KNOWLEDGE ATTITUDE AND PRACTICE OF FAMILY PLANNING AMONG MARRIED WOMEN IN OFFA TOWN, KWARA STATE - NIGERIA

BY

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DECLARATION:

I HERE BY DECLARED THAT THIS PIECE OF WORK WAS CARRIED OUT BY ME UNDER THE SUPERVISION OF PROFESSOR P. SHINGHA.

THIS WORK HAS NOT BEEN PRESENTED IN ANY PREVIOUS APPLICATION FOR AWARD OF HIGHER DEGREE. THE WORK OF OTHER COLLEAGUES ON THE FIELD ARE ACKNOWLEDGED AND REFERENCED ACCORDINGLY.

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CERTIFICATION

This thesis entitled: Assessment of knowledge, attitude and practice of family planning among married women in reproductive age group 15 – 45yrs in Offa town Kwara State Nigeria by J. A. Oyeniyi meets the regulations governing the award of the Degree of Master of Public Health of Ahmadu Bello University Zaria. and is approved for its contribution to science knowledge and literacy presentation.

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ABSTRACT

TOPIC:

Assessment of knowledge, attitude and practice of family planning was carried out on married women in Offa Town, between a reproductive are group of 15 - 45 from 2[n]*-27,[h] September 2000.

METHOD

Two Stage sampling, proportion sample unit, and random sampling were used depending on the stages.

DEMOGRAPHY:

Age - group 15-45 was used. The modal class of the respondents was 26 -30 years - 24.5%. 89% of he respondents were Yoruba while the other ethnic-group made of 11%. By their religion affiliation, 74.8% were Muslim and 25.2% were Christians. Literacy level was high. 69% of respondents were literate. Primary education, secondary and post secondary education were 27.5%, 28.5% and 11.7% respectively.

KNOWLEDGE:

74% of respondents knew that family planning would prevent further birth after they had completed their family while 6.75% did not know. About 70% of respondents know at least three modern-methods of contraception - Oral pills, (1.U..C.D) Intra Uterine Contraceptive devices, Injection and Condom.

ATTITUDE

65.75% of respondents approved and 33.25% disapprove use of contraception. The major favoured reason for approval is for child spacing -59.1%. 49.5% of respondents favour few birth (1-3 children) while 51.5% favour large births (more than 4 children)..

PRACTICE

The percentages of ever-use was 35.8% and current users was 26%. Some of the reasons militating against using a method were rumour; mis information and exaggeration of side effect of contraception which is far from the truth.

CONCLUSION

Since majority favour large family size and use family planning mainly for child spacing and not to limit birth. Family planning may not have a remarkable effect on

the rapidly growing population but would help reduce infant and material mortality rate.

RECOMMENDATION

I recommend that women status should be improved. Strategies need to be made to bridge the communication barrier between Family Planning providers, religion leader, Community leader and users. Terminology like reproductive health and child spacing will be a better term than us of contraception. Retraining of service providers is very important. Adequate provision of family planning supplies and services would go along way to improve utilization of services.

Government need to embark on programme that would discourage desired for more children if reduction in fertility is to be achieved and promote gender equity.

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CHAPTER ONE

INTRODUCTIONS

The human population is growing at a faster rate in developing Country. After 2nd World War in 1946 there was baby boom to replace the dead. The annual growth rate for Nigeria population is 3% and the population was 113.8 million in 1999 (1) while the world population amount to 7.8 billion. This means that Nigeria population would double every 23years if not check. With increase in population there would be pressure on planet earth to cope with population growth. This would lead to inadequate provision of health services. employment, education, shelters and social amenities. This would eventually lead to strife. loss of properties and human life because population is growing at geometric progression while means of sustenance is growing at arithmetical progression.

This would lead to a massive increase in the number of people living in poverty with children and women bearing the brunt. Thus maternal and infant mortality rate would increase in developing Countries compared to developed Countries (2 & 3). Maternal mortality rate in Nigeria is 500,000 yearly. And globally, it is 585,000. Increase in parity, short birth interval, young maternal age, has lead to increase in population growth, incidence of infant and maternal mortality rate.

About 50% of pregnancies are unplanned (un wanted) in developing Countries and 16% of these pregnancies are terminated by abortion. Abortion account for 13% of 585,000 maternal death (78,000) every year. In addition about 2/3 of health resources are used to take care of the abortion cases and its complication in our hospitals.

- The remaining unwanted pregnancy resulted to unwanted children which are not look after and they roam about the street constituting a public health problem to the populate and adding to its population.
- The importance of child spacing, limiting of birth to a healthy period of reproductive lifetime and limiting total number of birth can improve infant and maternal health and curtail the growth rate of human population.

Family planning is not a new practice in our community. It is an old age practice which our grandparents practice. It is not imposed on us by imperialist! What is new about is the use of effective contraception methods, which allow couple to space their child effectively, time their birth and prevent unwanted pregnancy while they resume sexual relation soon after birth.

The prevalence of contraceptive methods remain low in sub-Saharan African less than 10% for women in reproductive age group. (4). It is a public health problem. As a result I would assess the knowledge; Attitude and practice of family planning among the married women in reproductive age group (15-45 yrs) to find out reason for low prevalence and proffer solutions.

Family planning means action taken by individual and couples to plan or determine the number, spacing and timing the children they want so as to promote the health and welfare of the family. It embraces prevention and treatment of both infertile and sub fertile couple so as to have desired number of children they want (5). Population planning involves society or nation to take action to determine the size and growth of its population.

Adoption of family planning by a nation would help the nation to achieve their population objectives/goals such as:

(i) To improve the standard of living and quality of life of the people.

(ii) Promote their health and welfare especially through preventing death and illness among high-risk group of mothers and children.

(iii) Achieve a lower population growth rates, through reduction birth rate by voluntary fertility regulation for the attainment of economic and social goal of a nation.

(iv) For even distribution of population between urban and rural areas.

It was on 4th February, 1988 that the Armed forces ruling council approved national policy on population for development, unity, progress and self-reliance (6).

The Federal Ministry of health, Nigeria (national health policy 1986) defined family planning as a service given to individuals and couples within the community in order to educate them as the art of healthy and stable family life. And so enable them

(i) To have children when they desire to do so.

(ii) To avoid pregnancy when it is unwanted or inadvisable.

(iii) To space the birth of their children and chose in order to improve socioeconomic condition of the family. Such education and practice must respect the culture of the people concerned (7).

- In 1974 there was much debate in Bucharest before family planning was accepted as a human right of individual and couples (8). At 1994 international conference of population development in Cairo, 179 countries agree to programme of action that every individual has the right to attain highest standard of physical and mental health and the right to freely and responsibly to the number, spacing, timing of their children and to have means and information to do so (1).

- Before the advent of modern methods, most European Societies managed to reduce their fertility with the use of less effective methods such as abstinence, coitus interuptus, and through abortion particularly in Eastern Europe, couple still rely on such practice-abstinence and coitus interruptus.

This traditional method has been in practice since ancient. Some of these are ineffective Hence there is a need to adopt a modern and effective method of contraception.

Rationale o: Justification For Study.

1. To generate data on family planning for Offa community since similar study has not been carried out. And to add to existing body of knowledge.
2. To determine constraints to use of family planning services and proffer solution to these problems. And improve the quality of family planning that is available.
3. To assess health risk behaviour of the people i.e. early marriage, early childbirth and parity.

MAIN OBJECTIVE: TO ASSESS THE KNOWLEDGE ATTITUDE AND PRACTICE OF FAMILY PLANNING AMONG MARRIED WOMEN IN REPRODUCTIVE AGE GROUP 15 – 45 YEARS IN OFFA TOWN:

Specific Objective:

1. To assess their knowledge of family planning
2) To assess their attitude and practice of family planning
3) To determine method used.
4) To determine factors that influence their fertility behavour

CHAPTER TWO

LITERATURE REVIEW

POPULATION GROWTH

Concern for high population growth led to the beginning of organization of family planning in Nigeria in 1957 (9) Government did not accept the reduction of population growth as a public policy. From study of Deborah L. Covington Otolorin et al traditional value for large family size are strong. And motivation to regulate fertility is weak in Nigeria. And people that adopt family planning do it mainly for child spacing and not for limiting birth according to study carry out in Ilorin by Oni Gbolahan and colleague (10). World population will increase by 20% (1000 million) with in 10 years (11).

- Morbidity and mortality associated with reproduction will be greater in the current decade than in any period in human history. 5-10 million children would die with in one year of birth. AIDS related infections will undermine health care in Africa and AIDS related death will reduce force. Growth in population and associated morbidity will inhibit global economic development according to Lincoln-Dw.
- Ajayi and colleague noted high level of fertility since 1950's and the need to make birth control popular and check rate of population growth which is currently affecting it's development. He said the population will double it self by 22 years. He suggested that present-day structure at which child bearing begin has an important demographic consequence on the population (12). In 1990 Nigerian demographic and health survey revealed that one-half of women become mothers before the age of 20 years. About 40% of teenagers that are 18 years have already begun child bearing.

Sexual Behaviour Reproductive knowledge and Attitude:

According to survey by Giershenge and colleague majority of women in shanga have had premarital sex (13). More among rural – 81%. 81% of premarital occur between ages of 20-21 years. Average age of first sexual intercourse was 21 years in rural and 23 years in urban.

Marot F. said that approximately 1:5 sexually active girl become pregnant by the age of 20 years and one-third of these pregnancies end in termination. Girls at 18 years are highly fertile. Marot said that sexually active girl who had received sexual education is significantly more likely to use effective contraceptive method (14).

He noted that the following tend to decrease premarital sex:

Having a strict parent, the more educated a lady is and being older. While the following encourage premarital sex: early puberty, feeling lonely, delay age of marriage and adoption of western education. Solutions to premarital sex are:

Improvement in sex education, Abstinence and delay in start of sexual intercourse is the most effective method in preventing the consequence of teenager sexual activity. Family life education and develop resistance to peer-pressure.

From Ajayi and colleague study, in kwara state show that 44.9% of adolescent attained menarche by their thirteen birthday and 68.1% by age of 14 (12). This means they have longer period of exposure to the risk of pregnancy. About 64% are sexually experience under 18 years or 20% under 15 years. 88.9% were sexually active by 20 years.

46.1% of the adolescent have used a method, which is mostly condom in 40% of cases. 12.2% of the adolescent had their first child by of 14 years. And more than 30% had abortion before they reach age of 18 years. The median age of first intercourse is just little over 16 years and 21.1% of schoolgirls had their first intercourse.

IDEAL AGE OF MARRIAGE-

From the survey, idea age for girls is between 18 –2 5 yrs when 55% would be expected to have entered in to marriage and for boys 20-30 years. By 1988, National population policy the acceptable minimum age is 18 years. Their desired number of children is

4-5 (12) .

MATERNAL HEALTH:-

According to J.Ties Boerma estimated that approximately 515,000 women died annually due to pregnancy-related causes in developing country between 1980 to 1985. Ninety percent of this death took place in Africa and South Asia due to frequent birth at short interval and maternal mortality level are high (16). An effort to check this lead to safe motherhood initiative in Nairobi by W.H.O. UNICEF and UNFPA (2). If child bearing become less, maternal mortality ratio will decline. In Nigeria maternal mortality rate was 704 per 100,000 liver birth in 1999 (Unicef 1999).

FERTILITY DETERMINANTS.

John Bongaarts an epidemilogist classified factors that influence fertility directly as proximate determinants. They are:

- Use of effective contraception
- Age at first marriage

- Post pa.tum Infecundability (because of breast-feeding) and sexual abstinence following birth.)
- Induced abortion
- Infertility
- Spontaneous abortion
- Frequency of Intercourse

The indirect determinants of fertility of women are:- Education, Occupation, Income, Social status, Cultural Factors or Value.

Thus the knowledge Altitude and practice of family planning depends on socio-Cultural background of the community.

- Religious practice and belief: The principle of some religion of Roman Catholism and some Muslim who believe that the idea of publicity of contraceptive and accessibility will lead to promiscuity. They do not support family planning using modern method. Pope John condemn family planning method in British broad casting Programme in Kenya on Tuesday 1916 of September that Catholic should not adopt it as away of life (7). President Moi also condemned the use of contraception. From survey work of Mac Dolald U.S in 1982 among black in Salisbury, Zimbabwe, 36.5% of non acceptor are Roman Catholic and 34.77% of husband that are resistance were Roman Catholic (17). Among the Muslim they differ in their opinion. It Depending on Islamic sects from study conducted by Yusuf among the women of Pakata, Ilorin in Nigeria (18).

Haneefiyat set permit abortion less than 120 days because it could stop lactation.

While MaleKenyat Theologician dislike Induction of abortion before forty day of conception (18).

Education: Recognation of contraception vary with women education. Nearly women with more than Primary education know at least one family planning method from Rutenberg and colleague analysis of survey data (4). From the annual report of 1991 by the Director of Planned Parenthood Federation of Nigeria, there is no change between approval and knowledge among educated women with Secondary or tertiary education. Both rate are the same 90% For women without education, there was a gap between approval and knowledge (19). It was 59% and 29% respectively for approval and knowledge.

Broad understanding: Women that have broad knowledge of family planning are more likely to choose an appropriate method. Couples that know several effective methods are likely to switch if they are not satisfied with a particular method. Many abandon family planning because of misinformation, fear, supply problem, side effect and do not switch immediately to another method.

Information: Letten Maier-c and colleague said that programme combine mass media and popular entertainment formats can be a potent force in health communication since they reach audience with persuasive message (20)

Such programme increase knowledge and

Stimulate approval and when use effectively

Can change behaviour. Oheneba Saky-y.

Said motivation of couple to share responsibility, would increase husband approval of family planning method (21).

Communication: Sarah Salway conducted a study in Ghana using data from 1988 Ghana Demographic Health survey shown that 77% of Cohabiting couple held similar attitude toward family planning and 73% of concordant couple approves of contraceptives use. 44% gave

concordant responses on ideal size. 35% of wives had discussed with their spouse during previous year (22).

- Wife perception of husband attitude to family planning:

  Wives who belief that their husband approve of family planning were significantly more likely to be practicing contraception. About 26% of women who believe that their husband approve were using contraception compared with 5% among women who believe that their husband disapprove family planning (22).

  Son preference: Men and women prefer male sex for reason of continuity, propagation of family name, for financial support for aging parents and to help the family in farm work

- In Bangladesh fertility is four times increased because of male gender preference in Ban flash women (23). Glenmon M.J and Fegan D-J discovered that couple rarely start family planning until they have one or more male child in Dharan, East Nepal (24).Mauren J. Graham study in Anhui province show a sex ratio of male to female in the first, 2^{nd} and 3^{rd} birth order were 1.17,1.12,1.16 respectively against the normal ratio of 1.06(25). The overall estimate was 1.18 male birth per female birth.

  This was achieved through:

  (i) Sex selective infanticide

  (ii) *Gender specific abortion*

  (iii) Concealment of female birth.

- Family with many daughters continues to have child until a son is born. Female child are breast fed for a shorter period compared to male baby. And childbirth interval is

shorter for female. The proportion of couple that went for sterilization increased witl increased in number of male baby per couple.

Women status: Women that have radio, television and use them will know more informatio about family planning and tend to use them.

Govindasamy P. and Malhotra studies in Egypt show that women autonomy have importan influence on contraception (26).

Charles Westoff and German Rodrigue found that women exposure to family plannin messages in mass media- their desire for smaller families and their use of family planning wer closely related from the study of 1989 Kenya's demography Health survey (4).

Age at marriage or union: Age of first union depend on education attained (19). It is lower i urban compared to urban (12). It is lowest with out education. Rise in marriage age reduc fertility level. It is lower in the north than in the southern part of Nigeria.

Younger age increase fertility. In sub Sahara Africa majority of marriage occur by 20 years.

Culture: C. Meade et al studies among the women in Cindad Juarez of Mexico emphasis tha regular menses reassure women that they are not pregnant. Hence they prefer monthly injectio and switch from long acting injection to a method that allows a monthly menses. This reflec the cultural belief that their body needs to cleanse it self and expel week blood.

Societal value for children: Demographic health survey by Ezeh et al show that west Africa men are far more likely to want another child than men in other regions (4).

Post partum sexual abstinence: The period is about three months in most survey by Rav Sharma and Shea Rutstein on the average. The highest period in Nigeria is 9 month (4).Fertility tend to rise when post partum abstinence is very short and the woman is not usin contraception.

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Number of children: Use of contraception increase sharply with the number of children a woman has. A woman that has three children tend to use an effective family planning than a woman with one child.

In 1990, Paraguay demography survey show that 36% of women with one child or none used family planning, rising to 59% of women with three children later falling to 46%of women with four or more children (4).

Rutenberg and colleague report that while some women with many children may not use contraception because they want to have a large family. Others may have more children than they want because of lack of access to contraception. And also many women with more children may not be using contraception for reason associated with age.

Governmen: policies: Policies that promotes the small family norm and widely provided family planning services can speed the adoption of new reproductive attitude and use of contraception.

This is what happened in Indonesia. It was on 4th February, 1998 that the Armed Forces Ruling Council approved a national policy on population development, Unity and self reliance of four children per a woman (6).

URBAN/RURAL RESIDENCE: - Urban women are more likely to use contraception than rural women (19). The difference is more in Countries with low contraceptive prevalence. For example in Cameroun 1991 Demography health survey report contraceptive prevalence of 16%, prevalence was 11% in rural compared to 25% among urban women. The reason been that urban women are more educated, have modern attitude for smaller size. They spend more to raise children in the cities and living condition is crowded. They have less need for children labour than couple in Agriculture.

Country/region: From survey studies, fertility is lowest in South Korea at 1.7 children per woman, which is below 2.1-repalacement levels. That is the number of children just to replace the couple.

- In Mauritius it was 2.2 children per woman and recorded in 1991 survey (4)

  In sub Sahara fertility is much higher at age under 20 and over 35 years. They start child bearing at younger age than women in other country and make less use of family planning to limit child bearing when they are old. It is much lowered in developed Country two per woman. For Japan 1.7 and 1.9 per woman in United State of America.

CONTRACEPTIVE PREVALENCE:-

From the annual report of Planned Parenthood Federal of Nigeria in 1991, total fertility is slightly below 6 children per a woman. Prevalence for modern method is below 6% in Nigeria and the main reason for adoption is for child spacing in 50% of cases (19).

Study carried out by Ibrahim M.T that is a facility based in Sokoto, the prevalence was 65% (27). 82.9% Christian and 45.9% of Muslim approved. 83.5% of respondents desired more than four children per a woman. Major favour reason for approval was for child spacing – 61%. Mean and median age of respondent was 27.4 years. Approval was higher among monogamous than polygamous. Among the ethnic group Ibo has highest rate of approval follow by Yorubas and then Housa/Fulani. The modal age group was 26 years. Their choices of methods are: Oral pill – 44%, Injectable – 19% I.U.C.D. 9% and rhythm 10%.

Preference for Contraception:

Kahley and Gillapsy study Bogotal Columbia suggested that income level of education; parity and age were associated with contraceptive choice (28).

Con chrane study black women in United State and found that pill user were younger, had fewer children than I.U.D users (28). Studying Thailand show that women that use pill are more likely to want more children than those that use I.U.D.

Ball Weg found that phillipine women that choose I.U.D do not want more children. And continuation of I.U.C.D. is more among older women for those whose husband approve of family planning.

With balance information and free choice women preferences according to Ball Weg studies in Philippine depend on the time desired for next pregnancy.

And that preference is not a consistent with education, employment status and method choice.

Obionu C.M. and Agbaji M.N. found that family practice is affected by: maternal education, Contraceptive awareness, perinatal out come, child survival, cultural practice and occupation (29)

Rachael Snow et al said that women preference for a method depends on effectiveness, reversibility, duration of protection, and little side effect (30).

Voluntary approval of Family Planning by a woman in urban is 70% and 60% in rural area. Approval increases up to age of 35 years before it then decreased.

Effectiveness of various Family Planning methods (31)

FAMILY PLANNING METHOD	PREGNANCIES PER 100 WOMEN IN FIRST MONTHS OF USE	
	Average rate or As commonly used	Applied to couple. Used correctly and Consistently
Nor plant	Less than 1	Less than 1
Vasectomy	" " 1	" " 1
Injectable	Less than 1	Less than 1
Female sterilization	" " 1	" " 1
T Cu 380A I.U.C.D.	" " 1	" " 1
Progestin only oral post partum	" " 1	" " 1
Lactotion anmenorrher for 6 months	2	Less than 1
Combine Oral contraceptive	6-8	Less than 1
Condom	14	3
Fertility awareness based on abstinence	Less than 20	1 – 9
Female condom	21	5
Spermicider	26	6
No method	85	85

SOURCE: POPULATION REPORTS VOL. XXVI NUMBER 4 DECEMBER 1998 PAGE 26

Key	Score	Interpretation
	0-1	Very effective
	2-9	Effective
	10-30	Some what effective

Table "B" below show effectiveness of contraception between United State and Philipine Survey

Pregnancy per 100 women during first year of use

Contraceptive method	Lowest reported rate	Rate in two large U.S. survey	Rate in two large philipine
I.U.C.D	1.5	4.8	2.4
Condom	2.0	9.6	10.4
Sperm.cidel	3 – 5	17 .7	N.A
Oral contraceptive	0.5	2.5	5.1
Periodic abstinence	2 – 20	18.8	13.8
Female sterilization	0(N/A)	0(N/A)	N.A(Not available)

Source – KAP study be Yusuf M. Ribaden (5)

EXPLANATION:- The lowest reported rate gauge effectiveness for couples who use the method correctly and consistently.

Typical rate gauge effective for typical group of users some of which may not use it correctly and consistently. Both type of pregnancy rate are most often reported for the first year per 100 women users.

The greater differences between couple and typical pregnancy rate in the use of condom, spermicidal, and period at stinence show that couple have difficulty using this methods.

CONSTRA'NSTS ON USING EFFECTIVE FAMILY PLANNING:

Study of Urban Sudan by Amna M. Swar – Eldahay among 305 married women aged 15 – 49 from a field survey in Khartoum City show fertility of 5.8 per a woman with a population growth of 3.1% in 1991. The high level of fertility is a result of very low level of contraceptive prevalence – especially of effective methods.

This is due to lack of demand for family planning among their population. Factors that restrict. These women who required family planning from using them were identified (32) Namely:-

Fear of religion disapproval 4.5%

Want to become pregnant – 48%

Fear of social disapproval 7.9%

Fear of contraceptive side effect 21.9%

Non-availability of methods 5.0%

Costliness of method – 2.8%

Lack of contraceptive knowledge – 9.6%

Some thought they are not at risk of conception.

The effect of Religion is very Important on approval of Family

Planning as show in the work of Ibrahim M.T(27)

METHODS OF FAMILY PLANNING:-

We have natural and modern methods.

i) NATURAL METHOD: FOLK METHOD.

inadu M.K and colleague conducted prospective study with 72 married Yoruba women in outhwestern Nigeria in reproductive age group 19-40 years. Four folks method were used: vearing special ring drinking herbal soup, rubbing powder into incision made near vagina and vearing waist band of animal skin contain herbs(32). Control does not use any method. After 8 months 27% of women using no method had become pregnant compared with 6% of those using folks methods.

Non of those using incision and herbal soup method become pregnant. Reason for effectiveness not known.

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USE OF PLANTS AND OTHER LOCAL SURSTANCES

Women in rural area are more likely to be using plants and other local substances to control their fertility. There are about 500 different plants and substances in Africa.

1. Oil of seed of Buchholzia macrophylla has estrogenic effect and has been used by Zaire to reduce menstrual flow.
2. Osyris wightiana plants are drink like tea by Kenya women to stimulate flow of breast milk.
3. Hibscus Suratensis are pounded and rub on the breast by Tanganyika women.
4. Saponaria officinals or Enterobium Cyclocarpum are used in Egypt as spermicides. And Sphaeranthus Gnathulocdes in Tanzania is spermicides.
5. Parinaria Excelsa in Guinea is a labour inducing agents.
6. Combretodenron africanum used in cott dovee (Ivory Cost) has been show to have an anti-implantation effect in rat. And that of seponaria officinalis used as spermicidal in Egypt has proved effective.

b. BEHAVIOURAL PATTERN:-

Cultural norm related to reproduction and sexuality affect fertility.

POST PARTUM ABSTINENCE.

Abstinence from sex normally occurs following post partum and lactation. The duration of which depend on individual's culture and belief.

In Africa, some culture discourage intercourse shortly after delivery and the Woman is breast-feeding. They have the notion that semen will pollute breast milk.

The lactational ammenorrhea are being used in Senegal for Family Planning. This has help to keep the birth interval longer and fertility lower.

Polygny practice has also been important as a traditional mean of controlling fertility. This also re-in force effect of the post partum abstinence by providing husband with another sexual partner.

The cultural value placed on virginity in some area prohibit sexual activity until a girl is married eg Kasai and Shaba region of Zaire.

Also a grand mother is supposed to abstain in indefinitely from intercourse once their daughter is married and begging to give birth.

Cultural practices of female circumcision reduce stimulation and causes pain in girl to discourage promiscuity. This is practiced in Nigeria and Sudan – which should be discouraged.

The duration of abstinence is measured by the activity of child. When the child is able to carry three-legged stool or carry a bowl of food to the father. This is usually around 2 years of age.

c) SAFE PERIOD AWARENESS

A non profit family planning organization in Brazil is using 28 beads necklace to help women follow their mentral cycle and to be aware of when the risk of conception is greater. First bead is red to indicate first day of menses. The next seven beads are brown indicating a time of infertility follow by 11-white beads that glow in dark indicating designated fertile period. This serves as vivid remainders when the necklace is near a woman bedside at night (7).

This will help to prevent unwanted pregnancy in couple that practice periodic abstinence.

CONTRACEPTIVE EFFECT OF BREAST FEEDING

The contraceptive effect is reliable only in the absence of menstruation and the chances for conception is higher once menstruation resume from study of Indian women by Das and mitral in 1961 they observed that 12.2% ovulate prior to the first menses (33). And Peter et al 1972 observed that ovulation is more likely to precede the first menses in the later month of lactation than the early period. When menstruation resumes the risk of pregnancy is similar whether or not a woman breast feeds. Thus preventing property of breast-feeding is primarily limited to the ammenorrhetc period (34). A study in Rwanda show that 50% of breast feeding mother became pregnant with in 18 months after delivery compared with 50% of non breasting feeding women who became pregnant by 4 month (34).

Factor that enhance greater contraceptive effectiveness in rural women are: (i) Less us of breast milk supplement (ii) more prolonged breast feeding (iii) more breast feeding on demand (around the clock) (iv) simultaneous abstinence during best feeding. The effectiveness contraceptive occurs within 6 months when exclusive breast-feeding is practiced. And ovulation can occur prior to menstruation. It is advisable that contraception be started 6 weeks post partum.

Younger maternal are have a shorter period compared to older women. From study carried out on Bangladesh women under 30 year had a mean duration of lactation Ammenorrhea of 16.4 month compare to 23.2 months with women over 30 years.

PATHOPHYSIOLOGY OF LOCTATION AL AMMENORRHEA:

PROLACTIN REFLEX: As the baby sucks, impulse is sent to areola of nipple, then through vagus nerve to anterior pituitary.

Anterior pituitary secrect (i) prolaction hormone which stimulate glands in breast to produce milk and (ii) it produce a contraceptive action by decreasing level of Leuitinising hormone necessary for maintaining menstrual cycle.

Impulse from nipple pass to posterior pituitary through vagus. It cause release of oxytocin, which causes the muscle cell of areoler to contract, and squeeze out milk.

The following can be used with lactational ammenorrhea: IUCD, Barrier, Mini Pill, Abstinence and Spermicidal.

MODERN CONTRACEPTIVE METHOD:

1. Hormonal Contraceptive Steroids:-

Ovulation can be suppressed by given estrogen alone above a critical level or combine it with progestogen. It is very effective to prevent pregnancy.

Examples:

Oestrogen:- contain either ethinyl vestrediol or its 3 – methyl ether, menstranol which is pharmacologically and biologically a weak oestrogen.

Progresterone:- They are available in these form

i. Those derived from testosterone by replacing the methyl groups of the carbon 19 atom with hydrogen atom

ii. Those derived from 17 acetoxy progesterone and

iii. Norgestinate, gestoldene – new generation progrestogen

Formulation of homanel Contraceptive:(9)

a) Combline pill monophasic – An oestrogen and progetogen are taken from 5th day to 25th day of menstrual cycle.

b) Sequential Pill: Here for the first 11 days oestrogen and small quantity of progestogen used together. For the last ten day the concentration of oestrogen and progestogen are the same as in combined pill. Is good for women with scanty menstration and those that have acne.

c) Triphasic:- Here the level of progesterone is increase gradual on the first 6th day 50mg of levonogestestrel with 30mg of ethinyl oestradiol, the next five day 75mg of levonorgestrel with 40mg of ethinyl oestradiol for the last 10 days 125mg of levonorgestrel with 30mg of ethinyl estradiol is taken.

d) The progestrogen:- Is a low dose of progestogen which is taken daily with out interruption. A work was carried out on exluton – mill pill by Ifenne D., Shittu S.O. et al in Zaria to assess its acceptability and its side effect (35).

The drug does not affect quality and quantity of breast milk production when commenced six weeks post partum. The efficiency is 98% and highly acceptable among the study group of 50% clients. The following side effect were noted, nausea, persistent headache,

raised blood pressure which is due to vassoconstruction of blood vessel and 2% failure rate.

e) Once a month preparation:- a 3mg of quinestrol, which is a long acting

Oestrogen is been used on day one of the cycle. It is combine with a short acting progestogin which is given on the 22nd day of cycle. It is store in body fat and slowly released.

Long Acting Injectable Progrestrogens:-

They are:-

i) Norethisterone (Noresterat) injection which is given at 2 month interval.

ii) Medroxy progesterone acetate (Depo-provera) which is given at three month interval.

Progestogen – releasing vaginal ring:- still under study. It contain 50mg. Levonorgestrel which is released at 20mg a day. It is inserted high into the vagina. It is change every 3 months. Pregnancy rate of 3 per women year (7).

Subdermal implants: Six silastic capsules measuring 30mm by 2.5mm and contain 36mg of levonorgestrel each are introduced into anterior aspect of fore arm through a trocar. Rizk-DE study in Cairo Egypt confirmed three-year cumulative pregnancy rate of 0.98% among 350 cllent (36).

Mode of action of hormonal contraceptive:

Action depends on the composition of steroid and their ratio. In all formulation oestrogen suppress, follicle stimulating hormone (F.S.H) and reduce the release of lutenising hormone (L.H) either directly in the pituitary gland or probably by suppressing hypothalamic follicle

stimulating hormone and Luetunising releasing hormone (FSH and L.U.R.H). Thus ovulation is prevented and ovarian synthesis is reduced.

Further suppresses LH release and prevent peek of LH which proceeds and important for ovulation, blocking positive oestrogen effect. Altered quality of cervical mucous rendering it less penetrable to spermotosoan. If progestogen is given alone the effect is mainly on the endomtrium.

Emergency Contraception:

Knowledge of Health workers in Hochi minth city, Vietnam about emergency contraception was assessed by Nguyen Thingoc and Colleague through a focus group discussion and in-depth interview of health worker and other family provider using (47).

i) Post coltal insertion of cupper bearing IUD which must be inserted 5-7 days after intercourse. Failure rate of 0.1%.

ii) Yuzpe regimen – 200 mcg ethinyl estradiol with 1-2mg of levonongestrel. In which half of the dose must be given within 72 hours of intercourse and remaining half by 12 hours. It reduce pregnancy by 75%.

iii) Levonorgestrel only regimen – Two 0.75mg levonorgestrel with in 48 hours to be repeated after 12 hours. It reduces pregnancy by 60% (postinor).

The emergency contraception prevent pregnancy after unprotected intercourse (rape) (37). It lower number of unwanted pregnancy and decrease need for abortion. For sexual unmarried aldolescent women with infrequent coitus. This can be of great importance in developing Countries.

Non contraceptive advantages of hormonal contraceptive:-

It reduces incidence of dysmeno rrhoea

Being breast cancer (benign mammary dysplasia and fibro adonoma) is reduce.

It has protective effect against pelvic inflammatory disease a

It reduce incidence of rheumatoid arthritis in the perimenopausal year is reduced for women that take pill for 5 years.

There is reduction in chance of developing uterine myometa.

It is used to monitore the level of Beta human gonadotripin hormone(B-hcg) in women after treatment for molar gestation

Side effect of hormonal contraceptives:

-Implicated in aetiology of breast cancer.

-Oestrogen raised High density lipoprotein while progestogen reduce high density lipoprotein H.D.L to a vary degree thus predisposing to cardiovascular disease especially with added risk – cigarette smoking, ischaemic heart disease, subarachnoiod haemmorhage (34)

-Chloasma – when taken pill and expose to sunlight

-Depression, mood changes

-It may accelerate development of gall bladder disease in susceptible women

-Headache and migraine – become worsen premenstrually.

-It may lead to a small increase in systolic blood pressure which is reversible

-Nausea and vomiting

-Thrombo embolic phenemenous:- predisposing factors are: over weight, cigerrete smoking, old age in a woman taking pill.

-Vagina discharge and vaginitis

-Weight gain can occur.

2. INTRA UTERINE CONCTRACEPTIVE DEVICE (IUCD)

They are made of polyethylene. At present two or three are in general use to which Copper and zinc have been added with the addition of cupper it has to be replaced after 3-5 years because cupper ionised slowly. IUCD shaped like a T and is inserted in to the uterus where it stay to prevent pregnancy.

Eren N and Colleague reported that they were no significant difference between the service rendered by physician and trained Auxiliary Nurse Midwives for IUCD insertion in Philipine. Service discontinuation due to expulsion removal or pregnancy are the same (38).

Irving siving in 1974 established a link between IUCD and ectopic pregnancy and noted that the peak period for IUCD users is between 25-35 years.

Combined oral contraceptive has a protective effect against ectopic preganancy (39).

Two cupper T provide effective contraceptive for at least 12 years. The cumulative 12 years pregnancy rate for Tcu 220c and Tcu 380A were 7.6 and 2.2 per 100 women respectively. About 3,000 women were recruited for the study. It was agreed that T cu 380 A is significantly more effective and is an acceptable alternative to female sterilization or depot hormonal method for a very long term pregnancy prevention. Pregnancy rate were highest in the first few year after insertion. No pregnancy occur after eight years of use among women relying on T cuper 380 A.

Mechamision of Action:

Presence of IUCD causes a marked allergic reaction in endometrim with infilteration by monocytes and macrophages. These infilterate possible nidation site and Phagocytose the implanting eggs. It also interfer with sperm motility. Survival and implantation of ova. IUCD

prompts an endometrial reaction that promote release of leukocytes and locally acting substances called prostaglandin. These act simultaneous in the oviduct, uterine cavity, cervix, and genitalia tract to impede sperm and egg development.

Contra indication to use of LUCD:-

Relative contra indicetion:-

Not to be use in primip.

Women who have several sexual pertner

Clients on evaluation for menorrhagia, anemia, and allergy to cupper

Absolute contra indication:

Pelvic infection.

Suspected or known Pregnancy.

Gynaecological bleeding disorder before diagnosis.

Congenital uterine abnormalties.

Side effect of IUCD

Ectopic gestation

Intermenstral bleeding

Pelvic infection

Lowere abdominal pain

Expulsion of IUCD may occur in first three menstral period after insertion.

3. CONDOM

The commonest and most acceptable mean of contraception available to male. Gabbey M. et al suggested that using additional spermicide with condom provides added contraceptive effect

and protection from infection (40). In 1998 about 2.5 million people died of AIDS related causes and estimated 5.8 million become infected with HIV per day (39). This can be prevented with use of condom.

In 1982 – 1984, sixty of pregnancy that occur with use of condom are due to inconsistent use and spillage of sperm.

Mode of Action:

It is wore on erected penis and prevent transmission of semen in to vagina.

Contra indication:

Some men can't retain an erection if condom is used some men or women have been allergic to the rubber (condom),

Advantages: i) It is cheep

ii)allow men to participate inbirth

Control responsibilities

iii) Easily accessible (from counter, chemist)

iv) Condom are effective against transmission of veneral disease

Non contraceptive Benefit.

1. sex therapist recommend condom for treatment of premature ejaculation

2. Useful for those who do not want skin to skin contact of penis and vagina.

3.Lubricated condoms reduce friction and invitation of stain in vagina.

4.Tourniquet effect of the rim could be or benefit to those who can not sustation their errection.

5.Useful for female that are allegic to their partner

4. PERMANENT METHODS OF BIRTH CONTROL

A) Tubal ligation: Voluntry female sterilization is one of voluntary family planning methods in the World. Mini suprapubic approach is used and a small segment of oviduct is removed and ligatedi. Laparascopic tubal ligation has largely replaced laparatomy. Tuba ligation has not gained wide acceptance in developing Countries due low level of women education, Religion and social cultural factor.

It started in 1950 in puerto Rican women. Sterilization by posterior colpotomy was performed in 100 cases by Fort and Alexander in 1966 and in 60% of patient this was the only operative procedure. It reduce number of stay in bed to 3.3 days unlike 7.2 daysfor abdominal sterilization. The tube was graped between the finger and delivered to vagina with forceps and pomeroy. It has been in used since 1967. There is trivial post operative pain (41). 252mg of quinecrine pellets are inserted into fallopian tuba trans cervical during folicular phase of menstral cycle (42,43). The drug causes inflammatiom and fibrosis of proximal fallopian tube. This is non surgical method. This method was carried out by Hieu-DT and colleague at Vietnam on 31, 781 clients between January 2, 1989 to October 1992. Two doses of quinecrine were given at a month interval. This method is safe, acceptable and effctive for female sterilization.

Pregnancy rate per 100 at one year is 2.63.

b) VASECTOMY: It involves blocking or ligating vas deference to prevent passage of sperm (43,44). The level of sex hormone usually remain the same. It is suitable for couples who for medical reasons should not have any more children. It is

widely used only in few countries eg;; China, Indian, Thailand, Korea, United Kingdom Canad and United State of America.

The non surgical approach involve injection of alcohol and weak formal dehyde through scrotal skin to vas deference.

This method is simple, safer, economic and more reversible than female procedure. Indian is the first developing Country to advocate sterilization as a national policy to reduce fertility.

6. ABORTION: Misoprostol is an effective agent in inducing abortion at 12-22 week of gestation according to a study in Mapito, Mozambique. Expulsion was completed in within 24 hours. Mean time was 14.3 hours. 154 women were used and it only fail on ten clients. The main advantage of misoprostal at 600micro gram is it low cost, easy storage at room temp (45). It is used intra vaginal.

   Abortion as a method of family planning in Kwara State of Nigeria. This is used for pregnancy that are mostly below six weeksof Gestation.

   Ekiti women in South West Nigeria make use of plant herbs and patient medicine as abortifacient. They obtained dilation and currectage services in urban Centre to terminate unwanted preganancy(46)

FUTURE CONTRACEPTIVE

FEMALE CONTRACEPTIVE – USING IMMUNE SYSTEMS:

(i) Tal war GP and colleague produced a vacine that induce antibodies against human choronic gonadotrophin It consist of hetero species dimers women will not be pregnant at an antibody titre greater than 50ng of HCGbioneutralisation capacity per ml (47). This vacine is reversible

in its effect. No side effect on endocrine, cardiovascular and other body function. Ovulation was not disturbed and menstral regularity maintained.

(ii) Jones – W R major effort research and development involved the development of active immunization against specific antigen of sperm. Oocyte, Zygote and early embryo and pregnancy hormone hcg. Several anti hcg have entered clinical trial (48). They operate by preventing or intercepting pregnancy at the peri- implantation stage probably by neutralizing the luteo trophic effect of hcg(48). The most refined vaccine is one directed against the unique c – termina! peptitide on the beta sub-unit of hcg. Its antibodies are specific for hcg and do not cross react with human luternizing homone. It is effective for 12 months.

FUTURE MALE CONTRACEPTIVES

(i) Ru 486 FOR MEN: Dr. Etienne – Emile Beaulie, a French scientist develop mife pristone or Ru 486 which prevent calcium from penetrating sperm with out calcum sperm loss their motility and can not fertilize ova(44).

(ii) Dr Sussan Banoff of Norath Share University Hospital is manhasset. New York used the calcium chance blocking effect of Nifedipine (antihypertensive drug) on sperm. He found that it has dismantling effect on sperm(44).

(iii) Gossypol – an extract from cotto – wool when uced daily it decrease sperm count which return to normal when the drug is stopped.

(iv) Mustard and triethylene Melamine – This alkylating agents inhibit sperm production. The risk of causing mutation prevent it use for contraception.

(v) Nitrofuration has concraceptive effect.

(vi) Lohiya N.K. and Sharma administered Danazol plus Testosterone to male rabbits it decrease sperm motility and sperm count and 75% of animal become azoospermia. The sperm return to normal after 75 days of stoppage.

(vii) Chupol Pholpramool and Anant strikhao noted suppression effect of sufasalazine in male rat. When the drug is taken orally, its metabolite – 5 aminosolicylate and sufapyridire suppress sperm – motility. Rat recover from the effect of the drug 3 weeks after with drawal of drugs (300 – 600mg 1kg were used).

CHAPTER 3

GENERAL BACK GROUND OF STUDY AREA:-

Offa is the administrative headquarter of Offa Local Government Area. Offa Local Government was created on April 27th, 1991. The Federal Military Governemt carved it out of the former Oyun Local Government. It is one of the sixteen Local Government Areas in Kwara State. It is surrounded in the South, East, West and North by Erin-ile, Igosun, Igbona, Ikotun respectively. These towns surround Offa Local Governemt.

These villages/Towns constitute Oyun Local Government Area. Offa town is Located in the Southern part of Kwara State and consists of four Health districts. Each district has two political wards. – 474770

The Entire Offa Local Government consist of five health districts and occupies sixty square kilo meters. It is fifty five kilometer away from Ilorin, the State Capital.

The population of Offa Local Government Area by 1991 provision Census was 76,996 (49). 52% of the population were are women and 48% men. The percentage of women in reproductive age was 22% while the children less than five year account for 20%.

There are 31 villages in Offa Local Government. There are different ethnic groups – Hausa, Nupe, Ibo and Yoruba being the majority. The two prominent religions are Islam and Christainity with few traditional worshippers.

Offa has one specialist hospital. The hospital has Family Planning Unit, Maternity, and others units. The daily attendance at the Out Patient Department is about forty to fifty patients/clients.

There is one maternity hospital owned by Roman Catholic. There are ten health centers owned by Government and Ten private health clinics. There are about one hundred and twenty health posts in Offa Local Government.

Accessibility to health facility within 5km is almost 100%.

The Inhabitants are highly educated. Majority are Civil servants. Others engaged in Farming, Trading, Driving and Artistic work for their livelihood.

The provision of social amenities such as Electricity, Postal services, Telephone services, Clubhouses, Hotels and Parks make life easy.

There is one Federal Polytechnic and more than ten secondary schools in Offa town.

Climatic condition is tropical.

Housing pattern is mostly cement and it is not well planned. The drainage system is superficial for water supplies some part have pipe born water. There are boreholes, dung well and surface water. Within 200 meter about 26% have physical accessibility to portable water. They are making effort so that every part of the town will have pipe born water. More than half of the women are educated or literate. And the women are highly placed in society. Since more than 50% of the population are female it would be wise to assess their knowledge attitude and practice of family planning so as to be able to plan ahead for their health service needs in future.

METHOD AND MATERIAL

- Study design: It is cross sectional study.
- Sampling method: Two stage sampling
- First stage: Two heath district were randomly selected from the four health districts.

- Second stage: All married women in selected household were interviewed in the two health districts.

I observed in Offa Town that the proportion of household with atleast one woman practicing family planning is about 10%. Minimum number of household to be selected with at least one woman practicing family planning in household are 82 as worked out below with a precision of 6.5%

$D \sqrt{\frac{Pq}{n}}$ =1.96 at 95% confidence limit.

n= minimum number of household to be selected

p= proportion practicing family planning – (10%)

q= (1-p) proportion not practicing family planning (90%)

d= 6.5% level of precision.

$D \sqrt{\frac{Pq}{n}} = 1.96 = \frac{d^2}{pq} = (1.96)^2$

$0.004225n = 0.1 \times 0.9 \times 3.84$

$n = \frac{0.1 \times 0.9 \times 3.84}{0.4225} = \frac{3456}{42.25} = 82$

n = 82 household.

I employed two stage selection – first district and then households from the selected districts.

The propability of selecting a household from four districts is the product of probability of selecting a district and then probability of selecting a household from selected district.

Selecting two districts from four district is $\frac{2}{4} = \frac{1}{2}$

Then selecting a household from the selected district, the probability is

$\frac{1}{2} \times \frac{164}{14760} = \frac{82}{1476}$ approximately $\frac{1}{90}$

Two districts selected were Balogun and Shao.

Thirty households were selected from Balogun, which give a probablility of selection of

$\frac{30}{2710}$ approximately $\frac{1}{90}$.

Fifty two households were selected from Shao health district which give the probability of

selection $\frac{52}{4647}$, which is approximately $\frac{1}{90}$.

Thus the probability of selecting household from each of district is the same. From 82 selected households total respondents were 400. On the average 5 respondents from each household (using primary health care number)

List of Four Health District	*List of Estimated Household in each of district*	*Cumulative No. Of List of household*	*Total No. of House Holds chosen from each of health Districts*	*Total No. of respondents from each Health districts.*
(1) *Balogun	2,710	2710	30	150
(2) * SHA O	4647	7357	52	250
(3) ESS A	5,419	12,776		
(4) OJOMU	1984	14,760		
			Total 82	400

TOOL FOR DATA COLLECTION

QUESTIONAIRES:-A well structure and close ended questionnaires was pilot test in one of the health district that was not used for survey. Ambiguity corrected and omissions were added.

Final year students of health Technology were taught on how to administered questionnaires and how to record the responses of the clients according to the respondents answered for two days.

The questionnaires try to find out answers to the specific objectives of the study.

Questionnaires contain information on individual,demography, knowledge attitude, and practice of family planning with the assistance of Staff Nurse and Secretary of health Committee of each health district, and local map of the area, the randomly selected household with random table were Identified and questionnaires administered.

The questionnaire is attached at the back for review.

The result of quantitative data was analysed with epi info soft ware and the result were shown in next chapter.

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LIMITATION OF STUDY:

1. Time and finances will not enable me to cover the entire population which is the most ideal but a larger sample was taken to take care of this problem.
2. Some house number has been wiped off due to repainting and some number cannot be located when questionnaire were administered, the immediate number (before) proceeding such number was used.
3. Some new houses were built which added to the number of existing household number. These were also taken into consideration.
4. Some client does not cooperate fully to answer all the questions.
5. Some respondents are illiterate they may be misreporting especially pertaining to their age.

CHAPTER FOUR

RESULT AND DISSCUSSION

An Assessment of the knowledge, Attitude and practice of Family Planning on married women was done between 2nd – 27th September 2000 in Offa. Four hundred questionnaires were administered to the women. The results of my findings are displayed below. During the field survey the following summon table problems were encountered.

i) People not willing to complete the filling questionnaires

ii) Some felt family planning was a personal affairs and as such they were not sincere in their answer.

iii) Some respondents were in hurry and in patients

iv) Other problems were as earlier discussed in the limitation of the study.

I go through the completed questionnaires irregularities and ambiguities were corrected before processing with the aid of computer, using epi info statistical package

Focus Group Discussion:

Six different groups where gathered together in their familiar environment for group discussion. Between 6-8 married women in each group with in the same age group, social and education background. The discussion was conducted in local language (Yoruba) and English Language. It lasted for 45 – 60 minutes.

The salient points are listed.

Above 90% of them are aware of family planning services. 70% of them can mention three methods on their own. But only between 2-4 women were using a modern method in each group, and in one group none of them is using a method. Majority claimed to be using withdrawal method and safe period. The main reason for using family planning is for child

spacing. So that they could recover blood loss during delivery and have enough time to breast-feed the baby and for good health.

The mention Local Methods: Tira, Pad lock, Band waist incision at private part, Concoction, abstinence, with drawal method as method of family planning.

Majority of them support four children per women. They claimed that it is men that determine number of children but there occasion when women decided cleverly by using family planning without the husband knowledge.

Less down one-third of women know their safe period. The acknowledge preference for male child. They said the male would carry the family name and inherit family property.

Majority of women breast-fed for 1-1½ years. Educate women favour 1 year while illiterate favour one and half year.

The duration of post partum abstinence varies and the time for return of menses after childbirth shows a wide variation. Opinion differs on approval of family planning in to school curriculum. Those that support it said it would give the student opportunity to complete their education while the other group said it would increase promiscuity.

Majority of women that use family planning said they have had 2 0r 3 issues or children before they taught of family planning.

Some of the reason why some women are not using family planning are:- due to

failure of some method (IUCD)

Due to bad attitude of service providers

Irregular supplies of services

They over-emphasized side affect of some method – Abdominal pain, bleeding

Some due to husband or religion oppositions

Ahmadu Bello University, Zaria, Nigeria.

Mis-information and rumors about the side effect that are far from truith.

They said failure rate is due to incompetent of service provider.

Majority of people that use family planning claimed that they obtain family planning services from chemist, Government hospital and few from private hospital.

In-depth Interview:

Some of the family planning providers were interviewed.

They admitted that the commonly available method are Oral, Injection, IUCD. And those that use condom bought from chemist.

They said some of them that have complaints with one particular method switch over to another method.

They said some of the clients that come to clinic have had a pre-determined method that they want to use because their friends are using such a method.

Those that have contra indication are persuaded to use another method. But those with out contra indication have their way but they still explain to them all the methods that are available with their side effect. They give the client monthly appointments for follow up.

Emergency Contraception:

They do not use IUCD, Injection and Oral pill for emergency contraception. And that such patient that have such unprotected intercourse go to general hospital to lodge their complaints to medical officer.

a) GENERAL CHARACTERISTIC OF RESPONDENTS.

The knowledge of demography, Socio Economic, and Cultural factor of the respondents would enable reader to understand better the interpretation of other findings or the study.

TABLE 1.01 SHOW AGE DISTRIBUTION OF RESPONDENTS

Age	No. of respond	%	No. using	%	No. not using	%
15 – 19	16	(4%)	4	(25%)	12	(75%)
20 – 24	52	(13%)	9	(17.30%)	42	(80.76%)
25 – 29	98	(24.5%)	27	(27.55%)	67	(68.36%)
30 – 34	84	(21%)	27	(32.14%)	53	(63.09%)
35 – 39	75	(18.75)	22	(29.33%)	49	(65.33%)
40 – 44	52	(13%)	10	(19.23%)	39	(75.0%)
45 – 49	23	(5.75)	5	(21.74%)	18	(78.26%)
No response	16	(4%)				
Total	400	(100%)	104	(26%)	280	(70%)

The % of correspondents that use family planning increases with age up to their thirties before it then decrease.

Age:- The women in reproductive age group of 15 – 50 years were interviewed. The percentages of age distribution are as shown in table 1.01. The mean age of women was 34 years and the modal class was 26 – 30 years with highest respondents of 24.5% (5). The percentages of women in prime reproductive age of 20 – 35 years was 58%. Four percent (4%) of respondents were below 20 years and 38% above 35 years. The percentage distribution of each age group of respondents using and those that are not using were shown in table 1.0. The use of family planning increase with age up thirty-five and it later decreased (39).

This findings is in keeping with what was obtained from KAP studying by Yusuf M.and Ibrahim M.T (5, 27).

Table 1.02 Shows distribution of respondents according to their LEVEL of Education

Education	No. of Respon. %	No Using %	Not using %	No.response %	X^2	P- Value
No Education	126 (31.50%)	19 (15.07%)	100 (79.37%)	7 (5.56%)	28.40 (7.815)	0.0003
Primary	109 (27.25%)	21 (19.27%)	83 (79.82%)	1 .(0.91%)		
Secondary	114 (28.50%)	38 (33.33)	71 (62.28%)	5 (4.39%)		
Post secondary	47 (11.75%)	23 (48.94)	20 (44.68%0)	3 (6.38%)		
No Response	7 (2%)					
Total	400 (100%)	101 (25.25%)	274 (68.5%)	16 (4%)		

α=0.05, df= 3, X^2=28.40 P<0.003. It is statistically significant.

There is significant relationship between level of education and use of contraception.

EDUCATION:

68.50% of respondents had formal education. 31.5% do not have formal education as shown in table 1.02. The percentage of respondents with primary education was 27.25% while that of secondary education was 28.5%. 11.75% of respondents attained post secondary education.

The proportion number of respondents that practice family planning increase with the level of their education (6,19). This finding corresponds to the study carried out by Ibrahim in Sokoto.

RELIGION:

Table 1.03 shows distribution of respondents into their religion affiliation

Religion	No.of respons. %	No Using %	No Not using %	No response %	X^2	P-value
Christian	101 (24.25%)	39 (38.61%)	58 (57.43%)	4 (3.96%)	7	0.01
Muslim	299 (74.75%)	65 (21.74%)	222 (74.25%)	12 (4.01%)	(3.84)	
Total	400 (100%)	104 (26%)	280 (70%)	16 (4%)		

α=0.05 df=1, X^2=7.0, P<0.01. It is statistically significant.

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Zaria, Nigeria.

Seventy four point eight percent (74.8%) and twenty four point twenty five percent (24.25%) of respondents were Muslim and Christians respectively. See table 1.03 higher percentage of Christians 38.61% were using a method compared to 21.74% of Muslim respondents. This result is similar to the finding of Ribadu Yusuf from the Kap study on married women in Sabon gari, L.G.A. in Zaria (5). This finding is supported by the work of Ibrahim M.T. and Agbaji(27, 29)

Table 1.04 shows distribution of respondent according to their tribes or ethnicity

Tribe	No of respon.	%	No Using	%	No Not using	%	No response	%	x^2	P-value
Yoruba	356	(89.0%)	83	(23.31%)	258	(72.47%)	11	(3.10%)	18.30	0.003
Ibo	30	(7.5%)	16	(53.33%)	13	(43.33%)	1	(33%)	(7.8815)	
Hausa	12	(3%)	3	(25%)	9	(75%)				
Others	2	(0.5%)	2							
Total	400	(100%)	104	(26%)	280	(70%)	16	(4%)		

α=0.05 df=3, X^2=18.30, P<0.003. It is statistically significant.

25% of Hausa and 23% of Yoruba were using a method.

53% of Ibo were using a modern method. This is significant.

Ethnicity Group: 89% were Yoruba, 7.5% of respondents were Ibo, 3.0% Hausa and 0.5% of other ethnic group. The others were Tiv Ibira and Nupe. This is shown in Table 1.04. The highest percentage of Ibo (53.33%) were using family planning while the least users were Yoruba (23.31%). This finding is supported by the work of Ribadu Yusuf amongst Sabon Gari Women in Zaria and that of Ibrahim M.T. which is facility base in Sokoto(5,27).

Table 1.05 shows distribution of respondent of respondent according to their type of marriage

Type of marriage	No of respon. %	Using %	Not using %	No response %	x	P-value
Monogamy	273 (68.25%)	79 (28.94%)	186 (68.13%)	8 (2.93%)	3.94	0.02
Polygamy	127 (31.75%)	24 (18.90%)	94 (74.01%)	9 (7.10%)	3.84	
No response	17 (4.25%)					
Total	400 (100%)	103(25.75)	280 (70%)	17 (4.25%)		

α=0.05 df=1, X^2=3.94, P<0.02. It is statistically significant.

28.94% of wife in Monogamy were using a method compare to 18.90% of wife in polygamy relationship. Type of marriage has a strong correlation to use of family planning.

Type of marriage: 68.25% and 31.75% of respondent were involved in monogamy and polygamy type of marriage respectively. This is shown in table 1.05. Higher percentage of respondent involved in monogamy marriage were using family planning (28.94%) compared to respondent in polygamy relationship. This work is supported by the survey work of Agbaji, Ibrahim M.T., Ribadu Yusuf (5, 27,29).

Table 1.06 show distribution of respondents by the nature of their occupation.

Type of job	No of respon. %	No Using %	No Not using %	No response %	X^2	P
Unskilled	276 (69%)	67 (24.28%)	196 (71.01%)	13 (4.71%)		
Semi skill	91 (22.75%)	26 (28.57%)	40 (43.96%)	25 (27.47%)	31.05	0.019
Highly skill	25 (6.25%)	10 (40.00%)	12 (48.0%)	3 (12.0%)	27.581	
No response	8 (2%)					
Total	400 (100%)	103 (25.75%)	248 (62%)	41 (10.25%)		

α=0.05 df=2, X^2=31.05, P<0.019. It is statistically significant.

(24.28% of use1 are unskilled, 28.57 are semi-skilled while 40% are highly skilled).

OCCUPATION: The distribution of respondents on the type of job been performed are as shown in table 1.06. The proportion of respondents using family planning increases as the technical skill of their job increases. 40% of highly skill respondents were using family planning compared to 28.57% of semi skill workers. 24% of unskilled workers were using family planning method. This work is supported by Oni Gbolahan and the annual report of executive director of planned parentalhood federation of Nigeria 1991(10, 19). This study also conform to the finding of Ibrahim M.T. (27).

TABLE 1.07 SHOW DISTRIBUTION OF RESPONDENTS WITH RESPECT OF THEIR SOCIAL CLASS

Social	No of Respon.	%	No Using	%	No Not Using	%	No response	%	X^2	P-val
Lower	271	(69%)	57	(20.65%)	209	(75.74%)	10	(3.62%)	16.61	0.000
Middle	112	(28%)	39	(34.82%)	67	(57.82%)	6	(5.36%)	(5.991)	
Upper	9	(2.25%)	6	(66.67%)	3	(33.33%)				
No response	3	(0.75)								
Total	400	(100%)	102	(25.5%)	279	(69.5%)	16	(4%)		

α=0.05 df=2, X^2=16.61, P<0.00024. It is statistically significant.

20.65% of lower social status were using contraception; 34.82% of people from middle class and 66.67 of upper class were using a method.

Table 1.07 shows the number of respondents in each class of social status. Majority of respondents were in lower social status- 69.0%. 28.0% and 2.25% were middle and upper classes respectively.

The percentages of respondents that were using family planning increases as the level of their social status increases. 66.67% and 20.65% of respondents in upper and lower social status were using family planning respectively. The classification into social classes was based on income, level of education, type of job and possession. This finding is also the same in other survey (4, 27). Improvement in women sautés would improve approval and use of family planning services (26). The use of family planning increase with improvement in social status of women from findings of Oni Gbolahan and Agbaji et al (10,29).

THE FOLLOWING WERE NOTED TO HAVE A STRONG CORRELATION WITH THE USE OF FAMILY PLANNING

- Type of marriage –monogamy wife use family planning than wife in polygamytype of marriage
- Level of education –use of family planning increases with the increase in educational level
- Religion –Christian prentice family than Muslim
- Type of employment –Highly skill worker use family planning more than unskilled worker.
- Ethnicity: use of family panning vary from one tribe to another. Ibo use family planning than Yoruba.

- Age use of family panning increases with age until they reach 35yrs before it decreases.
- Social status. The use of family planning increases with social status.

FAMIL Y PLANNING KNOWLEDGE

Table 1.08 shows respondents awareness of various contraceptive devices

Methods	No of Respon %	Aware %	Not Aware %	No Response %
Condom	400 (100%)	282 (70.5%)	43 (10.75%)	75 (18.75%)
Oral Pills	400 (100 %)	282 (70.5%)	37 (11.75%)	71 (17.75%)
Injection	400 (100%)	268 (69.7%)	46 (11.5%)	8 (21.5%)
IUCD	400 (100%)	260 (65%)	64 (16%)	76 (19%)
Norplant	400 (100%)	199 (49.75%)	106 (26.5%)	95 (23.75%)
Padlock	400 (100%)	243 (60.75%)	52 (13%)	105 (26.25%)

70% are aware of condom and oral pill, 69.7% injection, 655 of IUCD 49% of Norplant and 60.75% of padlock.

Family Planning Knowledge

Knowledge : Respondents knowledge about family planning was assess to find out how much they know about family planning.

AWARENESS OF METHOD

From the focus group discussion more than 90% of the community has had of family planning in the community. Between 65-70% of the respondents can mention two or three modern method on their own. Majority do not know how the devices work. 70.5% of the respondents knew condom and oral pill as it can be seen from table 1.08. 65% and 49.75% of respondents known of IUCD and norplant respectively. The increase in level of awareness is due to the fact that nurse normal give heath talk to the women when they go for post-natal and child welfare clinic.

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Sixty percent (60%) of respondents recognize pad lock as a traditional method of family planning. In addition, they mentioned other traditional during focus group discussion such as: Tira concortion bad waist, incision around vulva region, withdrawal and abstinence (33). Jinadu M.K and Ajuwon B.Survey work testified to the fact that folks methods prevent conception though does not know how it work.

Table 1.09 show sources of health information on family planning among respondents

Major source of information	**Frequency**	**Percentage**
Health worker	281	70.25
Radio	61	15.25
T/V	21	5.25
Friend	24	6%
Chemist	1	0.25%
Reading	7	1.75%
No response	5	1.25
Total	400	100%

70. 25% of respondents obtain their information from health workers 15.25% from radio, 6% from friend, 5.25% from Television, 1.75% from reading, and 0.25% from chemist.

Source of information on family planning knowledge

Seventy percents of respondents obtain their information from health workers. 20% from mass media, 6% from friends. Lettern Maier-c and collagen said combine programme with mass media would increase respondents knowledge (20). Study of the Yusuf support the findings. Major sources of family planning information is from health workers.

THEIR KNOWLEDGE OF SAFE PERIOD

Table 1.0 show distribution of respondents knowledge about safe period]

Period in mental Cycle when pregnant can occur	Frequency	Percentages
Five drays before or After meanness	220	55%
Mid menstrual Cycle	153	38.25
During mensurual flow	25	6.25
No response	2	0.5%
Total	400	100%

38.25% of respondents have a correct knowledge of their safe period while 61.75% do not know their safe period. 38.25% of the respondents known the period when it is not safe to have intercourse.

61% of the respondents do not know the fertile period. This information can be obtained from Table 1.0. To prevent unwanted pregnancy a voluntary organization

nonprofit oriented introduces the use of beads so that woman can know their fertile period (7). Brazil is using 28 beads necklace to help women follow their menstrual cycle.

First bead is red to indicate first day of meanness. The next seven beads are brows. Indicating a time of infertility follow by 11-white beads that glow in darkness indicating designated fertile period. This is helpful for couple that practices abstinence. Level of maternal education increase their knowledge of safe period (19).

FAMILY PLANING CAN HELP TO MAINTAIN DESIRED NUMBER OF CHILDREN

Table 1.1 Show Distribution Of Respondents Knowledge About Use Of Family Planning To Maintained desire number of children

Family planning can be used to prevent further pregnancy	Frequency	Percentages
Agree	296	74%
Do not agreed	27	6.75
No response	77	19.25
Total	400	100%

74% Agreed while 6.75% do not agree that family planning prevent further pregnancy.

From table 1.1 74% of respondents agreed that family planning could be used to prevent further pregnancy after they have had desired number of children for their families. 6.75% of the respondents disagreed to the fact that family planning services could help to prevent further pregnancy.

From the analysis of Planned Parenthood Federation of Nigeria. There is no change between approval and knowledge among educated women with secondary school or tertiary education. Both rate are the same 90% (19). For women with not education there is a gap between their knowledge and approval.

It is 29% and 59% respectively. Letter Maier-c said programme combine with potent force in health communication since they reach the audience with persuasive message and such programme increase their knowledge (20).

Table 1.2 show distribution of respondents with respect to their desire birth interval

Birth interval	Frequency	Percentages
Less than one year	2	0.5%
1-2 years	99	24.75%
2-3 years	209	52.25%
Above 3 year	85	21.25%
No response	5	1.25%
Total	400	100%

0.5% desire less than one year, 24.75% desire 1-2 yrs, 52.25 % desire 2-3 years while 21.25% desire more than 3 years.

Respondents knowledge of ideal birth interval

The knowledge of respondents was asked about the ideal birth interval. Their responses were as shown on table 1.2. 24.75% of respondents said 1-2 years, 52 % of respondents choose between 2-3 years while 21% said above 3 years. 0.5% desire a birth interval of less than 1 year.

From study of Yusuf the ideal birth interval is between 2-4 years and not more than five years (5). Thus 73% of respondent has a good knowledge of child spacing.

Table 1.3 a shows why respondent were using family planning

Reason for using family planing	Pregnancy	Percentage
Child spacing	169	59.1%
Limit Birth	62	21.7%
Sexual enjoyments	24	8.4%
Financial Constraints	31	10.8%
Total	400	100%

59.1% were using contraception for child spacing 21.7% to limit birth, 8.4% for sexual enjoyment and 10.8% of users is due to financial constraints.

Reasonl for family planning respondents knowledge about the essence for family planning in the community was asked,. Each of them gave various reason why they were using family planning. This is as shown in table 1.3 a

© REPRODUCTIVE HISTORY: The knowledge of reproductive history of respondents would have effect on their reproductive behavior.

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Table 1.4 shows Age distribution of which respondents attain menarche

Age at menarche	Frequency	Percentages
10-13yrs	80	20%
14-17 yrs	224	56%
18-21yrs	96	24%
Total	400	1000

20% attained menarche between 10-13yrs, 56% between 14-17yrs and 24% between 18-21yrs.

Age at menarche: 76% of respondent's attained menarche by their 17th birth day and the rest by their 21st birth day. This is show in table 1.4.

Ajayi and colleague reported that 68% of Adolescent attained menarche by their 17th birthday (12). This findings is similar to Ajayi and colleague study.

Table 1.5a shows distribution age at which respondents become sexually active

Age of first intercourse	Frequency	Percentages
15-19yrs	121	30.25
20-24years	194	48.5
25-29 years	63	13.25
30-34 years	11	2.75
No response	21	5.25
Total	400	100%

30.25% become sexually active between 15-20years, 48.5% between 21-25yrs, 13.25% between 26-30years and 2.75% between 31-35 years.

Age at which respondent become sexually active

From this study 30.25% and 48.5% of respondents were sexually active by their 20th and 25th birthday respectively. This can be contrives from table 1.5a 44.5% of respondents are sexually active before marriage. This is show in table 1.5a

Table 1.5b shows distribution of respondents as per premarital sexual activity

Time at first sexual intercourse	Frequency	Percentage
Before marriage	178	44.5%
After marriage	217	54.25%
No response	5	1.25%
Total	400	100

44.5% of respondents has pre marital sex and 54.25 become sexually active after marriage.

From study carried out in Kwara State by Ajayi and colleague, said 64% are sexually experience under 18 years or 20% under 15 years. The Figure obtained from this study is lower that that from study by Ajayi this might be due to the fact that majority of respondent were educated or are feeling shy to admit the actual age they had first intercourse Marot mentioned some ways to reduce premarital sex (14).

Able 1.6 show Age at which respondents get married

Age at Marriage	Frequency	Percentages
15-18 years	50	12.5
19-22	174	43 .5
Above 23	174	43.5
No response	2	0.5
Total	400	100%

12.5% of respondents got married between ages of 15-18 yrs 43.5% between 19-22 years and 43.5% above 23 years.

MARRIAGE AGE

12.6% of respo ident got married below age of 18 years. This is shown in table 1.6 43.5% got married between ages of 19-22 years and the rest 43.5% After 23 years. Th ideal marriage age is from 18 years above according to population commission policy. From survey carried out by Ajayi and colleague in Kwara State. Ideal age for girls expected to enter in to marriage and for boys 20-30 years (12). This finding is similar to the work of Marot(14).

AGE AT FIRST PREGNANCY

Table 1 7 shows use distribution at which respondents had their first pregnancy

Age at first pregnancy	Frequency	Percentages	Degree in angle
15 –18 yrs	43	10.75	38.7
19-22 years	147	36.75	132.3
Above 23 years	206	51.5	185.4
No response	4	1%	3.6
Total	400	100%	36%

10.75 had 1st pregnancy at between 15-18 yrs, 36.75% between 19-22 years and 51.5% above 23 years.



Fig 1.01 is a pie chart showing age at which respondents had their first child.

10.75% women had their first baby before 18 years of age. 36.75% had their firs baby between 19-22 years while 51.5% of respondents had their from 23 years and above.

Ajayi survey found that 12.2% of Adolescent had their first baby by age of 14 years. This finding is similar to the survey carried our by Ajayi (12). The distribution of respondents ages at which they had their first born is displayed by pie chart in fig 1.01. This finding is supported by the findings of Marot(14).

Table 1.8 show experience of abortion by respondents

Abortion Experience	Frequency	Percentages
Yes	111	27.755
No	279	69.75
No response	10	2.5
Total	400	100%

27.75 of respondents experience abortion while 69.75 do not experience abortion.

ABORTION

27.75% of respondents Experienced abortion at one time or the other. This is shown in table 1.8 69.75 do not experience abortion while 2.5% do not responded. 56.36% all abortion occurs spontaneously

Table 1.9 shows type of abortion experience by respondents by respondents

Type of Abortion	Frequency	Percentages
Spontaneous	62	56.36
Induced	33	30.%
Not specified	15	13.64
Total	110	100%

56.36% of abortion were spontaneous and 30% were induced.

13.64% of the abortion not specified.

This finding is supportive of work done by Renne E.P on Ekiti women in the southern part of Nigeria that women make use of abortion as a method of contraception (46). This findings of Fasubaa at UITH Ife acknowledge abortion as one of the causes of maternal mortality in the country(3).

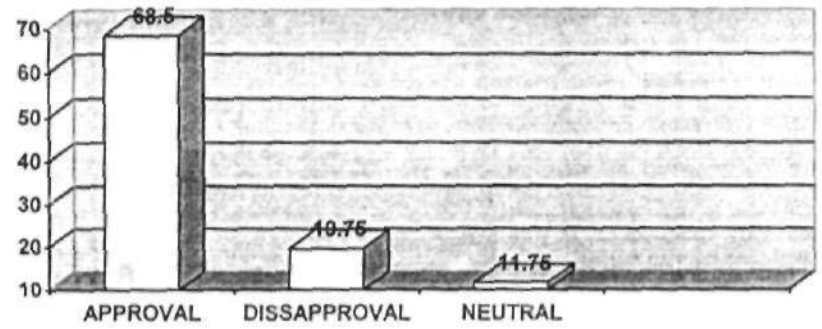
ATTITUDE TOWARD FAMILY PLANNING

Table 2.00 shows respondents opinion about family planning

Opinion	Frequency	Percentages
Approved	274	68.5
Disapproved	79	19.75
Neutral	47	11.75
Total	400	100%

68.5% of respondents approve while 19.75% disapproved 11.75% were neural

Fig 1.02 show a Bar chart display of opinion of respondents about family planing.



Opinion: 68.5% of respondents approved family planning while 19.755 disapproved the use of modern method of contraception. 11. 5% of respondents are neutral.

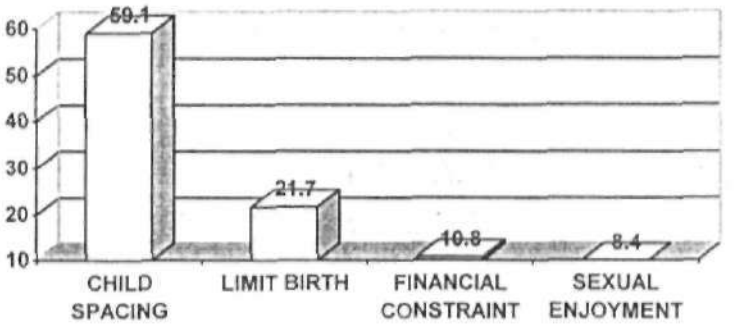
It is as show in table 2.00 and fig 1.02. the approval here is slightly greater than the approval in KAP study by Yusuf and Ibrahim M.T. which was 50 and 63 respectively (5,27). The reason is due to the facts that nurse give health education to client every time they come for postnatal clinic and baby welfare clinic.

Table 2.01 shows reasons for approval of family planning by respondents

Reasons for approval	Frequency	Percentages
Child spacing	162	59.1%
Limit birth,	60	21.7%
Financial Problem	30	10.8
Sexual enjoyment	22	8.4
Total	274	100%

59.1% for child spacing, 21.7% to limit birth, 10.8% for finical constraints and 8.4% for sexual enjoyment.

Fig 1.03 show Bar chart display of reasons for approval of family planing by respondent



REASON FOR APPROVAL

5 9.1% Of respondents approved family planning for child spacing and 21.7% approved to limit birth. 10.8% and 8.4% of mothers approved due to financial problem and for sexual enjoyment respectively. This is as show in table 2.01 and Fig 1.03. This findings is the same from the survey work of Gbolahan Oni, Ibrahim M.T. and Yusuf (5,10.27.)

Majority are doing family planning 50 that they could space their child and time their birth effectively.

REASON FOR DISAPPROVAL

Table 2.02 shows reason for disapproval of family planing

Method by respondents	Frequency	Percentages
Religion disapproval	33	41.77%
Husband disapproval	17	21.52%
Want more Child	21	26.58
Motherland health	8	10.13%
Total	79	100%

41.77% due to Religious believe, 21.52% husband disapproval, 26.58% want more children and 10.13% due to maternal health.

From table 2.02: 41.1% of disapproved was due to religion believer which.

17.9% disapproved due to their husband influence 19% and 22.1% of respondent disapproved due to maternal health and because they want more child (32). This is similar to the work carried out by Amnar Swar-Eidahab on constraints on use of effective family planning among Khartoun women. Some of the reasons forwarded were religion and husband disapproval, costlines, maternal health, want to get pregnant and ignorant. Similar findings was obtained from survey work of Agbaji and Ibrahim M.T. (27,29).

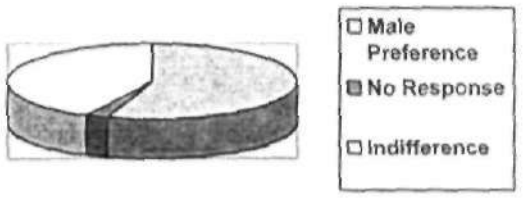
Table 2.03 shows distribution of respondents on preference for male child

Male child preference	Frequency	Percentage	Degree in angle
Yes	220	55%	198
No	170	42.5%	153
No response	10	2.5%	9
Total	400	100	360^0

55% of respondents shows preference for male child while 42.5% were indifference

2.5% do not respond.

Fig 1.04 is a pie chart display of male child preference among respondents



MALE CHILD PREFERENCE

55% of respondents said they would not stop giving birth untill they have one or more male child irrespective of number of female children they had. 42.5% of respondents do not support or agree to this while 2.5% do not responded. This is shown in table 2.03 and figure 1.04.

Study by Glenmon M.J and Fegan D.I confirmed that couple in Dharan would not start family planing until they have one or more male child (24).

In Anhui province sex of male to female child ratio in the 1st, 2nd and 3rd birth order were 1.17, 1.12 and 1.16 respectively against the normal ratio of 1.06 (25). This was made possible through gender specific abortion, sex selective infanticide and concealment of female birth. This study it was Maureen J.Grahan from his study in Anhu province that family with many daughters continue to give birth until a boy is born. The interval between male birth is longer wider compared to birth interval between female.

Table 2.04 show discussion of family planing between couple

Communication	Frequency	Percentages
Discussed with husbands	194	48.5
Do not discuses with husband	180	45
No response	26	6.5
Total	400	100

48.5% discussed family planning with husband while 45% do not discuses with their husband.

Discussion o f family planning among couple

48.5% of respondents had discussed family planning with their husbands while 45% do not discuss with their husband. 6.5% of women do not responded. See table 2.04 . Oye wole Olaleye and Akinrinola said advertisement of contraceptive in mass media in Ghana affected positively the use of contraception from their study (4). Discussion between spouses of family planning increase the use of family planning services. This finding is supported from the survey work of Sarah Salway(22).

Table 2.05 shows condom uses among the respondent family

Condom	Frequency	Percentages
Husband uses condom	107	26.75
Husband do not use condom	282	70. 5%
No response	11	2.75
Total	400	100%

26.75% of husband use condom at home while 70.5% do not use condom

CONDOM USE AMONG COUPLE: 26.75% of the respondents husband uses condom while 70.5% of respondents husband do not use condom at home. This is shown in table 2.05. from study of maier-c and colleague, it was noted that popular entertainment and mass madia can be used as a potent force in health information (20). Oheneba Sakyi said motivation of couple to share responsibility would increase husband approval of a family planning method (21).

Table 2.06 shows Distribution of respondents as to who determine number of children for the family

Husband only	57	14.25%
Wife and husband	294	73.5
Wife only	41	10.25
No response	8	2
Total	400	100%

In 73.5% wife and husband determines no. of children for the family. In 14.25% husband decide alone and in 10.255 of family wife take a decision alone.

FAMILY SIZE DETERMINATION

73.5% of respondents said that family size is jointly determined by husband and wife. 14.25% agreed that family size was solely determined by husband and wife respectively. This can be seen from table 2.06.

From study conducted among the skit women it has been found that men has a greater influence on de_ision on the number of children per family. It was also realised that some women are clever enough to decide the number of children they want for the family by use of family planning with out the knowledge of their husband.

Table 2.07 shows opinion of represents to the government policy of our children per a woman

Opinion about four children per women	Frequency	Percentage	Degree
Agreed	2.63	65.75	236.7
Do not agree	133	33.25	119.7
No response	4	1	3.6
Total	400	100	360

65.75% of respondent agree while 33.25% disagree to issue of 4 children per a woman.

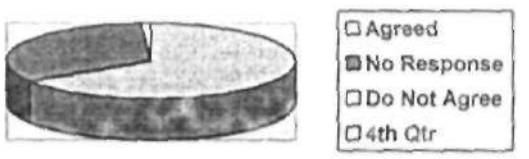


Fig 1.04 show pie chart display of respondent opinion on policy of four children per a woman

NUMBER OF CHILDREN PER WOMAN

Opinion of respondents were sought about the policy of four children per a woman as it is contain in population commission policy of February 1988. 65.75% of women Agreed while 33.25% disagree to policy of four children per woman. This is as shown in table 2.07 and fig.1. 04. From study of Ezeh et al, it shows that Africa men are for more likely to want another child than men in other region (4). From study of Deborah L. Covington, Otolorin et al traditional value for large size are strong and motivation to regulate fertility weak in Nigerians (9).

Organization of family planning begin in 1957 in Nigeria and Government did not accept the reduction of population until February 1988 when a population commission policy was made by General Ibrahim Babangida(6). The number of children per a woman in the north is greater than the number of children per a woman in south.

NUMBER OF LIVE BIRTH/DESIRED NUMBER OF CHILDREN

Table 2.08 shows number of live birth by respondents

Number of live birth	Frequency	Percentages
1-3	198	49.5%
4-6	153	38.25
More than 7	34	8.5
No response	15	3.75
Total	400	100%

49.5% of respondents has between 1-3 children, 38.25% has 4-6 children while 8.5% had more than 7 children.

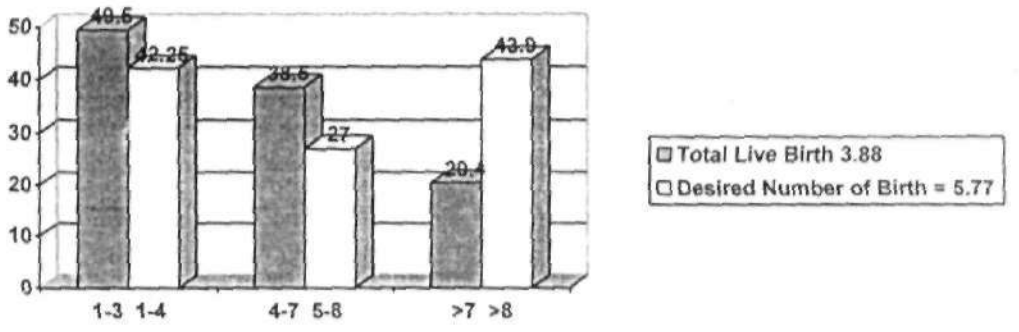
Table 2.09 shows distribution of respondents as to desire number of children per a woman

Number of desired children	Frequency	Percentages	Total No. of desires
1-4	169	42.25	676
5-8	108	27	648
Greater than 8	123	30.75	984
Total	400	100	2308

Average desire birth per woman = 2308/400=5.77(6.0).

Fore desire number of children 42.25% of respondents desire between 1-4 children 27% desire 5-8 children and 30.75% desire more than 8 children per a woman.

Fig 1.05 is a bar chart display of live birth/no. of desired birth against the frequency of respondents women



NUMBER OF LIVE BIRTH

At the time of survey 49.5% of respondents had between 1-3 children. While 38% had between 4-6 children. 8.5% of respondents has more than 7 children. This as shown table 2.08 their desire number of births they has 42. 25% desired between 1-4 children while 27% want more than eight children is more (30.75%). This is as shown in table 2.09.

From study conducted by Ibrahim M.T. which is facility based in Sokoto, higher parity was noted.

Deliberate decision of couple to replace children who might die or have died so that enough childrer would outlive the couple. Figure 1.05 shows frequency of total live birth/desire number of birth among respondents. The average number of total live birth was 3.88-4.0 and the average number of desired birth per woman would be 5.77–(6.0.)

Table 2.10 shows distribution of respondents opinion on introduction of family in to school curriculum

Family Planning in to school curriculum	Frequency	Percentage
Agreed	237	55.75
Disagree	168	42.0
No response	9	2.25
Total	400	100

55.75% of respondents agreed while 42.0% disagree to introduction of family planning in to school curriculum.

OPINION ABOUT INTRODUCTION OF FAMILY PLANNING IN TO SCHOOL CURRICULUM

The respondents differ in opinion on introducing family planning in to school curriculum for the singular fear that it may lead to promiscuous among the students, 55.75 support it while 42% of the this is shown in table 2.10.

Marot said that approximately 1.5 sexually active girl become pregnant by the age of 20 years and one-third of this pregnancy end in termination. And that mortality and morbidity are

high in babes born in to teenage mother (14). He argued that sexually active girl who had received sexual education are significantly more likely to use effective contraceptive method.

He proffers the following as solution to premarital sex: improvement in sex education family life education development of resistance to pear-pressure, abstinence and Delay in start of sexual intercourse.

TABLE 2.1/ AND FIG 1.06 DISPLAY THE LEVEL AT WHICH IT COULD BE INTRODUCED IN TO SCHOOL CURRICULUM

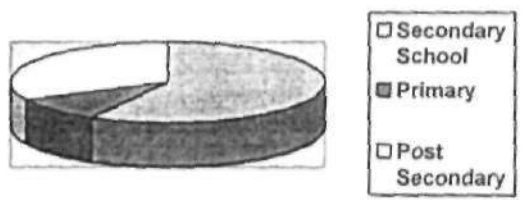
Table 2.1/ shows distribution of respondents at the level of introducing family planning in to school curriculum

Educational level	Frequency	Percentages	Degree
Primary-6	28	12.0	43.2
Secondary	132	56.7	204.12
Post secondary	73	31.3	112.68
Total	233	100.	360

12.0% support primary-6 56.7% support secondary school and 31.3 support post secondary school.

Fig 1.06 Pie chart display of respondents Distribution on introduction of family planning in to school curriculum.

12% of respondents primary 6, since some some of them have



support its introduction at of the girls are mature and attained menarche which exposes them to risk of pregnancy (12). The median age of first intercourse is just over 16

years. 56.7% want secondary students to aware so as to give them opportunity to complete the education while 31.7% support introduction at post secondary level this is shown in table 2.11.

Table 2.12 shows respondents last child birth

Last child birth	Frequency	Percentage
Less than 6 month	34	8.5
6-12 month	39	9.75
13-24 month	55	13.75
More than 24 months	248	62
No response	24	6%
Total	400	100%

Duration of last child birth by respondents: 62% of respondent has their last child birth more than 2yrs, 13.75% between 1-2yrs, 9.75% between 6-12 months, and 8.5delivered less than 6 months ago.

Table 2.13 show duration of breast feeding among respondents

Duration of breast feeding	Frequency	Percentages
Less than 6 months	30	7.5
7.12 months	74	18.5
13-18 months	220	55
19- 24 months	67	16
More than 24 months	9	2.25
Total	400	100

55% of respondent breast feed between 13-18 months, 18.5% between 7-12 months, 16% between 19-24 month and 2.25% mare than 24 months.

Breast feeding: The length time they breast feed their child was assessed. This is shown in table 2.13 7.5% breast feed for less than 6 months, 18.5% for 7-12 months 55% for 13-18 months, 16.17 for 19-24 months and 2.25% for more than 24 months and supplement feeding is added. And baby can breast feed for 11/2 –2 years. From study of Rustier in sub-Saharan duration of breast feeding is between 1-2 years and only 30% of mother exclusive breast feeding between 4-6 months (4).

Breast-feeding suppress ovulation and this effect are been used as a contraceptive method. The contraceptive effect is only limited to ammenorrheic period (34). And it can be enhance by prolonged breast feeding. Feed baby every time on demand and contraceptive effect usually last for 6 months. It must be noted that ovulation can occur prior to resumption of menses. Hence it is advisable to start on family planing 6 weeks post partum with used of minipill (35).

Table 2.14 show distribution of respondents on the length of post parted abstinence

Post partum abstinence	Frequency	Percentages
Lass than 3 months	58	14.5
3-6 months	137	34.25
6-12 months	186	46.5
No response	19	4.75
Total	400	100%

PRACTICE OF FAMILY PLANNING

Table 2.15 show distribution of respondents as to use of family planning.

CHARACTER	FREQUENCY	PERCENTAGE
EVER USE:		
Yes	143	35.8
No	257	64.2
Total	400	100
CURRENT USER:		
Yes	104	26
No	280	70
No Response	16	4
Total	400	100
PROMISE TO USE IN FUTURE:		
Yes	155	38.5
No	150	37.5
No Response	95	23.75
Total	400	100

38.5 promise to use a method in future, 35.8% of respondents are ever users and 26% are current users

Practice:

35.8% of respondents are ever users of modern method of family planning and 26% are currently using a method at the time of survey. This is shown in table 2.15. 38.5 promise to use in future.

The present contraceptive prevalence of 26% is greater tnan prevalence rate of below 10% that are quoted for sub Saharan Africa (4). This value is lower than 65% of contraceptive prevalence that was obtain in Sokoto by Ibrahim M.T. (27). The reason is because the study is facility based. The contraceptive prevalence in otta is greater than what was found y Golahan Oni in Ilorin (10).

SOURCES OF FAMILY PLANNING SERVICES:

Table 2.16 shows where respondent obtain their family planning method

Sources	Frequency	Percentage	Degree
Government Hospital	161	75	270
Private Hospital	20	9.4	33.84
Chemical Shop	18	8.5	30.6
Traditional Healer	14	6.6	23.76
Total	213	100%	360

75% of respondents use Government Hospital, 9.4% use private hospital 8.5% use chemist shop and 6.6% patronise traditional healers.

75% of respondents obtained their services from Government Hospitals while 9.4% obtained it from private hospital. 8.5% obtain from chemist shops and remaining 6.6% from traditional healers. This is as shown in table 2.16. Similar study has show that women

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patronize government hospital than private hospital to obtain family planning services.(27,29).

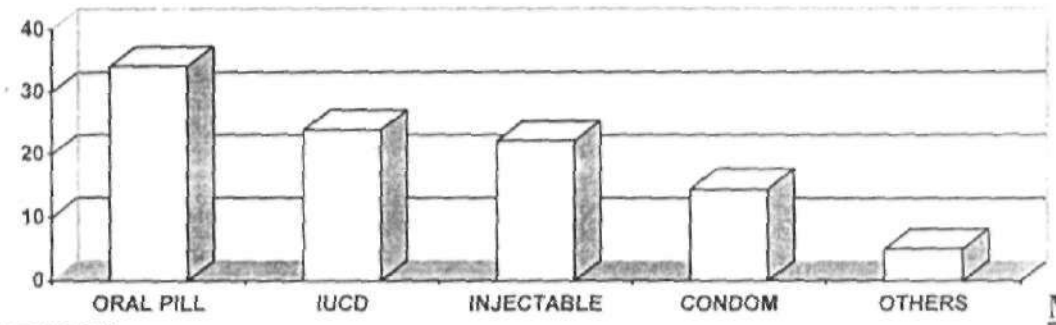
Studies conducted by Jinadu M.K. et al support this findings that 6.6% of women go to herbalist to obtain family planning services.

Table 2.17 Show method used by respondents.

Method Used	Frequency	Percentage
Oral Pill	49	34.2
Injection	32	22.2
IUCD	34	23.9
Condom	21	14.4
Others.	7	5.1
Total	143	100

34.2% were using oral pill, 23.9% IUCD, 22.2% Injectable, 14.4% condom and 5.1% other methods.

Fig. 1.08 is a bar chart display of family planning method used by respondents.



Methods:

Different methods were used by respondents. This is shown in table 2.17 and fig. 1.08. 34.2% used oral pill, 23.9% used IUCD, 22.2% used injectable, 14.5% used condom and 5.1% used other methods. other methods are the less effective method like abstinence safe period and use of local herbs. Ball weg et al has pointed out that individual preference for contraception methods depend on individual choice, age of mother, education, and the time required for next pregnancy (28) When the woman is given balanced information and free choices. A woman would use a method that is

effective, reversible with less side effects (30). Kahley and Gillapsy study Bogotal in Columbia suggested that parity and age were associated with contraceptive choice. From study by Cohchrane among black in United State of America found that pill user were younger and had fewer children than IUCD users. Ball Weg found that in Philippine women that chose IUCD do not want more children and continuation of IUCD is more among older women.

Table 2.18 show duration of breast feeding among respondents.

Duration	Frequency	Percentage
Less than 6 months	30	7.5
7-12 months	74	18.5
12-18 months	220	55.0
19-24 months	67	16.75
More than 24 months	9	2.25
Total	**400**	**100**

7.5% less than 6 months, 18.5% between 7-12 months, 55.0% between 13-18 months, 16.75% between 19-24 months 2.25% more than 24 months.

Breast Feeding With Post Partum Abstinence

Some combine breast feed with Post Partum abstinence 71% of respondents breast feed for 1-2 years and 18.5% for one year, 7.5% for 6 months and 2.225% for breast feed for more than 2 years. This is shown in table 2.13 & 2.18 from study of Ravisharma and Shea Rustin in Sub Sahara the duration of breast feeding is 1-2 years (4). And only 30% do exclusive breast feeding between 4-6 months. Exclusive breast feeding suppress ovulation. From study of Dan

and Mitra on Indian women in 1961 it was noted that 12.2% ovulate prior to the first menses following delivery (33). And that contraceptive effect of breast feeding can be enhanced when:

(i) There is no supplement feeding

(ii) Child feed on demand round the clock

(iii) There is prolong breast feeding. He suggested that women should start to use family planning from 6 weeks post partum to prevent unwanted pregnancy through the contraceptive effect of breast feeding in ammenorheic client would last for 6 months. The use of minipill is advantageous and has no effect on breast milk production (35).

Post Partum Abstinence

From survey 34.25% of respondent abstain from 3-6 months, and 46.5% abstain for 6-12 months from sexual intercourse following delivery. When post partum abstinence is combined with exclusive breast feeding was been used by some respondents (Table 2.14).

Table 2.19 shows distribution of respondents to the various side effect

Side Effect	Frequency	Percentage
Nausea/Vomiting	10	6.4
Heavy bleeding	39	25
Head ache	32	20.5
Others	75	48.1
Total	156	100

6.4% due to nausea and vomiting, 25% due to abnormal bleeding, 20.5 due to head ache and 48.1% due to other complaints.

Side Effects of the Methods:

6.4% complaints of nausea and head ache while the remaining 48% complaints of other symptoms. These other symptom include, intermentral spotting, lower abdominal disturbance, scanty menses and weight gain. This is shown in table 2.19.

All these are well known side effect of the method used from the study of Amner M. Swar-Eldahab, I Fenne D. and colleague, and Rizk – De (32,35, 36).

Table 2.20 shows distribution of respondents to various constrains by users

Constraints	Frequency	Percentage
Costly	71	31.98
Short Supply	71	31.98
Unit not accessible	69	30.08
Staff attitude/number	11	5.96
Total	222	100%

About 30% of respondent mentioned: cost, short supply and inaccessible clinic. 5.96% complaints about staff attitude/number.

Constraints to Obtain Services:

Some of the users identified some problems that affect judicious use of family planning in the community. This is shown in table 2.20. 31.7% complaint about the cost. Another 31.7% of the respondents complaints of irregular and short supplies of the services. 5.96% complain

about the attitude, and human relation of service provider to the client that is not good enough. And that their number is small which is not good enough. The remaining 30% complaints that the clinic is physical and psychological inaccessible to them. Those that do not approved put forward the following: Religion ad husband disapproval, material health and want more child (32).

Table 2.21 shows assessment of services provided to the community by respondents users

Satisfied	Frequency	Percentages
Yes	191	74.4
No	66	25.6
Total	257	100

74.4% of respondent were satisfied while 25.6% were dissatisfied with services then received from provider.

Assessment of family Planning Services By Users.

The respondents was asked to assessed the services provided for them by the provide as to create room for improvement and possibly make suggestion. 74.4% of respondent were satisfied while 25.6% were dissatisfied with services rendered to the communities. This is as shown in table 2.21.

THE DETERMINATION OF FERTILITY BEHEVIOUR AMONG RESPOSDENTS.

The following were known to influence of fertility behaviours of the respondents. The analysis were shown in the appendix.

Age at marriage : early marriage increases parity

Early onset of menarche lead to initiation of intercourse

Type of marriage – monogamy practice family planning more than woman in polygamy union

Maternal age:- usage of family planning increases with maternal age

Total number of live birth from 4 or 5 children women tend to use a method

Religion affliction – Christian women use family planning more than Islamic woman

Educational level :- as educational level increases proportion of women that use family planning increase

Social status. The use of family planning increase with social status.

Type of job – women involved in highly skill job uses family planning more than women involved in unskilled job.

Societal value for children :- where they have a high value for children the proportion of women that use family planning would be reduced among the women. Hence proportion of Yoruba women that uses family planning was less compared to Ibo women.

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Ahmadu Bello University
Zaria, Nigeria

CONCLUSION AND RECOMMENDATION

CONCLUSION:

I have examined the use of contraception among married women aged 15 – 45 years in Offa Kwara state of Nigeria, with particular focus on the use of contraceptive to lower population growth, maternal and child health. Women were using family planning mainly for child spacing. Contraceptive used was low (38 % of ever use and 26% of current users. There was significant variation in use among women with different socio economic. Demographic and cultural characteristics as earlier mentioned. They were using contraceptive as a substitute to maintaining long periods of post partum abstinence. Women prefer to maintain an interval of two years between birth and no longer observe long periods of lost partum sexual abstinence. There is therefore wide gap between birth interval and preferred period of post partum sexual abstinence. The magnitude of the gap is significant associated with ever use and current use of contraceptive.

The motivation for use of contraceptive a were due to disparity between desired birth spacing and post partum sexual abstinence and number of desired children. The result suggested that women that preferred to resume sexual intercourse shortly after birth were using contraceptive as an alternative strategy to achieve their desired birth interval.

Although the level of use is low, it is encouraging it show receptive on the part of women to substitute contraceptive for prolong abstinence, programme that aim reducing fertility and improve maternal and child health could build on this receptive and thus implement programmes activities that could successfully improve contraceptive prevalence.

The over all impact of this association on fertility is small because majority of women – 57% (table 2 .11 & fig 1.06) desire 7 or 8 children. This high demand for children constitute an obstacle to increase of contraceptive use for the purpose of limiting fertility (birth)

RECOMMENDATION

The following recommendations are made based on findings of my field work on the assessment of knowledge, attitude and practice of family planning among married women aged 15 – 45 years in offer town.

i. There importance of family planning should be stressed. There is need for advocacy to carry people along.

ii. Within the community, there is need for community participation women groups and youth groups can be used for delivery of services in the community. Opinion leader and village head could be used for dissemination of health information and health education.

iii. The men must be actively involve in family planning programme since they make decision for the family.

iv. Women status must be elevated. Government universal basic education is in the right direction

v. The government should proffer solution to some of the constraints mentioned:

They should provides enough supplies and equipment's for family planning services.

More health post in rural area to be used to deliver goods and supplies

Staff issue :- they need to train more staffs, the number of services providers are not enough. There is need to send them on refresher course to update their knowledge.

vi. government needs to embark on program that would discourage desire for more children

vii. Government need to promote gender equity

viii. The standard of living of people must be improved since low socio economic class is associated with high rate of contraceptive failure.

ix. Sex education should be given to young un married and sexually active lady.

x. Family planning should be introduced in to secondary school curriculum people shoul be aware before marriage.

xi. Virginity should be held with uttermost respect in the community, abstinence and a delay in start of sexual intercourse is the most effective method in preventing consequences of teenagers pregnancy.

xii. For those women that are bend on not using a modern method due to religion belief, they must be thought on how to make use of their safe period. With the use of remind to help them know their fertile period eg use of 28 bead necklace that correspond to their menstrual circle.

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HYPOTHESIS

1. To test if there is a relationship between type of marriage and use of family planning

H_0 = P < 0.05 There is no relationship

H_1 = p > 0.05 There is a relationship between use of family and type of marriage.

TYPE OF MARRIAGE	USING	MOTUSING	TOTAL
Mono	79	186	265
Poly	24	280	118
Total	103	280	383

□ = 0.05 (level of significance)

Degree of freedom = (r - 1) (c - 1)

= (2 - 1) (2 - 1) = 1

x^2 = 0.05 for one degree freedom = 3.84

$$x^2 = \frac{(ad - bc)^2 N}{(a+b)(b+c)(a+c)(b+d)} = \frac{[(79 \times 94) - (186 \times 24)3^2 \times 383}{103 \times 280 \times 118 \times 265}$$

$$= (7426 - 4464)^2 \times 383 = \frac{(2962)^2 \times 383}{901826800}$$

$$x^2 \quad \frac{8773444 \times 383}{90182680} \qquad 0.097285 \times 383 \qquad = 37.26$$

$$x^2 = \frac{8773444}{90182680} \times 383 \qquad = 37.26$$

As the calculated value of x = 37.26 fall with in critical limit, the null hypothesis : rejected and the alternative accepted i.e there is a relationship between type of marriage an using family planning.

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To test if tl ere is relationship between Ages group and using family planning at

$\alpha = 0.05$.

H = p< 0.005 There is no relationship

H1 = p> 0.05 There is relationship.

Age group		using		not using		Total
		O	E	O.	E	
Age	15-20	4	4. 33	12	11.67	16
	21- 25	9	13.81	42	37.19	51
	26 - 30	27	25.46	67	68.54	94
	3- -25	27	21.67	53	58.33	80
	36 - 40	22	19.23	49	51.77	71
	41 -45	10	13.27	39	35.73	49
	46 - 50	56.23		18	16.77	23
		104		208		384

Expected value $\frac{\text{Column x row total}}{\text{Grand total}}$

X^2 = □ (o- □)^2 □ = 5% level of significance

□ df = (r - 1) (c - 1)

df = (7 - 1) (2 - 1) = 6

X^2 = □ = 0.025 + 1.675 + 0.093 + 1.311 + 0.399 + 0.806 + 0.443 + 0.01 + 0.622 +

0.035 + 0.487 + 0.148 + 0.299 + 0.090

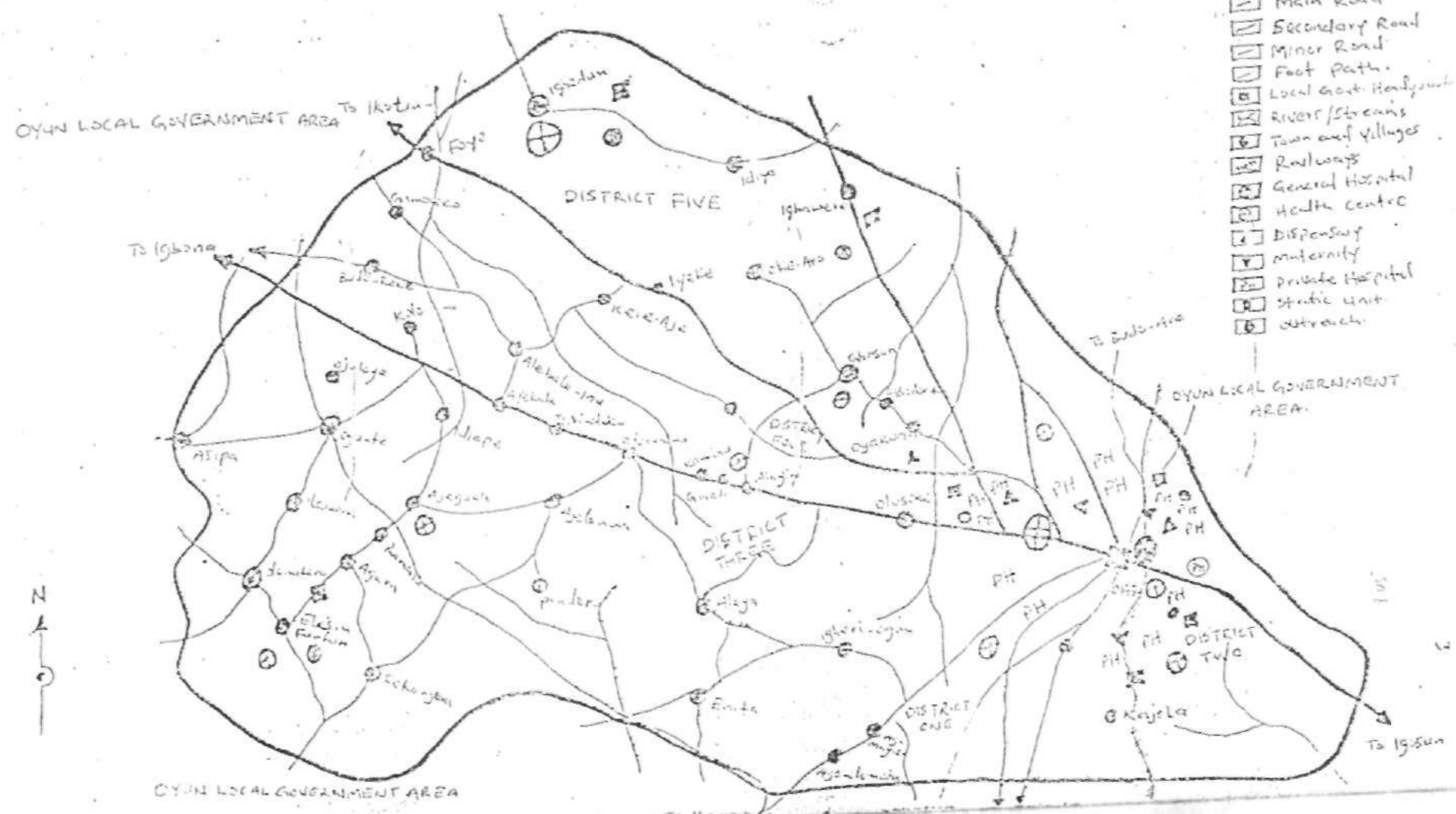
Calculated X^2 =6.243

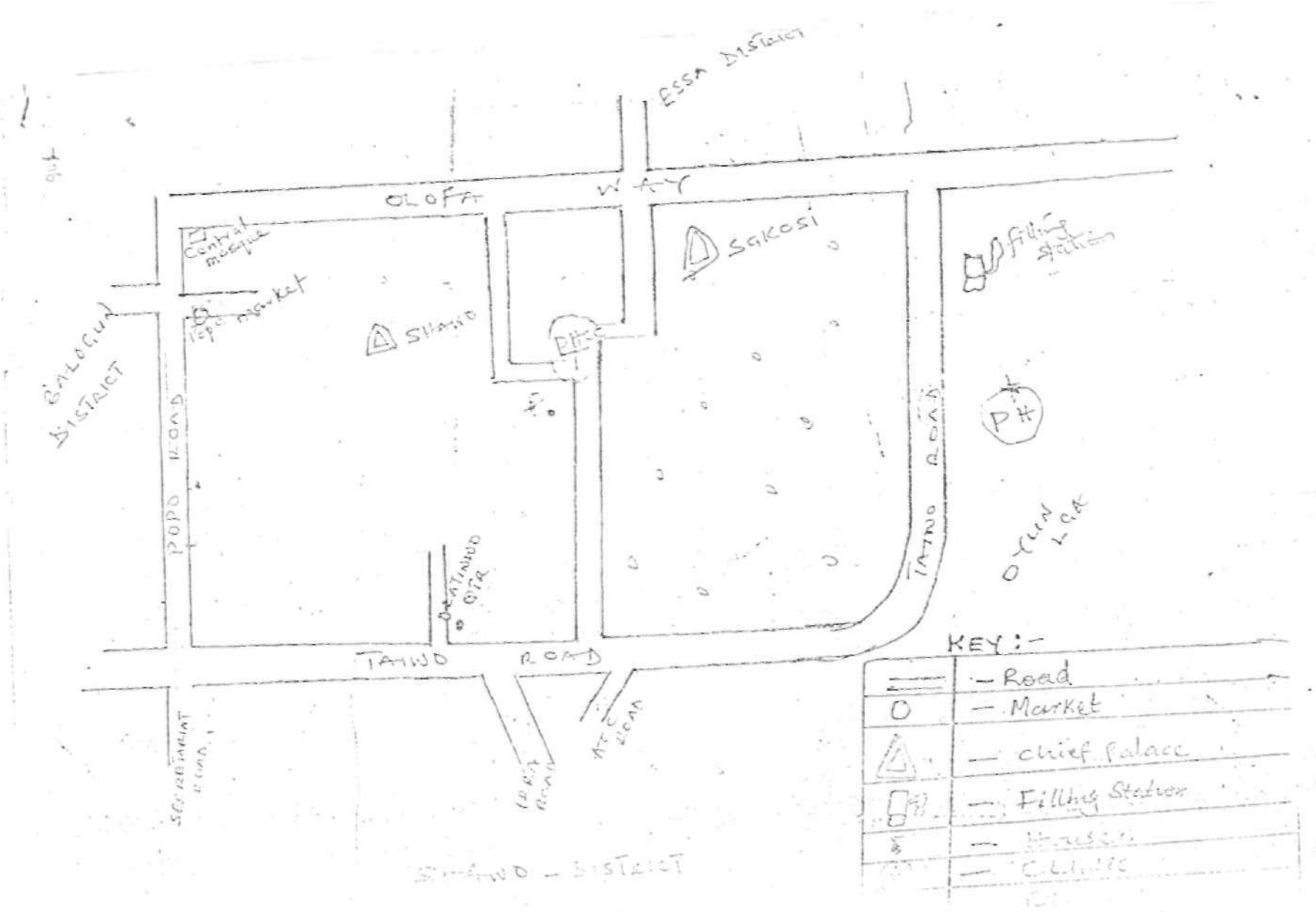
$\alpha = 0.05$ = df = 6 = 12.592 p = 0.03

Calculated X^2 is 6.243 and less than value at 0.05 (12.592) null hypothesis is accpted. There is no reason to reject it.

OFFA LOCAL GOVERNMENT Kwara State, Nigeria.

HEALTH DISTRICTS
(PROVISIONAL MAP)




ESSA DISTRICT
OLOFA WAY
Central mosque
Fish market
SHANO
SAKOSI
filling station
P#
BALOGUN DISTRICT
POPO ROAD
TAHNO ROAD
TAHNO ROAD
SERGEANT'S QUARTERS
KEY:-
— Road
— Market
— chief Palace
— Filling Station
— Hospital
— Clinic


SETTLEMENT
MAP OF BALOGUN DISTRICT OFFA
RAIL LINE
ALUBATA OJU-IRIN
ESSA-OYAN STREET
OLOFA PALACE
BABA ISALE AREA
BALOGUN ORIAFA
ARODE
AROMASODY
OLOWA AREA
ITA ARABA
ITA ERIN
← Olofa Way
AJOBA AREA
BATA STREET
OGANLA ABATA
BALOGUN AREA
OSA-MAGBU SHRINE
POPO RD
ILU-LOSIN RD
CLINIC
OLUWO
AGBELSA MAGAJI
AJILO
TATA OBA
AIKINSOLA AREA
IGINGBASA
ESUNJAI AREA
AROGE
AMAKO
AWUSERE AREA
AKINGBASA AREA
A.U.S. AREA
ORITA MERIN
AFOLABI AAT
IYERU PRIM SCHOOL
IBRAHIM TAIWO RD →
KEYS
OLOFA'S PALACE
MARKET
STREAM
CLINIC
BALOGUN'S PALACE
SCHOOLS.
RAIL LINE
DEMACATION
SETTLEMENT

QUESTIONNAIRE BY DR. J. A. OYENIYI

FAMILY PLANNING KNOWLEDGE ATTITUDE AND PRACTICE:

(a) PERSONAL DATA HOUSE NUMBER:

S/NO	NAME	SEX	1 AGE	2 Marital Status M/S	3 Type of marriage Mon/Pol	4 Education 0,1,2,3	5 Religion	6 Occupation U.S S.S, H.S	13 Social status L,M,U.	14 Stat of health Good Fair bad

(b) FAMILY BACKGROUND Serial No .....

7. Religion (a) Muslim (b) Christian (c) Traditional Worshiper (d) others

8. Tribe (a) Yoruba (b) Ibo (c) Hausa (d) others

9. Total No. of room for the family .....

10. Total No. of eligible couple (from age of 15) per family .....

11. Total No. in the family .....

12. Do you have any of these?

(a) TV (b) Radio (c) Own a housse.

KEY:

- Age : (a) 15-19 (a) 20-24 (c) 25-29 (d) 30-34 (e) 35-39 (f) 40-44

- Occupation: (a) Student (b) House-wife (c) Trader (d) Civil Servant (e) Farming

Social Status (a) Lower status (b) Middle (c) Upper status

(C) REPRODUCTIVE HISTORY

15. Age at which you start menses

(a) 10 -13 years (b) 14-17 years (c) 18-21 years

16. For married, age at which you get married

(a) 15-18 years (b) 19-22 years (c) Above 23 years

17. Age at first pregnancy (a) 15-18 years (b) 19-22 years (c) Above 23 years.

18. Dc you experience any abortion Yes ( ) No ( )

19. If yes type of abortion? (a) Spontaneous (b) Induced

20. Total No. of live birth (a) 1-3 (b) 4-6 (c) 7-10

.21. Total No. of pregnancies (a) 2-4 (b) 6-8 (c) above 8

22. Are you pregnant no Yes ( ) No ( )

23. Age of last born (a) Less than 6 month (b) 6-12 months (c) 1-2 years (d) more than 2 years.

<u>Knowledge Assessment</u>

24. When do you think pregnancy can occur during menstrual cycle?

(a) Five days before or after menses\

(b) Middle of menstral cycle

(c) During menstral flow.

25. Would family planning help you to prevent further pregnancy after you have had the desired number of children you want Yes ( ) No ( )

26 What is the source of your information?

(a) Health worker (b) Reading book (c) Radio (d) T/V (e) friend

(f) Chemist shop.

27. What Is the best interval for child spacing?

(a) 'ess than 1 year (b) 1-2 years (c) Years (d) Above 3 years

28. Do you have knowledge about family planning? Yes ( ) No ( )

29. What are your reasons for the use of family planning?

(a) for child spacing (b) To limit birth (c) for sexual enjoyment (d) I don ' know.

30. Condom prevents unwanted pregnancies, transmission of gonorrhea and AIDS?

Yes ( ) No ( )

31. Where can you obtained family planning service in your area?

(a) General Hospital (b) Chemist shop (c) Traditional leader.

32 True of false, each of these are modern method of family planning in the clinic/hospital.

a)	Condom	True	( )	False	( )
b)	Oral pill	True	( )	False	( )
c)	Withdrawal	True	( )	False	( )
d)	Norplant	True	( )	False	( )
e)	Padlock	True	( )	False	( )

f) 2 or 3 monthly injection True ( ) False ( )

33 ATTITUDE

Who determine the number of children for the family?

a) Husband only b) Wife and husband c) Wife only.

34 Do you discuss about family planning with your husband? Yes ( ) No ( )

35 What is your opinion about family planning?.

a) Approve it b) Disapprove it c) Neutral

36. If you approve, give reason for approval.

a) For child spacing b) To limit birth c) For sexual enjoyment

d) Due to financial problem.

36 If you disapprove, give reason.

a) Religious believe b) Husband disapproval

c) Want more children d) Maternal health.

38. Is your husband using condom at home Yes ( ) No ( )

39. Do you feel family planning should be introduced into school curriculum

Yes ( ) No ( )

40. If yes, at what level.

a) Primary b) Secondary c) Post secondary

41. Do you support government policy of four children per woman?

a) Yes ( ) No ( )

42. Does family planning encourage promiscuity? Yes ( ) No ( )

43. What is the number of children you want to have?

a) 1 - 4 b) 4 - 8 c) As many as God provides.

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Practices

44. Have you ever use family planning? Yes ( ) No ( )

45. If No, do you intend to use in future? Yes ( ) No ( )

46. If yes which method have you used before?

a) Oral pill b) Injection c) IUCD d) Condom e) Abortion

47 Are you using family planning now? Yes ( ) No ( )

48 If yes, which method.

a) Oral pill b) Injection c) IUCD d) Condom e) Abortion

49 At what age do you become sexually active single?

a) 15 - 19 b) 20 - 24 c) 25 - 29 d) 30 - 34

50 For married, when did you first have intercourse?

a) Before marriage b) After marriage.

51 Where do you obtain family planning services?

a) General Hospital b) Private Hospital c) Chemist shop

d) Traditional healer.

52. What side effect do you experience with the method you are using?

a) Nausea vomiting b) Heavy bleeding c) Headache d) Others

53. How long do you abstain from intercourse after birth?

a) Less than 3 months b) 3 - 6 months c) 6 - 12 months

54. What are the constraints to obtain family planning service in your community?

a) Costly service in your community b) Short supplies of goods/services

c) Clinic is too far/not accessible d) No staff.

55. Are you satisfied with family planning service in your community?

a) Yes ( ) No ( )

56. Suggest how family planning service in your community?

i.....

.....

ii.....

.....

57 Total No of child birth, Boys_____ Girls_____

Total No of death_____

58. If all your 4 children are females, would you still give birth in order to have a male child. Yes ( ) No ( )

59. How long do you breastfeed your child?

a) Less than 6 months b) 7 months - 12 months c) 12 - 18 months
d) 19 - 24 months e) More than 24 months.

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