Nigeria were of the opinion that the increase in awareness of family planning methods may not be unconnected with rising awareness creation in different parts of Nigeria to draw attention to the issue of growing population in Nigeria. A closer look at the data from this study showed that, even though the knowledge of the respondents on family planning methods was generally high, there were marked variations among the various family planning methods. For example, while male condom knowledge was at 91.3%, pills, 72.3% and injectables 64.2% respectively, emergency contraceptive was at 23.9%, male sterilisation was at (23.2%) and female sterilisation stood at 9.3%. The revelation from the observed pattern is that, while some methods such as male condom, pills and injectables were very popular, the level of awareness and knowledge of others such as: emergency contraceptives, male sterilisation and female sterilisation were relatively unpopular. The lack of the popularity of the later contraceptives may be as result of the fact that they were not available, more expensively, the expertise needed for the use of some of them and fear of the side effects associated with their usage. Condom was the most popular FP method (probably due to campaigns on HIV/AIDS) in this study just as reported in previous studies [9, 34,59]. However, this study was in contrast to the one done in Korea by Renjhen et al.[58] where the most known FP methods were depo provera which ranked 78.0%, followed by oral contraceptive pills (74.0%) and condom (71.0%). In this study, while the figure of pills was second in ranking compared to the Korea study, there was a reversal of trend with condom being ranked as third FP method.

This study was concerned about the knowledge of respondents regarding the definition of family planning, sources of family planning, side-effects of family planning and who decides on the usage of family planning methods. On the definition of family planning, most of the respondents (37.7%) saw family planning as limiting the family size, 34.6% were of the opinion that it was about child spacing, and 21.2% agreed that it was related to prevention of unwanted pregnancy. Only 6.5% believed that family planning was about prevention of unwanted pregnancy. There were variations about the definition of FP based on residence. More women believed that FP is related to limiting family size and child spacing in rural communities compared to their urban counterpart, while more urban dwellers believed that FP helps to prevent unwanted pregnancies and prevention of STIs in the urban dwelling than rural women.

Regarding source of information about family planning, more of the respondents got their information from health personnel (36.7%), followed by friends or relatives (28.4%) and electronic media with 24.1%. Differences existed between urban communities compared to their rural localities. For example, more women have health personnel and friends/relatives as their sources of information in rural dwellings compared to those in urban areas who used more of electronic media as well as printed media. The result of this study contrast previous studies where it was reported that the electronic media was the highest source of information on FP

[35,37]. However, this study agreed with Shah et al. (2008) and Olugbenga-Bello, et al. (2011) where health personnel were the major sources of information. It is important that attempts to promote family planning should involve the use of the health personnel as well as friends/relative which are already documented as some of the major sources of information in this study. Furthermore, the result from this study underscores the place of community health workers in Primary Health Centre as Olugbenga-Bello, et al [34] pointed out in his own study. Electronic media are also useful as this study equally indicates.

Though 74% of the respondents in this study did not indicate any side effects, 5.4% reported heavy menses, 4.8% of them talked about irregular menses while 3.4% weight gain. The figure reported for urban as well as rural localities regarding heavy and irregular menses including weight gain are almost the same both for urban and rural areas. The respondents (40.4%) agreed both spouses should be responsible in the choice of contraceptive – which is higher than the figure Olugbenga-Bello, et al [34] reported for both couple in their study.

On the attitude of respondents to family planning, most of them were highly in support of the national policy of 4 children per family (71.9%), 50.2% were of the opinion that husbands should be involved in family planning decision. Also 78.9% and 78.5% totally disagreed that FP is against their culture and only female should use family planning respectively, with 58.8% respondents who did not agree that family planning diminishes sexual pleasure, indicating a positive encouraging attitude toward family planning. This supports the rising trend of awareness creation among the people. However, the belief in culture and traditions was equally evident in the study. For example, 55.1% of the women were of the view that family planning was only for literate and 48.3% agreed that FP encourages promiscuity while 34.1% did not see any reason why men should be involved in family planning inspite of earlier evidence that this was necessary [34,60]. This study revealed that preponderant of women (78.4%) have used FP at one time or the other. However, a greater proportion of the respondents in the urban communities (94.3%) have used family planning methods than their counterpart in the rural locations with 78.4%. The most common family planning methods ever used by respondents were injectables (42.3%), male condom (20.4%) and pills (18.3%) in the studied area. In the urban communities, the most common FP methods ever used were injectables (42.7%), male condom (19.5%) and pills with 18.5%. Compared to rural areas, the FP methods ever used were injectables, pills and male condom.

The family planning prevalence in the studied area was 31.2%. The figure differed between rural dwellings and urban communities with greater proportion (46.4%) of the current users of family planning methods coming from urban settings compared to 16% in rural communities. The family planning methods mostly prevalent in the studied area were injectables (9.3%) and pills (5.5%). The FP methods that was mostly prevalent in rural areas was pills (4.5%) with injectables (14.5%) being the most prevalent in urban dwelling. The observed prevalent of FP methods in this study area was lower than that by Gaur et al, 2008 and Olugbenga-Bello, et al. 2011 that recorded a prevalent levels of 34.% and 66.3% respectively. However, the result here was higher than the prevalent of the study by Ndiaye, Delaunay and Adjmagbo [61] in rural Senegal which reported as low as 1.5% for modern contraceptives, Respondents' main reason adduced for the choice of FP in the studied area were little or no side effects (27.9%), affordability and availability (25.9%) and suitability and reliability (25.6%) . A good proportion of the respondents (47.9%) who were not currently using any method have no reason for their action but 23.5% believed it was as a result of side effects, 16.9% were of the opinion that their decision was based on disapproval from their husbands or boy friend's and as a result of personal desires to have children (11.7%) . There existed only slight different between rural communities and urban areas in term of the reason for not currently using FP. Most FP users have been doing this for 1-5 years (52.3%) and 6-10 years (30.3%) Most of the reasons reported in this study for the choice of FP method and the reasons for low contraceptives prevalent have been reported in earlier studies previously reported [34, 42, 43].

V. CONCLUSION/POLICY RECOMMENDATION

The women in this study have very high knowledge of family methods which tilted towards condom, pills, and injectables with relatively low contraceptive prevalence, thus indicating a wide gap between knowledge and current usage promoted by expectations of side effects of family planning methods. Put in others words even though the women were aware of family planning methods, the knowledge was in favour of a very few methods both in rural as well as urban areas. The women in study though showed good attitude to FP, there were however a handful of them who were still very conservative - having negative attitude towards family planning methods. The main sources of information to the women in the study were health personnel and friends/relative. Hence, these sources should be leverage upon by the government keying into them to promote higher access to family planning, so as to move up in the figure of higher prevalence as obtained in developed countries. Additionally, there is need to expand and educate the women in the state on other methods of family planning which may be more preferred if they know about them. There must be deliberate attempt by all governments in Nigeria to educate the citizens on the benefits inherent in knowing and using appropriate family planning method which

will make the citizens to plan their births as a way of managing their standard of living, controlling the birth rates in the families and for the government to manage the upsurge in the population growth.

ACKNOWLEDGEMENTS

This publication as well as the research leading to it was sponsored by the Think Tank Initiative (TTI) of IDRC, Canada and Centre for Populations and Environmental Development Benin City, Nigeria. We are grateful to Ms. Elizabeth Oghenechovwe Ejohwovbo, Ms. Onome Osio, Mr. Stanley Epini and Mr. Fedelix Boyi who were involved in the data collection. We also appreciate the time that the community participants put into the project the various days the research team visited their communities for data collection.

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