ASSESSMENT OF KNOWLEDGE, ATTITUDE AND PRACTICE (KAP) OF FAMILY PLANNING AMONG RURAL WOMEN IN KOGI STATE, NIGERIA

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JANUARY, 2018

DECLARATION

I declare that the research entitled "Assessment of Knowledge, Attitude and Practice (KAP) of family Planning among rural women in Kogi State, Nigeria" was written by Monday JIMOH under the supervision of Prof. (Mrs.) V. Dashe and Prof. (Mrs.) M. A. Suleiman. All sources of information cited in this work were duly acknowledged. No part of this dissertation was previously presented for another degree at this or any other institutions.

_____ _____

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CERTIFICATION

This dissertation entitled "Assessment of Knowledge, Attitude and Practice (KAP) of Family Planning among Rural Women in Kogi State, Nigeria; written by Monday JIMOH meets the regulation governing the awards of master degree in Health Education (M.Ed) in the Department of Physical and Health Education, Ahmadu Bello University, Zaria and is approved for its contribution to body of knowledge and literacy presentation.

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DEDICATION

This dissertation is dedicated to God Almighty for his infinite mercy and protection throughout my course of study.

ABSTRACT

The purpose of this study was to assess knowledge, attitude and practice (KAP) of family planning among rural women in Kogi state, Nigeria. Ex-post facto research design was used for this study and the sample size consisted of 384 respondents. To achieve this purpose, a researcher developed questionnaire was used as instrument for data collection. The population of the study comprised of 72,844 women of reproductive age. The instrument was vetted by five jurors from the Departments of Physical and Health Education and Nursing Sciences. Three hundred and eighty four (384) copies of questionnaire were distributed to the respondents. Three hundred and seventy nine (379; 98.7%) were adequately filled and retrieved from respondents. Five (5; 1.3%) copies of questionnaire were not filled correctly and therefore, those were not used. A multi-stage sampling procedure was employed which comprised of; stratified, simple random, purposive, proportionate sampling procedure. The data collected was analyzed using descriptive statistics of frequencies and percentages, mean and standard deviation. To test the formulated hypotheses, one sample t-test was used. All the formulated null hypotheses were tested at 0.05 alpha level of significance. The results of the study revealed that rural women in Kogi state, Nigeria have significant knowledge of family planning with a t-value of 3.201 (p-value of 0.021). The findings further showed that rural women in Kogi state do not have significant attitude towards family planning with t-value of 1.291 and p-value of 0.18, finally the results of the study revealed that rural women in Kogi State do not significantly practice family planning with a (p-value of 1.05). On the basis of the research findings, the following conclusions are drawn; that rural women in Kogi State were knowledgeable about family planning, that rural women in Kogi state do not have positive attitude and practice of family planning. The following recommendations were made based on the conclusions. Federal, state and local government health units should encourage women in sustaining their knowledge of family planning through community mobilization and enlighten programmes. The health directorate in collaboration with the family planning unit should roll out more programmes such as organizing workshops, seminars, to educate married couples on the benefits of family planning practices. This will bridge the gap between knowledge and practice of family planning.

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LIST OF ABBREVIATIONS

1. **W.H.O-** World Health Organization
2. **I.C.P.D-** International Conference on Population Development
3. **F.M.O.H-** Federal Ministry of Health
4. **S.T.Ds-** Sexually Transmitted Diseases
5. **N.D.H.S-** National Demographic Health Survey
6. **C.D.C-** Center For Disease Control
7. **U.S.A.I.D-** United States Agency For International Development
8. **U.N.F.P.A-** United Nation Fund for Population Activities
9. **P.P.F.A-** Planned Parenthood Federation of America
10. **I.P.P.F-** International Planned Parenthood Federation
11. **.B.B.T-** Body Basal Temperature
12. **C.P.R-** Contraceptive Prevalence Rate

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Operational Definitions of Terms

1. **Attitude**: Attitude refers to inclinations to react in a certain way to certain situations; to see and interpret events according to certain predispositions.
2. **Knowledge**: To the capacity to acquire retain and use information, a mixture of comprehension, experience, discernment and skill.
3. **Practice**: Application of roles and knowledge that leads to action.
4. **Rural Women:** Women who lives in areas or communities with a populations less than a thousand persons.

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

The act of giving birth is the most serious labour in the world (Ademowore, 2011). The explosive increase in the nation's population emanating from indiscriminate child-bearing, apart from a small number of privileged and conscientious countries that have succeeded in reducing the population growth, each pregnancy and birth remains a risk fatal experience for hundreds of millions of women worldwide.

Family planning is a means by which individuals or couples space the process of conception, pregnancy and childbirth in intervals, mutually determined by both husband and wife in order to have desired number of children that they can conveniently cater for their needs (Delano, 2010).

According to Ahmed (2014), Family Planning is the factor that may be considered by a couple in a committed relationship and each individual involved in deciding if and when to have children. Though, rarely articulated, family planning may involve consideration of the number of children a couple wish to have as well as the age at which they wish to have them. Family Planning are obviously influenced by external factors such as marital situation, career considerations, financial position, any disabilities that may affect their ability to have children and raise them, beside many other considerations.

World Health Organization (2011), describe family planning as a way of thinking and living that is adopted voluntarily, upon the basis of knowledge, attitudes, and responsible decisions by individuals and couples, in order to promote the health and welfare

of the family group and thus contribute effectively to the social development of a country. The World Health Organization (WHO) (2012) estimates that 287,000 material deaths occurred in 2010, sub-Saharan Africa (56%) and southern Asia (29%) accounted for the global burden of maternal deaths.

National Demography Health Survey (2012), reported in Nigeria on maternal mortality rate, revealed that, 600,000 women died in agony every year. It is not an exaggeration to say that the issue of maternal mortality, fast in its conspiracy of silence in scale and severity, the most neglected tragedy of our time. Also 585,000 women die during pregnancy and child birth, and result from often pregnancy and child bearing.

Family planning is sometimes used as a synonym for the use of birth control; however, it often includes a wide variety of methods, and practices that are for birth control. It is most usually applied to a female-male couple who wish to limit the number of children they have and/or to control the timing of pregnancy (also known as child-spacing). Family planning may encompass sterilization, as well as abortion. The pervasive problem presently is population rapid growth, especially in developing countries where this population growth matters, because it has enormous impact on the human life. It will not be wrong to say that the most urgent conflict facing the contemporary world today is not between the states of ideologies but between the pace of growth of the human race and the disproportionate increase in the production of resources, necessary to support mankind in peace, prosperity and dignity (Sehgal, 2014).

Odimegwu (2011) Opined that, rapid growth of population is not caused by any single reason, but it is obvious that how crucial the demographic factor can be in the

political stability and the socio-economic development of a country. It has now universally recognized that a massive population size, its rapid growth rate, and its controlled transfer of population from rural areas to the cities can create pressure on the resources of a country, adversely affecting its economic prosperity. There is convincing evidence that poverty incidence is always higher among larger households.

Indeed, Orbeta (2010); figured out an enduring positive association between family size and poverty incidence and severity. Studies by Orbeta (2010) also showed how a large family size creates the conditions leading to greater poverty through its negative impact on household saving, labour force participation. Earnings of parents, as well as on the human capital investment in children. Besides, it is stated that uncontrolled population growth is recognized as the single most important impediment to national development. Although population growth is not the only problem dividing rich and poor countries, it is one important variable that has widened the gap in growth in per capital income between developed and developing nations. Advocates of birth control see it as a means to prevent the personal and social pressures that result from rapid population growth (Encyclopedia, 2013). Family planning services are defined as "Educational, comprehensive medical or social activities which enable individuals, including minors, to determine freely the number and spacing of their children and to select the means by which this may be achieved (Maisamari, 2010).

Generally, it is because of this over population of the family has resulted to unhealthy, the unemployed, the ill-educated and the under-fed, which has no small measures aggravated crime rate as the populace are left with no better option, than involving themselves in various notorious and corrupt practiced earn a timing. With the recognition

and consideration of the consequence of population explosion it is obvious that family planning remains the only acceptable and practicable option for the reduction of incessant population growth. Family planning is the process of choosing the number of children in a family and the length of time between their births. It involves adoption of contraceptive devices to prevent unwanted pregnancies and thereby determining the number and spacing of children in the family (Encarta, 2010). Also family planning practices is therefore, the various ways of controlling births which may not conform to the approved standard either as a result of ignorance or apathy, couples ignorance and wrong perception of family planning, has created a rat-race situation where survival is for the fittest; (Agbakuribe, 2011).

Despite the recent increase in contraceptive use, Nigeria is still characterized by high levels of fertility and a considerable unmet need for contraception. The total fertility rate in Nigeria is 6.0 births per women and considerably higher in the rural areas than in the urban areas. Hence, men should be actively involved at the knowledge level (the concept of family planning), the supportive level (being supportive for other to use contraception) and the "acceptor" level, (as contraceptive user). Their decision-making role should be taken into account in order to promote family planning. Research indicates that accepting pregnancy, knowledge on different methods choice, and the understanding of the side effects of different methods are among the factors related to family planning.

Knowledge of family planning is a key variable in any discussion of fertility regulation and in the evaluation of family planning program. Acquiring knowledge about family planning is an important step toward gaining access to and then using suitable contraceptive methods in a timely and effective manner. Information of knowledge of family planning will help the couples to avoid or delay pregnancy; (Umar, 2012).

Knowledge is facts, information and skills acquired through experiences or Knowledge of family planning – this consisted of knowledge of modern contraceptives source of information about family planning, sex education ins school and sexual transmitted diseases STDs the alarming rate of indiscriminate child bearing emanated from lack of knowledge of family planning (Chingpaye, 2013).

In a study conducted by Dangat (2013) in Hai district, Northern Tanzania among married women attending antenatal clinic, 65% of the Tanzanian population is under the age of 24 and almost 20% of the population is aged 15-24 years, important group faces many significant health challenges, such as early sexual debut, early pregnancies, risky behaviours and sexual transmitted infections. The objective of this study was to assess knowledge, attitudes and practices on family planning services among adolescents in secondary schools in Hai district in northern Tanzania. A cross sectorial study was conducted between April and June 2011 among 36 randomly selected students into secondary schools using a self administered pre-tested questionnaire, median age of participants was 17 years (15-19 years0. Two-thirds (67-4%) of the respondents had adequate level of knowledge on family planning services (FPS) and the most popular source of information was the radio (65.8%). Being in a lower class (X^2 = 8.6; P<0.02) and FPS most 71.2% (225/316) respondents reported that FPS should not be used adolescents and mentioned several reasons against it used. Less than 6% (18/316) of all respondents had used FP I their lifetime, with 44.4% (8/316) in the past month 33.3% (6/318) in the past year, and 22.3% (4/18) in the past 5 years. In conclusion, most secondary school students in Hai Districts do not practice family planning services despite of adequate level of knowledge on FPS. Interventions to improve

utilization of FPS among secondary school students address barriers to low utilization of Family Planning Services in this study.

Attitude towards family planning is any strong belief, feeling, approval or disapproval toward people and situations. Attitude are learned tendency to evaluate things in a certain way. This can include evaluation of people issues, objects or events. Such evaluations are often positive or negative. (Paul, 2010).

Study conducted by Dauda and Oberiri (2016) in Taraba state, Nigeria, on the perception of married women aged 18-45 or the practice of family planning in Ardo Kola local government of Taraba state of Nigeria. This study adopted the survey research design method with questionnaire as the instrument used for data collection. The research deployed multi-stage sampling techniques to select 5 wards out of the 12 wards in Ardo-kola, Jauro-ginu Lamido-Borno, Mallam and then sets questionnaire were distributed to 400 respondents gthat were randomly selected from the 5 wards. Data collected were analyzed using simple percentages, frequencies and micro soft excel chart analysis. The study reveals among other things that married women in Ardo-Kola LGA are aware of family planning/method but do not practice family planning because their husband are not favourably disposed to the practice. The study recommends that husbands in Ardo-Kola should be enlightened properly by healthcare providers on the benefits derivable from family planning, and the attendant socio-economic and health problems where the practice is ignored.

Practice of family planning – Are the extent to which people are making use of whatever health services that are available. Knowledge and positive attitude can be seen but the practice is not found; which means that not having knowledge and the positive attitude

and knowledge matters. (Becher, 2014). A survey of 600 Atyap (Kataf) women aged between 15-49 by Avong (2009) in the study, perception and attitude towards Nigeria population policy, family planning programme and family planning in Kaduna State". Discovered that most of the respondents (98%) knew one form of modern method of family planning or the other but nearly all of them do not practice these modern methods of family planning due to fear of risk factors such as sterility, cancer, high blood pressure (HBP), weight increase, or weight loss, or fear of untimely death. A 34 year old undergraduate woman was reported to have made such remarks after been interviewed.

Contraceptive almost killed me if I were not educated. I`m sure I would have died (34 year old undergraduate women). The ascertain above corroborated what Hellandendu (2013) said in the study of violence against females. The research observed of artificial fertility regulation techniques are perpetuated by economic; political and gender structure in contemporary societies most of which work to the detriment of women. This is so because most of the artificial contraceptives are directed towards women which have detrimental health effects. Therefore, this study was to assess knowledge, attitude and practice of family planning among rural women in Kogi state, Nigeria.

1.2 Statement of the Problem

There is no doubt that Nigeria is one of the most populous country in Africa. The researcher observed that the problem of many children per family contributes to poverty, unhealthy, under-fed and ill-educated. The researcher observed that frequent birth by the mothers had been associated to a serious health problem to the mothers and their children; the health of the mothers is in coma due to frequent discharge of blood which is not regained

before the conception of another pregnancy; and this accounted for thousands of deaths of women in Kogi state. Fertility in the country remains high with a total fertility of 6.0 births per women and considerably higher in the rural areas than in the Urban (Population Bureau, 2012).

Maternal mortality is high due to the short interval of pregnancy which amounted to births related cases, this trends has causes pre-term birth (birth within 37 weeks of pregnancy) low birth weight (child birth less than 2,500grams) and infant morbidity in the rural area for instance in Kogi state. The weaned children are in a serious health condition because the period for normal breast feeding is lacking, thereby resulting to low immunity that prone to contagious diseases.

In spite of the importance of population growth to the society, couples, cultural resistance to child-spacing has brought about numerous social problems like indiscriminate child bearing, unwanted pregnancies, high rate of infant morbidity, drop-out from schools, and the low standard of living which has been on the increase with poverty also contributing to the incidence where families continue to reproduce uncontrollably because, of the believe that. It is a taboo to regulate fertility; these ugly threat has been observed by the researcher in Kogi state; Nigeria.

National Demographic Health Survey (NDHS) (2012), estimated on maternal mortality rate that 600,000 women died every year out of 585,000 women died during pregnancy and child birth, to break this vicious threats in our various rural areas. This study is out to assess knowledge, attitude and practice (KAP) of family planning among rural

women in Kogi State, Nigeria. This is to know whether the rural women have knowledge about family planning, their attitude and practice towards family planning.

1.3 Purpose of the Study

The main purpose of this study was to assess the knowledge, attitude, and practice (KAP) of family planning among rural women in Kogi State, Nigeria. The specific purposes of the study are to assess:

1. the knowledge on family planning among rural women of Kogi State, Nigeria.
2. the attitude of rural women towards family planning in Kogi state, Nigeria.
3. the practice of family planning among rural women in Kogi State, Nigeria.

1.4 Research Questions

The study is proposed to answer the following research questions:

1. what is the knowledge of rural women about family planning in Kogi State?
2. what is the attitude of rural women towards family planning in Kogi State?
3. what is the practice of family planning among the rural women in Kogi State?

1.5 Significance of the Study

The result of this study will be beneficial to:

The health educators in planning awareness program for the client, thereby creating enlighten to the client in making decision that are related to family planning methods.

Findings of this study will enable the client to benefit from the awareness programs that are provided by the health educators in areas that are related to family planning methods.

Findings of this study will sensitize the policy makers in creating policies that would support family planning practices.

Findings of this study will help tremendously in reducing mortality and morbidity through the awareness program on issues or family planning and unwanted pregnancies.

Findings of this study would contribute to the body of knowledge for Researchers and other educational purposes.

1.6 Research Hypotheses

On the basis of the research questions, the following hypotheses were formulated for the purpose of this study:

Major Hypotheses

The knowledge, attitude and practice of family planning among rural women in Kogi state of Nigeria are not significant.

Sub – Hypotheses

1.6.1 There is no significant knowledge of family planning among rural women in Kogi State, Nigeria.

1.6.2 There is no significant attitude towards family planning among rural women in Kogi State, Nigeria.

1.6.3 There is no significant practice of family planning among rural women in Kogi State, Nigeria.

1.7 Basic Assumptions

On the basis of available research evidence the following assumptions were made for the purpose of the study.

1. Knowledge of rural women towards family planning is low in Kogi State, Nigeria.
2. That attitude of rural women towards family planning is positive.
3. Practice of family planning services among rural women in Kogi State is in poor conditions.

1.8 Delimitation of the Study

This study is delimited to "Assessment of knowledge, attitude and practice (KAP) of family planning among rural women of reproductive age 15-49, in Kogi State, Nigeria. Also, delimited to the following variables;

- Knowledge of family planning among rural women in Kogi state Nigeria.
- Attitude of rural women towards family planning.
- Practices of family planning among rural women.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1 Introduction

Literature was reviewed on the subject matter using sub-headings beneath in a manner pertinent and reflective of the topic with the intent to discuss on the "Assessment of knowledge, attitude, and practice (KAP) of family planning among rural women in Kogi State, Nigeria under the following sub-headings:

2.2 Conceptual Framework

2.2.1 Concept of Knowledge, Attitude and Practice

2.2.2 Knowledge of Family Planning among Rural Women

2.2.3 Attitude of Rural Women towards Family Planning

2.2.4 Practice of Family Planning among Rural Women

2.2.5 Benefits of Family Planning to rural women

2.2.6 Obstacles to Family Planning Practices

2.2.7 Population Policy: A Focus of Family Planning

2.2.8 Method of Family Planning used by Rural Women

2.2.9 Contraceptive Practices and Factors that Influence Practice

2.2.10 Importance of Family Planning

2.2.11 Female Education and Family Planning

2.2.12 Level of Education and Family Planning

2.2.13 Religious Perspectives on Family Planning

2.3 Theoretical Framework

2.4 Empirical Studies

Summary

2.2 Conceptual Framework

Family planning has attracted attentions all over the world due to its relevance in decision making. Population growth and development (Samuel 2010), defined family planning as the practice that helps individuals or couples to attain certain objectives such as avoiding unwanted pregnancies, bringing about wanted babies at the right time, regulating, the interval between pregnancies, controlling the time at which birth occurs in relation to the ages of parents and determining the number of children in the family. Family planning is a means of reproductive health. In spite of the hue and cry in and outside Nigeria about family planning or birth control. Individuals are still confused about its meaning, the methods involved, the advantages and disadvantages and the factors hindering its wide application in Nigeria, (Hiffh and Ezeah, 2014).

According to Kende (2013), family planning is of birth control and other techniques to implement such plans which include sexual education, prevention and management of sexual transmitted disease (STDS), pre-conception counseling and management of infertility. It further conceptualizes that family planning educational, comprehensive,

medical or social activities which enable individual's .to determine freely the number and spacing of their children and to select the means by which this may be achieved.

Brown, (2010), Views family planning as the deliberate prevention or delaying of birth by means of sexual abstinence, contraception, sterilization, abortion, and prolonged breast feeding or it is the policies, program, services designed to assist people in practicing birth control. Women`s education resulted in women empowerment and it enable them to use family planning services more effectively. WHO (2013) found out that women`s education is in line with lower fertility which constitutes management of reproduction resources, maternal education has been linked with reduction of child mortality among rural dwellers. Women`s education enhances their capability and also their reproductive rights to decide freely and responsibly the number, spacing and timing of their children and to have other necessary information regarding reproductive rights. Studies have shown that education is a determinant of awareness of family planning practices in Nigeria. For instance, Olaitan (2011) concluded a study on factors influencing the choice of family planning among couples in South East Nigeria. The findings revealed that educational background of the couples significantly influenced the choice of family planning among couples.

There is a growing awareness to the negative effects of unlimited childbirth, on the health of women, the children and society. This awareness stems from the alarm raised about the Gross Domestic Product (GDP) of any country. It is as a result of this that family planning was introduced to help guide the choice and timing of pregnancy in order that childbirth is controlled. This program has help tremendously in the reduction of birth rate in developed countries yet the trends seem unchanging in the developing countries.

In Nigeria, the condition has been very bad as the annual birthrate ranges between 4.8% and 5.5%. it portends danger for developmental aspiration; and specially rural areas, there is a dragging context over family planning misunderstanding between couples emanating from family planning. This with health, social and financial problems from broken homes, which in turn poses serious dangers to the society and the individuals involved.

In 1994, 179 nations came together in Cairo at the International conference on Population and Development (ICPD) to address issues of population growth and sustainable development. These nations emphasized the importance of social and economic development and individual and family well – being of achieving reproductive health for all. During the conference a program of action was developed to set out a series of recommended actions targeting population growth and development. Included in this program of action was a pledge from all 179 nations to transform and fund reproductive health services around the world including the assurance that everyone who wanted to limit or space their children could do so with appropriate access to relevant services (Danlaire, 2012).

The ICPD redefined the term reproductive health as … a state of complete physical, mental, and social well – being and not merely the absence of infirmity, in all matters related to the reproductive system and to its functions and processes. Reproductive health, therefore, implies that people are able to have a satisfying and safe sex – life and they have the capability to reproduce and they have the freedom to decided if, when and how often to do so, implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their

choice, as well as other methods for the regulation of fertility which are not against the law, and the right of access to appropriate health – care services that will enable women to go safely through pregnancy and child birth and provide couples with the best chance of having a healthy infant (ICPD Program of action 1994 as cited in Daulaire, 2012).

Specific attention should be drawn to the part of the definition of reproductive health that clearly states that both men and women have the right "… to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of family planning of their choice, as well as other methods for the regulation of fertility which are not against the law." In rural parts of Kogi state, men and women do not have access to family planning, which likely leads to unmet needs and increase unwanted pregnancies.

According to World Health Organization, (2008) (WHO) found "family planning is a way of thinking and living that is adopted voluntarily, upon the basis of knowledge, attitudes, and responsible decision by individuals and couples, in order to promote the health and welfare of the family group and thus contribute effectively to the social development of a country. The conscious effort of couples to regulate the number and spacing births through artificial and natural method of contraception; family planning connotes conception control to avoid pregnancy and spontaneous abortion, but it also includes efforts of couple to induce pregnancy. Access to family planning and contraceptives has altered social and economic roles of women. Family planning has provided health benefits such as smaller children, increased opportunities for preconception counseling and screening; fever infant, child and maternal death; and use of barrier contraceptives to prevent pregnancy and transmission of human Immunodeficiency Virus and STDs, (Paul, 2009).

Family planning simply refers to the system whereby people are expected to plan adequately for their families in accordance with their individual means of earning, while the term child – spacing refers to the system where couples plan and determined the space between their issues that is, when and where not to have a child accordance to their plan.

Alamin, (2012), found family planning as factor that may be considered by a couple in a committed relationship and each individual involved in deciding if and when to have children. Through rarely articulated, family planning may involve consideration of the number of children a couple wish to have as well as the age at which they wish to have them. These matters are obviously influenced by external factors such as marital situation, career considerations, financial position, any disabilities that may affect their ability to have children and raise them; besides many other considerations. If sexually active, family planning may involve the use of contraception and other technique commonly used includes sexuality education, prevention and management of sexually transmitted infections, pre-conception counseling and management, and infertility management. Family planning is sometimes used as a synonym or euphemism for the use of contraception. However, it often involves methods and practices in addition to contraception. It is most usually applied to a female – male couple who wish to limit the number of children they will have and/ or to control the timing of pregnancy (also known as spacing children) family planning may encompasses sterilization, as well as abortion. Family planning services are defined as "Educational, comprehensive, medical, or social activities which enable individuals, including minors to determine freely the number and spacing of their children and to select the means by which this may be achieved.

As a matter of fact, planning of the family and implement the plans, based on mutual understanding, are purely voluntary and wife in order to be healthy, wealthy, happy, and the same time contributing to social welfare, national progress and world peace at large. The significance of the family planning is that the household budget should so balance and adjusted as to accommodate every, item of expenditure within one's income. It is not only this but also to limit the family according to one's means and resources; (Agbakuribe, 2011).

Maternal mortality is not the only problem that stems from unintended pregnancies. According to the World Health Organization (WHO) "for every maternal death an estimated 40 additional women suffer pregnancy – related health problems that are frequently permanently debilitating," (WHO, 2009). Overall, an estimated 18 million women suffer from pregnancy – related problems which include uterine rupture, prolaspe, hemorrhage, vaginal tearing, urinary incontinence, pelvic inflammatory diseases and obstetric fistula (a muscle tear that allows urine or feaces to seep into the vagina). These conditions are more likely to occur among women who are on the cusp of child learning age, very young or very old, suffering poor health, malnutrition or have had multiple live births (Danlaire, 2015). The cost associated with such debilitating problems can lead to social and economic isolation as well as increasing the risk of maternal mortality during future pregnancies.

Family planning save lives and can improves the health of women, children and society as a whole. According to Bernstein (2008) gaining control of one's reproductive choices and fertility has health benefits for both mother and child. In 2006, about 90% of global abortion related and 20% of obstetric related mortality and morbidity could have been averted by the use of effective contraception by women wanting to either postpone or stop having children. In some cases, a mother's death is considered to be the death of the

household. In this regard, using family planning to increase the interval at which women bear children not only has benefits to the mother, but also to the child.

The adoption of universal access to reproductive health by 2015, as the second target under sustainable developmental goals is the recognition that family planning is a cornerstone in reducing maternal deaths and improving reproductive health. This affirmed declarations in support of sexual and reproductive health, made by 179 countries, in the 1994 International Conference on population and development program of Action. In 2005 an estimated 536, 000 women died from pregnancy and childbirth related causes. One in three of these deaths could have been avoided if all women who desired contraception were able to access to it. When a women is able to limit the number of pregnancies she has, the most immediate benefit is the reduced risk of death from pregnancy or childbirth. Preventing unwanted pregnancy results I fewer abortions, particularly unsafe abortion. Every year, unsafe abortion is estimated to kill between 65,000 and 70,000 women and girls and inflicts temporary or permanent disability upon five million others. The majority of these occur in developing countries. In Latin America, at least 30 percent of hospital beds dedicated to obstetrics and gynecology services are occupied by women suffering from abortion – related complications. The risk of infant and child mortality also declines as contraceptives are used to delay child bearing and to better space births. Family planning is arguably one of the two most powerful interventions for decreasing child mortality, the other being women's education contraception enable women to plan their families, to plan their lives and to make choices to ensure their own happiness.

2.2.1 Concept of Knowledge, Attitude and Practice

Knowledge is the ability to recall or recognize something such as a fact, concept, principle, and custom (Kalua, 2011). It is further stated that knowledge can be acquired through formal or informal settings either by the help of someone or alone. Knowledge is said to be a source of power necessary for everyone to make informed decisions about one's health and participate actively in promoting health of the community (Kalua, 2011). This seems to concord with Alfred Lord who said, "self – reverence, self – knowledge, self – control, these three alone lead to "soverign powers" for more than three hundred years, knowledge of the self has been considered to be at a very care of human behaviour messenger reminds that, "Sovereign Powers" for more than three hundred years, knowledge of the self has been considered to be at a very care of human behaviour messenger reminds that, "He that would govern others first master himself (William, 2009).

Knowledge of oneself has been considered to be at the very care of human behavior, messenger reminds that he that would govern others first master himself (William, 2009). Knowledge of oneself, self – awareness, self – insight and self – understanding is essential to one's productive and interpersonal functioning and in understanding and empathizing with other people. (William, 2009) state that the knowledge we possess about yourself, which make our self – concept, are control to improve our management skills.

Research in knowledge has shown that knowledge acquisition take place in two phases, namely assimilation and accommodation (Kalua, 2011). Where Assimilation is the process of making part of external environment become part of one – self, this happens when one is exposed to new pieces of information or cues. They believe one or more

important references think they should, and they are sufficiently motivated to comply with the referents (Venatesh, & Davis, 2010).

The health belief model (William, 2015), posited that individuals must perceive themselves to be at risk of the health threat before they will take actions to reduce risk behavior engage in health alternative behavior engage in health alternative behaviors. This may explain why people take their health for granted because they view themselves as not at risk or threatened by potential water borne diseases people attitude towards foods and drinks are challenging and economically, as well as scientifically, important. It is further stated that people define their personal needs, and based on them, they judge the quality of food and drinks. Therefore, but they also depend on more general parameters such as tradition or socio-economic circumstances (Rerchhort, 2013).

Practice is an action or behavior that individual engages in and is normally induced by attitude either consciously or unconsciously. It can also be referred to as behavior, specifically referring to a behavior that a person engages in (William, 2009). The terms, practice and behavior, are used synonymously in this study. Behavior is mostly learned and this learned action is a reaction to social or physical environment stimulus and is goal – oriented. It is an overt manifestation of inner feelings and thoughts which form attitude and is therefore an indirect mechanism of expressing attitude (Williams, 2015). The type of behavior an individual will attitude formed for instances, effective and timely case management contributes to reducing mortality to less 1%. However, for this to happen, enabling before such as time, self – esteem and availability and accessibility of needed technical power needs to be present (Williams, 2012). These make it possible for an individual to convert an attitude into behavior. Accommodation follows Assimilation, it is

the adaptation that one goes through to the newly assimilated object to make a meaningful in one's life. It is manifested in charged value and attitude. For knowledge to be meaningful and applicable, this theory persist that people know about things and events, around them through their senses and knowledge.

Attitudes are persistent tendency to feel and behave in a particular way towards some object. Attitudes are complex cognitive process which consists of three components, the emotional, information and behavioral. The emotional component includes the person's feeling about an object. The information component consists of person's tendencies to behave in particular way towards an object. It is further stated that attitudes tend to persist unless something is done to change them. Attitude can also fall anywhere along a continuum from very favourable to unfavourable. Finally, attitude can be directed forwards some objective which a person has feel and beliefs (Williams, 2013).

2.2.2 Knowledge of Family Planning among Rural Women

Knowledge is facts, information and skills acquired through experiences or, and education, the theoretical or practical understanding of a subject (Chingayipe 2014) revealed that rural women have shallow knowledge on practice of family planning. (Mcleod 2010), opined that lack of information and poor economic status contributed to this gap. The family planning knowledge consisted of knowledge of modern contraceptives and emergency contraceptives, source of information about family planning sex education at school, and the issue of sexual transmitted diseases (STDS).

Currently, there is low level of access to quality reproductive health information and services at the three levels of health care delivery namely, primary, secondary and tertiary.

Some of the major problem in this regard is limited information in terms of reproductive health issues especially at the rural setting. Specialized services such as voluntary confidential counseling and free health seeking services are currently at a pilot phase; and the low level of availability and utilization of relevant reproductive health services is another problem. The orientation of family service is inappropriate with an imbalance between resources for curative and promotive services.

Nwosu (2010), conducted a study on knowledge, attitude and practice at Manipur India, to assess the knowledge. Attitude and practice of family planning among Meitei women. The knowledge of condom and IUD usage is low at the age group 21-30 years, of (24.0%) and 31-35 years of (30.3%) and 36-40 years of about (20.0%). This indicates that there is low knowledge about contraceptives and tends to slow down the utilization of the services.

Expanding access to family planning in Nigeria is crucial for a number of reasons, which correspond most too basic human rights and the health and wellbeing of the urban and rural dwellers. The need for action regarding women`s reproductive health is reflected in the alarmingly high rates of material mortality and morbidity. The high rate occurs as a result of lack of knowledge about family planning program. The population of the country is increasing rapidly. The population doubles between 1990 to 2010 (plan 2012-2015). The rates of population growth exceeded changes in the rates of poverty and urbanization. Moreover the rate of contraceptives use increased from 10% to 12%, making it one of the lowest rates of contraceptive use in Africa.

Only 13% of married women use any method of family planning: 12% are using a modern method, and injectables 5% and the pill (4%) are the most popular methods (Kebe 2012). The male condom takes most popular method of family planning. (11%) among sexually active women who are married, though only one in four sexually active unmarried women use a modern method of family planning. This is concerning because their number are growing in urban areas, and they often lack knowledge of family planning methods and protection from sexually transmitted diseases, (STDS) because of the great stigmatization of sexual activity before marriage. Woman with higher level of education are more likely to use modern contraception techniques: only (8%) of all women with no education use modern methods, whereas (26%) of women with secondary or higher education use modern techniques. Additionally, modern contraception techniques are used more frequently in urban areas, at a rate of (20%), than in rural areas, at a rate (7%). The rates of family planning in rural areas are alarming low with major health and wellbeing implications on both women and their families.

2.2.3 Attitude towards Family Planning among Rural Women

Attitude is any strong belief, feeling, approval or disapproval toward people and situations. It is possible to have favourable or unfavourable attitudes towards people, things, and situations. Psychologist define attitude as a learned tendency to evaluate things in a certain way. This can include evaluation of people issues, objects or events. Such evaluations are often positive or negative, but they can also be uncertain at times. For example, might have mixed feeling about a particular issue (Kendra, 2013).

Attitude is the most difficult part to measure as it is characterized in a very abstract way. To gauge the attitudes towards family planning, it was noted in the study conducted by Chingyayi (2013) that attitudes toward family planning among the rural women is poor due to how they felt when they heard other people talking about family planning. Stigmatization was established by some rural women in terms hearing other people talking about side effect of some methods of contraceptives.

Chingyayipe (2013), stated that people have negative attitude and still lack adequate knowledge and safe practice in family planning methods. The attitude, belief and method toward family planning sometimes differs that is, both in urban and rural areas. It may be individual knowledge, background, culture, religion, awareness or educational status. A study conducted by Fogodi (2016) indicates significant difference between rural and urban women on their attitudes towards family planning. It is revealed that women on the urban areas has positive attitude than those women at the rural dwellers due to lack of appropriate knowledge, and awareness on the issue of contraceptives.

Wahed (2013) conducted a study which focused on attitude of women toward family planning method of Kawa resident in Bauchi state, using a sample of 320, (2.3%) could recognize the importance of family planning, (16.3%) have heard of family planning but not practicing any method and (64.4%) has negative perception or attitude towards family planning. This indicates that attitude of some rural women are still negative toward family planning and use of contraceptives.

2.2.4 Practical of Family Planning among Rural Women

Utilization refer to the extent to which people are making use of whatever health services that are already available in the community or society for the forget group (Wilson, 2010). Practice of family planning include age of getting married, after marriage use of contraceptives; planned pregnancy birth spacing, cause of induced abortion, desire for more children.

The level of utilization of modern contraceptives in Nigeria and mostly at the rural areas is still very low, although it has increased over the decades with an increase in the contraceptive prevalence rate (CPR) from 3.5 percent to 8.6 percent as recorded in the (2013) national demographic health survey respectively. The level of contraception among sexually active adolescents is particularly low, contributing to the high level of teenage pregnancy, usage abortions and maternal mortality, among others. On the whole, the total demand for family planning is still relatively low as only 29 percent of women demanded for family planning in 2009 as indicated by (NDHS). The level of unmet needs for family planning increases from 3.3 percent to 18.6 percent between 1990 to 2009.

Factors affecting the level of utilization of family planning services in Nigeria and mostly at the rural areas are: low level of education, low level of knowledge, myths and misconceptions, low quality of services including non-availability of contraceptive commodities and poor attitude of service providers (Nwosu 2011), and oppositions from husbands. Additionally, child-spacing, prevention of pregnancy and sexually transmitted infections (STIS) appear to be among the major factors influencing contraceptive usage in

Nigeria. The utilization rates of reproductive health services were higher amongst population of urban than that of rural.

2.2.5 Benefits of Family Planning

Raising a child requires significant amount of resources, time, social, financial and environmental planning can help assure that resources are available the purpose of family planning is to make sure that any couple, man and woman who has the desired to have a child has the resources that goal. With these resources, an experience man and woman can explore the options of natural birth, surogany, artificial insemination, or adoptions. In the other case, if the person does not wish to have a child at the specific time, they can investigate the resources that are needed to prevent pregnancy, such as birth control, contraceptives, or physical protection and prevention. Promotion of family planning and ensuring access to preferred contraceptive methods for women and couples is essential to securing the well – being and autonary of women, while supporting the health and development of communities; (Adeotu, 2012) the following are the benefits of family planning:

i. **Preventing pregnancy** – related health risk in women. A women's ability too choose if and when to become pregnant has a direct impact on her spacing of pregnancies and can delay pregnancies in young women at increased risk of health problems and death from early child-health problems and death from early child-bearing. It prevents unintended pregnancies; include those of older women who face increased risk related of pregnancies. Family planning enables women who wish to limit the size of their families to do so. Evidence suggests that women who have

more than 4 children are at increased rate of maternal mortality. By reducing rates of unintended pregnancies, family planning also reduces the need for unsafe abortion.

ii. **Reducing Infant mortality** – family planning can prevent closely spaced and ill – timed pregnancies and births, which contribute to some of the world's highest infant mortality rates. Infants of mothers who die as a result of giving birth also have a greater risk of death and poor health.

iii. Helping to prevent Hiv/AIDS – family planning reduces the risk of unintended pregnancies among women living with Hiv, resulting in fewer infected babies and orphans. In – addition, male and female condoms provide dual protection against unintended pregnancies and against unintended pregnancies and against STI's including Hiv.

iv. **Empowering people and enhancing education** – family planning enables people to make informed choices about their sexual and reproductive health. Family planning represents an opportunity for women to pursue additional education and participate in public life, including paid employment in non – family organizations. Additionally, having smaller families allows parents to invest more in each child. Children with fewer siblings tend to stay in school longer than those with many siblings.

v. **Reducing adolescent pregnancies**: Pregnant adolescents are more likely to have preterm or low birth weight babies. Babies born to adolescents have higher rates of neonatal mortality. Many adolescent girls who become pregnant have to leave school. This has long – term implications for them as individuals, their families and communities.

vi. **Slowing population growth**: family planning is a key to slowing unsustainable population growth and the resulting negative impacts on the economy, environment, national and regional development efforts.

2.2.6 Obstacles to Family Planning

There are many reasons as to why women do not use contraceptives. These reasons include logistical problems, limited access to transportation in order to access health clinics, lack of education and knowledge, efforts to increase access must be sensitive to cultural and national contexts, and must consider economic geography and age disparity within countries poorer women and those in the rural areas often groups – including adolescent, unmarried people, the urban poor, rural population, sex workers and people liming. This can lead to higher rates of unintended pregnancy, increased risk of Hiv and others STIs limited choice of choice of contraceptive methods, and higher levels of unmet need for family planning observed by (Rose, 2013).

2.2.7 Population Policy: A Focus of Family Planning

Conference on population and Development of Action 2005, around the middle of this century, concern with levels of reproduction in countries of the developing world began to intensify, The high rate of growth experienced in those countries as a result of declining mortality level while fertility remained high was considered a population problem that formed an obstacle to development and threatened the balance of distribution of the world's population. Rates of growth experienced in many large developing countries came close to three percent and their population size doubled in less than 30 years. In many developing countries around forty percent of the population was under 15 years. To address this

situation, population policy in developing countries came to be equated with fertility reduction and family planning policy was born as the only viable short term mechanism for addressing the inflated rate of growth. Over the decades that followed huge material resources and strong expert support mechanism which found its counterpart in developing countries, and came to determine to a large extent, how reproductive needs, particularly of women, were constructed and how solutions were defined. Yet as awareness of the population problem intensified, others believed the solution to lie in a wider approach covering the societal context of high fertility. They emphasized development as a process which would serve to raise standards of living in developing countries, and eventually bring fertility down. This approach found it first worldwide expression at the international population conference in Nigeria (2003). Many countries mainly from developing world, called for expanding the scope of population policy beyond family planning and strong argued that "development" was the best contraceptive". However, because of the perceived urgency of the problem of population growth, the family planning component in population policy once again gained ground as a more direct mechanism for lowering fertility, as became apparent at the conference.

Family planning program continued to grow in strength and focused on establishing national coverage in developing countries. Pressure was eventually stepped up in these programs to recruit on increasing number of contraceptives acceptor. Although this type of policy persists in many developing countries today, the debate on the scope of population policy continues with new voices joining in and will again be a key issue for the international population conference.

Recent strong voices have come forward from feminists and health advocate supporting a broader view of the domain of population policy. On the other hand, they situate reproduction in its larger social context and argue that population policy cannot divorce itself from concern with wider societal factors influencing fertility. On the other hand also, they argue that population policy must direct itself to a broader concern for individual needs of women, thus widening its strategy from providing family planning only to including reproductive health services. They see the objectives of these services as assisting couples to meet their reproductive intentions, needs of children and particularly of women who bear the task of childbearing. Being complemented by more structural interventions, both societal goals of a reduced rate of growth and individual goals of desired and healthy reproduction and well – being are satisfied.

2.2.8 Family Planning Methods

An ideal family planning method must meet the following criteria:

a. Must be completely safe and without side effects
b. Must be 100% effective
c. Must be completely reversible
d. Must be cheap or free to users,
e. Must be acceptable to users
f. Must be easy to use and not under medical control and must be independent of coitus, that is, unrelated to the time of sexual intercourse.

No single method meets all the above criteria and each method has its own advantages and disadvantages. The following available methods are described briefly on centre for Disease Control (2010), Reviewed 2016

1. Abstinence
   - Total abstinence
   - Period abstinence
2. Contraception
   - Coitus Interruptus
   - Barrier method (condoms, diaphragms cervical caps chemical substances).
   - Intra uterine device (IUD)
   - Hormonal Contraceptive (pills, injectables, implant).
3. Sterilization
   - Tubal ligation
   - Vasectomy
4. Breast feeding as a method for contraception

2.2.8.1 Abstinence (Natural Methods)

Total Abstinence – This is the complete avoidance of sexual intercourse. Abstinence is the most effective method of family planning if strictly practiced, but it calls for self discipline and determination. It has also no side effect and no complications.

2.2.8.2 Periodic Abstinence (Rhythm or Safe Period)

This implies the avoidance of sexual intercourse during the time the woman may be fertile in the monthly cycle. Rhythm or safe period can be practiced in three different ways

based on the knowledge of the physiology, of the female reproductive system, including menstruation, conception and changes in the quality of vaginal secretion. The rhythm method is not suitable for women with irregular menses and the failure rate is about 14 – 50 per 100 women.

i. **Calendar (rhythm) Method**: This method is designated to predict the fertile period based on the duration of the previous cycles. Using a calendar, the length of each menstrual cycle over the last 6 – 12 cycles is recorded. The earliest day on which the woman is likely to be fertile is computed by subtracting 20 days from the length of the shortest cycle. In the same vein subtracting 10 days from the length of the longest cycle determines the first day on which the women is no longer likely to be fertile. For example, if the woman's menstrual records show that her shortest cycle was 26 days and her longest cycle was 30, the first fertile day 20 (30 – 10 = 20). Abstinence shall therefore extend from day 6 of her menses to day 20, the first day of bleeding being day 1 in each cycle.

ii. **Basal Body Temperature (BBT)**: This involves using the body temperature to detect ovulation. Ovulation is detected by identifying an increase in body temperature (usually about 0.5^0c – 1^0c) from a relatively lower level following the release of eggs from the ovary. This temperature shift can be defined as one that occurs 48 hours after the release of eggs and will remain at this level until the next period. It is presumed that three days after the temperature rise will be safer for sexual intercourse. To avoid pregnancy therefore a woman will abstain from sexual intercourse from the time of her menses up to three days after the temperature rise.

iii. **Cervical Mucus (Billing's Ovulation) Method:** This is based on the woman's observation of a sequence of changes in the consistency or quality of cervical mucus. Shortly before ovulation, that is, at early pre-ovulatory days, the mucus is sticky and moist. During ovulation the mucus becomes thinner, slippery, watery and stretchy so as to hang in strings without breaking (spinnbarkeit). This is followed again by immediate postovulatory days of sticky and moist mucus and subsequently postovulatory days of fertile period of scanty or no mucus in which the woman feels dry. Ideally abstinence should extend through the early ovulatory (sticky, moist mucus) to the ovulatory period of clear, wet stretchy mucus whereas intercourse can be permitted beginning on the fourth day after the last day of wet, stretchy mucus.

Periodic abstinence, especially the Billings method has the advantage that it wins the support of the Roman Catholic church. It is also without cost and can be taught by a nurse or a lay worker. Most importantly, the knowledge of this method can help couples achieve pregnancy. Ovulation occurs about the middle of the monthly circle, usually 14 days before the next menstrual cycle begins. Consequently, two or three days immediately before the ovulation are fertile because sperm cells can survive about two days in the uterine tubes, and two or three days after ovulation are also fertile since the eggs remain active after release for two to three days. The value of understanding the fertile days in the month is advantageous when giving advice on infertility. Periodic abstinence and however not suitable for women with irregular menses and cannot be used when fertility is returning after a delivery because the first ovulation after delivery may not be preceded by a menstrual period. Moreover it requires long initial instruction, strong commitment and cooperation from partners and may be generally less effective than other methods.

2.2.8.3 Contraception

This is the interruption of conception at any level achieved by interfering in the function of the organs of reproduction (for instance hormonal contraception), or by preventing a normal healthy spermatozoa from reaching and fertilizing a normal healthy female egg (for instance coitus interruptus, condom, diaphragm, cervical cap). There are different methods of contraception and they include the following;

i. **Coitus Interruptus (Withdrawal)**

In using this method the man withdraws his penis from the vagina before he ejaculates. This method costs nothing and if properly carried out is effective. However, it needs lot of self – control and discipline from the man and sometimes the woman. Continuation of intercourse after ejaculation is not possible in view of the residual spermatozoa which can be reintroduced into the vagina.

ii. **Barrier Methods**

Condom

The condom, a rubber – like ballon is worn over the man's erect penis before intercourse to collect the semen and prevent its entering into the vagina. It acts as a mechanical barrier between the penis and the vagina and also protects against sexually transmitted diseases. If well used, a condom can be highly effective in preventing pregnancy. The disadvantages of condom are that its use may interrupt foreplay and some users may complain of reduced sensation. There are rare cases of allergy to the rubber.

iii. **Diaphram and Cervical Cap (Duch Cap)**

There are like condom contraceptive barriers, but unlike condom, they are used by women. Diaphragm is the most commonly used. It is made of soft dome – shaped rubber resembling a cup with flexible rim. It is inserted into the vagina before intercourse and acts as mechanical barrier to the cervix by preventing semen from entering the cervical canal. The addition of spermicidal cream or jelly to a diaphragm before use enhance its effectiveness.

iv. **Spermicides**

These are chemical substances inserted into the vaginal shortly before sexual intercourse to inactivate the spermatozoa and also prevent them entering the uterus. Spermicides may be in form of foams, creams, jellies, tablets or pessaries. Apart from having a high failure rate, spermicides have a short lasting effect and require a short waiting time of about 10 minutes between insertion and sexual intercourse.

v. **Intra Uterine Contraceptive Device (IUCD)**

These are plastic or metal (silver or copper) device inserted into the uterus to prevent pregnancy. There are different types of IUCDs and includes the Lippes 'Loop' (the coil), copper "T", Copper 250, 375, 380, and multi-load. The mode of action of IUCDs is not confirmed but it is believed that their presence in the uterus interferes with conception either by immobilizing or inactivating the spermatozoa, interfering with the eggs or acting as local foreign body to prevent implantation of the ovum.

IUCDs are very effective and do not interfere with intercourse. They are easily reversible. Disadvantages include Inflammatory disease and rarely uterine perforation.

Because of the risk of pelvic inflammatory disease and attendant infertility, IUCDs should be inserted at the time of menstruation, so as to ensure the women is not pregnant or immediately post – partum.

2.2.8.4 Sterilization (Surgical Contraception)

This is a safe and often permanent contraception of either a female (tubal ligation) or a male (vasectomy).

Tubal Ligation

In women the sterilization operation involves blocking or cutting both fallopian tubes to prevent the passage of ova and spermatozoa. The operation must be voluntary and after proper counseling and can be performed just after delivery or abortion or at any point between pregnancies. The operation has no effect on feminity, menstruation, sexual relationship or health of the woman.

Vasectomy

This is a similar operation and involves the cutting and typing of the vas deferens – a thin tube responsible for the transportation of the spermatozoa from the testes to the penis during intercourse like tubal ligation, vasectomy does not affect the man's health, potency, sexual drive or masculinity. Sterilization is highly effective but due to its irreversibility, it is not recommended for couples under 30 years of age with less than three children.

2.2.8.5 Breastfeeding as a Contraceptive Method

Ovulation and therefore conception is unlikely to occur for about five to six weeks after delivery, but after this time pregnancy is possible. To avoid such pregnancies,

contraception may need to be started about five weeks post partum or the length of lactational amenorrhoea prolonged by prolonged breastfeeding. This is because frequent stimulation from suckling of the baby is sufficient to prevent ovulation. The suckling baby on the mother's nipple sends messages back to the pituitary gland that prevents the production of gonadotrphine, follicle stimulating and lactating hormones and so stop ovulation. One of the commonest disadvantages of breastfeeding as a family planning method is the risk that pregnancy can occur. This is because ovulation can take place at some time during lactation, thus allowing a further pregnancy to occur following sexual intercourse, sometimes even without a woman seeing a menstrual period. The taboo against sexual intercourse during lactation as practiced in some places therefore enhances the effectiveness of breastfeeding as a contraceptive method.

2.2.9 Contraceptive Practices and Factors that Influence Practice

Contraceptive use and choices vary widely in Nigeria according to type of health facility, geopolitical zone, and within urban and rural settings. Various factors, related to both supply and demand, account for these variations and contribute to the low levels of contraceptives use and choices in Nigeria. On the supply side are issues such as limited availability, quality and cost of family planning services. As a consequence of limited availability, many Nigerians (particularly in rural areas) lack access to modern contraceptive and family planning services. In areas where services do exist, their quality is often poor, with inadequate contraceptive supplies, insufficient numbers of trained services providers, poor interpersonal skills on the part of providers, and limited essential equipment. Research on factors associated with demand for contraceptives and family planning services in Nigeria has identified the relative powerlessness of women (especially in Northern Nigeria),

household poverty, how level of education in the rural areas, also myths and rumors about family planning, parity, pro-natalist attitudes, and widespread preference for male children as key influences on contraceptive use. In addition to these factors, and especially in the study area, are early marriage and ignorance about family planning benefits, (Demographic and Health Survey (2003); the condom is reported to be the main contraceptive method known of and used by Nigerian women of reproductive age. The extensive marketing of condoms in response to the Human Immunodeficiency Virus (HIV) epidemic, with the active involvement of both governmental and non – governmental organizations, has been responsible for this increase awareness and subsequent increase in condom use. Condoms are also the preferred choice for post partum contraception, especially among educated women with high parity. Demographic studies in Nigeria have indicated that because patient medicine stores are common sources of contraceptives and because condoms are readily available over the counter at these stores, there is much less restriction on contraceptive purchases and use compared with the family planning clinics and health facilities where there are more restrictions. Oral contraceptive pills as already stated above, OCPs like the condom, are readily available over the counter at medicine stores and pharmacy in Nigeria. A significant problem in Nigeria is lack of adequate information about the OCP. The myths that prolonged use of the OCP Leads to permanent sterility. Many factor, can influence decision – making about family planning and choice of contraceptives to be adopted, religious, factors, ignorance, superstition based beliefs, are the determinants hindering its practice in Nigeria especially in the rural areas, and fear of surgical complications; (Omideyi, 2010).

2.2.10 Importance of Family Planning Practices

According to (Ahmed, 2009), observed the following helps to everyone in the society in relation to family planning, they are as follows:

- **Women** – family planning helps women to protect themselves from unwanted pregnancies. Vividly, many women life have be saved from high – risk pregnancies or unsafe abortions. If all women of reproductive age avoid unwanted pregnancies, the number of maternal deaths could fall by one quarter. Also, many family planning methods have other health benefits. For instance, some hormonal, methods help to prevent certain cancers and condom help to prevent sexually transmitted diseases, including Hiv/AIDs.
- **Children:** family planning saves the lives of children by helping in keeping space between births, between 13 to 15 million children, under the age of 5 die each year. If all children were born at least two years apart, 3 to 4 million of these deaths would be avoided.
- **Men:** family planning helps men and women to care for their families. Men around the world say that planning their families help them to provide a better life for their families.
- **Families:** family planning improves family wellbeing couples with fewer children are better able to provide them with enough food, clothing, housing and education.
- **Nations –** family planning helps nations in their development. In countries where women are having far fewer children than their development.
- **The Earth –** If couples have fewer children in future, the world population of 5.9 billion people will avoid doubting in less than 50 years. Future demands on natural resources

such as water and fertile soil will be less. Everyone will have a better opportunity for a good life.

2.2.11 Female Education and Family Planning

The modern social factors that influence the fertility, the education of females is particularly relevant to the family planning. In fact female education has long been considered as the key to the population control. An educated women has a better understanding about choices of family size and an improvement of basic health care. Women can and must play a powerful role in sustainable development and poverty reduction. When women are educated and healthy their families, communities and nation are defiantly benefited; (Jamiu, 2010).

An educated woman usually less confined, physically and psychologically, within her husband's family and its narrow family concerns as compared to the woman who has been brought into such home as an uneducated girls. A well-educated female will not be in favour of joint family system where she is likely to have no decision-making power and dominated her mother-in-law. She shall break such social constraints, if any, prevailing in the family. She is more likely to feel conditions of her life including the conditions of her pregnancies in close successions or her later reproductive years. In our society the only alternative available to woman, especially uneducated, has been to prove her feminist by bearing children; but an educated wife is not today as likely to want to keep on proving herself though, obstetrical channels throughout the whole reproductive of her life.

In modern set-up, educating a woman means educating a whole family. Education has been recognized as a major instrument which society can use to direct the process of

change and development towards desired goals. Even though all avenues of education are legally open to females in Nigeria, still a vast majority of them are not only less educated but even illiterate especially in rural areas. Today despite education is free for some children in government schools, the number of girls in schools is more than boys and the dropout rate among girls in schools is ominously high. This is hardly surprising given the fact that in rural society girls from a very young age are expected to stay home and bear the burden of child care, looking after household in order to relieve their mothers who have to work in fields. However, there has been a small improvement in female literacy, the figure today stands perfect compared with percent in 1980s. There is a need for creating awareness among women about the advantages of education, without given proper attention to the female education in the country, it is impossible to achieve the targeted goals of population

2.2.12 Level of Education and Family Planning

Education confers a range of benefits to individuals and societies. (Hannum, 2010) find that countries with better educated citizens tend to have healthier population, as educated individuals make more informed health choices, like longer, and have healthier children. In addition, the populations of countries with more educated citizens tend to grow more slowly, as educated people are able to lower their fertility." Female education, particularly completion of primary school and into secondary school, has emerged as strongly related to lowered fertility. In a study of the spread of primary schooling in sub-Saharan Africa; use contraception practice as a marker of the fertility transition and found that "all countries that have achieved mass schooling also show evidence of having entered the fertility transition." Small amounts of education can result in higher levels of fertility, leading to an inverted U shape relationship, and that the relationship varies across countries

and communities. Generally, higher levels of education are associated with lower levels of fertility control to avoid unintended pregnancies. Using data from 26 DHS, assessed the relationship between female education and wanted fertility and found that more highly educated women did tend to have lower fertility desires, but that unequal implementation of fertility goals by means of contraceptive use appears to be a major factor behind observed differentials. Projection results show that when the education transition rate increases – under the Globa Education Trend (GET) and fast track Educational attainment (FT) scenarios, the Nigerian population growth rate declines. This is mainly due to the fact that having more educated women in the population derives down the national total fertility rate. Although increases in education will also reduce mortality as people with higher levels of education have higher life expectancy.

Moreover, the impact of an increasing education transition rate on life expectancy of the overall population is slightly underestimated. The GET and (GT) scenarios only consider the disparities in life expectancy among people of various education levels, due to improving socioeconomic status, better knowledge about medicine and health, adaption of healthier life styles and sanitation habits, safer working levels of education on life expectancy such as better knowledge to raise healthier children and higher motivation to improve community health facilities.

Family planning enables people to make informed choices about their sexual and reproductive health. Family planning represents an opportunity for women to pursue additional education and participate in public life, including paid employment in non-family organizations.

WHO, 2013 stated that an educated women is close to better health information, and utilization of family planning methods which affects the health of their children. On the other hand illiterate women lack information of taking good care of themselves and their children.

2.2.13 Income Level of Rural women and Family Planning

It is already understood that people with lower income level or socio-demographic status are less chance to get family planning method. Women with high income and higher positions in the society are highly associated to fulfill their responsibility related to family planning. In minimizing child mortality, morbidity and pregnancy cases, sexual transmitted diseases are among the effective prevention. Fertility decreases as income increases; income is directly related to favourable attitudes to family planning, irrespective of caste.

Thus, empirical studies on the relationship between income and fertility highlight that increases in level of income tends to depress fertility at an early stage in certain cases and at a later stage in other cases. This study analyse the impact of changes in level of income on fertility, and finds an inverse relationship between these two. This findings show that, as income goes up from the lowest conceivable limit, fertility also tends to rise progressively up to a certain level, indicating a marked variation of positive correlation between the two. However, beyond that level of income, there appears to be a tendency for fertility to decline. This tends to suggest that minimum economic prosperity may be essential for decline in fertility Umar, (2012).

2.2.14 Religious Perspectives on Family Planning

Islam and Family Planning

Religion is commonly regarded as one of the greatest determinants of family planning in Nigeria. Securing the approval and support of family planning by religious leaders can go a long way expanding utilization and access. However, some Muslims perceive family planning and particularly birth control as immoral. The Quran, though, does not prohibit birth control nor does it forbid couples from spacing or limiting the number of pregnancies (Roudi-Fahimi 2014). The majority of Islamic jurists believe that family planning is permissible. Notably, all Islamic schools, with the exemption of the literalist – Zahiri school of Islam, declare the legality of family planning: for the Hanafi, Makili, Shites, it is subject to consent of the wife (Kebe, 2012). Moreover, there are clear indications in the Quran that says one must take all measures to save the lives of mothers and guard wellbeing: family planning does this by not only lowering maternal mortality, but also morbidity and neonatal and infant mortality (Kebse 2012).

Despite this, some Muslims still oppose family planning small groups of Islamic groups and other jurists oppose family planning on two major grounds. The first is that any practice that prevents pregnancy is infanticide which is repeatedly condemned in the Quran (Roudi-Rahirmi, 2014). The second ground is that the larger the number of Muslims and the larger their population, the greater their power. Even further, some view family planning as a practice imposed by the West to decrease the number of Muslims (Kebe, 2012).

Christianity and Family Planning

The first reference in the Bible on human procreation is found in Genesis 1:28 "Be fruitful and multiply, and fill the earth, and subdue it, and rule over the fish of the sea and the birds of the sky, and over every living thing that moves on the earth".

God has given human beings the power and command for increasing our number in the worlds. However, it does not imply that God intended for this to be done without considering the need for food, space and education. In the next verse, God gave the command for man to eat the fruits of the trees, but does not command to continually eat without considering the effects of our actions. Another Psalm 127 verse 3-5, "Behold, children are a gift of the Lord, the fruit of the womb is a reward. Like arrows in the hand of a warrior, so are children of one`s youth. How blessed is the man whose Quiver is full of them". Some believe since God`s word says children are his gift, we should not prevent conception or plan birth intervals. Planning is involved to achieve the harvest. Some argue that God will provide all the resources that children need. I believe God expects us to make decisions according to what he has given us, and not presume upon him to provide for our needs when we make unreasonable choices.

2.3 Theoretical Framework

Theory and research are very closely interrelated. In –fact there is a strong relationship between theory and research, especially in two ways: on the first hand, theory guides research by providing guidelines and basic assumptions, on the other hand research provides ways of establishing, formulating, strengthening, and revising a theory. "A theory is a set of systematically tested and logically interrelated propositions that have been

developed through research and explain social phenomena" (Sarantakos, 2013). The theoretical framework in relation to these studies are:

2.3.1 Demographic Transition Theory

An alternative to Malthusian theory is the demographic transition theory, developed initially in early 1940s by Kingsley Davis (1945) and extended by Ansley Coale (1974 to 1986) and others (Weeks, 2003). Demographic transition theory proposes that countries pass through a predictable and consistent sequence of population patterns linked to the degree of technological development in the society, ending with a situation in which the birthrates and death rates are both relatively low. Overall, the population level is predicted to eventually stabilized, with little subsequent increase or decrease over the long term.

Population change involves three main stages, according to demographic transition theory. Stage one is characterized by a high birth rate and high death rate. United States during its colonial period was in this stage. Women began bearing children at younger ages, and it was common for a woman to have twelve or thirteen children – a very high birthrate. However, infant mortality was high, as was the overall death rate owing to primitive medical techniques and unhealthy sanitary conditions.

Stage 2 in the demographic transition theory, is characterized by a high birthrate but a lowering death rate, increasing the overall level of the population. Europe are centered stage 2 in the second half of the nineteenth century as industrialization tool hold in earnest. The norms of the day continued to encourage large families, and thus high birthrates, while advances in medical and public sanitation whittled away at the infant mortality rate and overall death rate. Life expectancy increased, and the population grew in size.

Stage 3 of the demographic transition theory by a low birthrate and low death rate. The overall level of population tends to stabilize in stage 3. Medical advances continue, and the general property of the society is reflected in lowered death rates. Cultural changes also take place, such as lowering of the family size most people consider ideal. Demographic transition theory concludes by saying, increase in birthrate will also lead to increase in death rate, there is planning of our family size, there is need to apply this formular by lowering the birthrate in our various societies.

2.3.2 Social Ecological Theory

According to Mcleroy (1988), authors of an Ecological model on health promotion programs.

The importance of ecological models in social science is that they view behaviors as being affected by, and affecting the social environment. Many of the models also divide the social environment into analytic levels that can be used to focus attention on different levels and types of social influences, and to develop appropriate interventions. Thus, ecological models are systems models, but they differ from tradition system models by viewing patterned behavior – of individuals or aggregates – as the outcomes of interest.

There are five levels within this theoretical that is, the individual, interpersonal, community, institutional, and societal. In order to effectively change a persons or a community's attitudes, it is important to be aware of influences from each level. This gives researcher the ability to adapt the program of choice to fit the specific needs on multiple levels for the target population. The application of the theory will based on the following levels.

The individual level – In social ecological theory (SET), is the first level to analyse; some individual factors that may influence women in the rural areas to utilize or not utilize family planning services include a women's personal history as well as biological factors. Some examples of individual influences are a women's knowledge about family planning, her religious beliefs about taking contraception, and personal history of taking contraceptives. For instance, is rural women receives antibiotics for an STDs / STIs and not aware that the medication may make her birth control method ineffective, she may become pregnant and believe that birth control does not work and is a waste of money. A woman who experiences side effects from oral contraceptives, including severe headaches, blood loss or depression, may believe that they are responsible for the way she feels and she may quit taking it. Education is also a factor that may influence a woman's choice to use family planning services. As 2.6% rural women complete primary education and the percentage fall to 0.1% for secondary level education.

Another critical example of an individual level factor is the religious beliefs that woman hold. A women's personnel beliefs or religious may influence her choice to use family planning services. She believes that the number of children she has is a gift from "God" and going against this would be going against her 'God'.

The Interpersonal Level

The second level of the social ecological theory is the interpersonal level, which involves relationship with family friends, peers and others that may influences a woman's decision to use family planning services. One example of a factor at this level is the doctor – patient relationship. Women who perceive their doctor as someone who is trustworthy and trying to help may be more likely listen to the doctor's advice. Conversely, a rural woman

who views the doctor – patient relationship as one where she feels discriminated against or disempowered may be less likely to listen to her doctor's advice.

Another example of an interpersonal level factor is the peer group influence. If the peer group has decided to take control of their sexual health and have supported each other through the process of getting family planning services. If the group is against the idea of using family planning method, the woman who chooses to utilize family planning methods may be shunned by her group of friends.

The community level the community level involves understanding the social networks and social norms of a community which may influence a woman's choice to use or not to use family planning services. The social norms, shared by many rural woman is that, women should be in appropriate attire, not "everyrags" when going to the doctor (Maternowska, 2008). Another social norms is the type of marriage and sexual relationship among the community.

The institutional level – the fourth level of the social ecological theory is the institutional level which involves rules, regulations, and structure of institutions and organizations that may influence a person's choice or behaviour regarding a specific health issue or situation. The lack of rules or regulations in the rural setting for building homes to code is an example of influencing factors of the (SET) within the institutional level. Without proper disaster relief in place, lack of access to quality health care centres or programs that provide quality health care services, especially family planning services, is one of the institutional factors of influence on these women's choice to use such services.

The societal level – the fifth level of the social ecological theory is the societal level. This level involves local, state and federal policies and or laws that influences a person's attitudes. For example, China has implemented and strictly enforced laws regarding the number of children a couple man have. Lack of policies and or laws may be an influence in the poor utilization of family planning services. If the two child policy was implemented in rural setting, family planning services will be utilized.

2.3.3 The Theory of Reasoned Action

Ajzen and Fishbein developed a versatile behavioral theory and model in 1980 called the theory of Reasoned Action. This theory was adapted from understanding attitudes and predicting human behavior. To them, communication and outreach theories can help us to develop our outreach programs by giving us a clear picture or understanding of human communication and human attitudes. This theory details the factor and inputs that result in any particular behavior. Very simply, the model looks like this:

Attitude > > Intension > > Behavior

In this theory, a person's attitude towards a behavior that consists of: (1) a belief that, particular behavior leads to a certain outcome and (2) an evaluation of the outcome of that behavior.

Ajzen and Fishbein (1980) also of the view that if the outcome seems beneficial to the individual, she may then intend to or actually participate in a particular behavior. Also include in one's attitudes towards a behavior is their concept of the subjective norm.

Subjective norm is a person's perception of what others around them believe that the individual should do. In its purest essence, subjective norm is a type of peer pressure. Whether or not a person participates or intends to participate in any behavior is influenced strongly by the people around them. These people may includes friends or a peer group, family, co-workers, church congregation members, community leaders and even celebrities. Within a rural setting, in most cases, a belief that most women who patronize traditional birth attendants (TBAs) during pregnancy and delivery have survive, it may not make others have interest in patronizing such TBAs. In relation to the finding, the theory suggested that every action must be reasoned by both couples, then they execute the plans.

Application of the TRA

Behavour that are associated with high risk and dangers, as well as deviant behavour. In contrast, objectives behavour connote with prior intention. Therefore, people are more likely to practice family planning if they have previously formed corresponding intentions, it is drives from attitude, subjective norms and perceived behavoural control.

Formula for the application

B1= (AB) W1 + (SN) W2

Therefore:

B1 = Behavoural intention
AB = Ones attitude towards performing the behavour
W = Empirically drived weights
SN = Ones subjective norms related to performed the behavour

2.3.4 Health Belief Model (HBM)

The Health Belief Model (HBM) is a model that attempts to explain and predict health behavior (Becker, Drachman, and Kirscht, 1974) by focusing on individual beliefs, perceptions, and attitudes. The HBM has been developed to encompass solutions practical problems in public health services, and was first developed in the 1950's by social psychologists Hochbaum, Rosenstock and Kegels working in the US public health services (Rosenstock, 1974).

The model illustrates that, there will be some predisposing factors that are together with certain enabling and supporting factors will lead people in different directions when they make choices related to how they are to their illness. Predisposing factors involve health beliefs and attitudes forward the illness. The related treatment, as seek help based on a certain medical direction and treatment. It is also includes, more specific health beliefs such as perceived susceptibility to the disease, belief in the diagnosis, and perceived severity of the condition. (Rosenstock 1974) The other main constructs that constitute assessment of the factors that discourage certain health related behavior, whereas "perceived benefits" is an individual's assessment of the factors that are seen as a positive consequence of adopting a certain behavior.

At a later stage the HBM include certain modifying factors such as demographic variables (for instance sex, age ethnicity, occupation, religion), socio-psychological variables (for instance socio-economic status, coping strategies), and the ones to action "(like information provided by powerful others, personals experience) (Becker, 1990). This means that perceptions and experience of socio-cultural factors or direct or indirect

economic costs related to the behavior are all influential. The combination of different factors will continuously be interpreted and evaluated and subsequently the "sum" of lead people in different directions, making different choice related to their health. This study presuppose beliefs related to family planning and reproduction to be an important factor which affects contraceptives use. The health belief model's emphasis on health beliefs fits this presupposition in the sense that it draws attention to people's belief which are regarded as central in understanding a varieties related to family planning. Even though a variety of modifying factors have been added to the HBM, the model has however been criticized for focusing too much on individual factors compared to factors such as socio-economic and environment factors. The strong focus on the individual's part in the model has been suggested to encourage victim blaming and thrusting too much responsibility upon individual's (Roden 2004). Due to the relative strong focus on the individuals.

Application of HBM

To improve in likelihood of engaging in family planning behavours then, we must first look at what environmental constraint may be preventing women from engaging in them and act on those (or help people to overcome problems) also the need to assess whether the person has the necessary skills to access an effectively used of family planning methods. Also able to change attitudes towards performing the behavour, perceived norms about performing the behavour, perceived self efficacy to be able to perform the behavour.

2.4 Empirical Studies

In this section, a review of relevant literature researches will be carried out. The essence is to have a critical look at how other researchers have approached the investigation on the study of knowledge, attitudes and practice of family planning among rural women in Kogi state, Nigeria; but also in other countries.

In a cross-sectional study conducted by Mbouda (2010), from Cameroon. Multi-stage random technique was used, 120 household were selected. Participants were women aged at least 15 years and above, sexually active. Data were collected using interview and structured pre-test questionnaire. A total of 101 women were enrolled, their ages ranging from 18-58 years with a mean of 31.7 ninety-six percent of these women had already heard about family planning. Almost all respondents (98%) were aware of at least one contraceptive method, the most method used is the uses of condom and safe period of (86.1%), injectables (76.2%) and oral pills (75.2%), sixty-six women (65.3%) were currently practicing at least one contraceptive method. The main reasons precluding women practicing family planning were lack of knowledge (31.4%), the division of the number of children to have was made by both the men and the woman in (59.5% of cases). The practice of family planning has been decided by the couple in 39.6% of cases and (9.4%) of men were not aware that their wives were currently practicing contraception. In conclusion, the level of awareness about family planning and contraceptive methods is quite satisfactory, the counseling and education intervention is should be undertaken among women, and family planning messages directed to men need to be included too.

A survey was conducted by Vong, (2010), to study the knowledge; attitude and practice (KAP) of family planning among married women in Banteay, Cambodia, where unmet family planning needs is higher. Structured interviews were performed with 139 married women in rural Cambodians selected through a simple random sampling method. The collected data were used to ascertain addition, the reasons for discouraging or encouraging women to practice family planning were defined.

The results showed that knowledge of modern contraceptives among the respondents is universal, with 99% of women being aware of at least one modern method of contraceptive. The respondents and stakeholders showed a positive attitude in their support of family planning programs, and more than half of the respondents knew where to obtain contraceptive methods. Around 56% of the women were practicing family planning at the time the survey was conducted, with their main reasons being fertility desire despite the side effects of some methods, and to maintain their standard of living.

In study conducted by Stanley (2011), Data were collected among 854 married couples, using a multi-stage sampling design. The concept of family planning was well known in the studied population. Sex-stratified analysis showed pills and injectables were commonly known by both sexes, while long-term contraceptive methods were better known by women and traditional methods by men. Formal education was most important factor associated with better knowledge about family planning methods. (P0-0001), in particular among women (women 2.27 and men -1.99 p-0.001). Only 4 out of 811 men ever used contraception, while 64% and 43% females ever used and were currently using contraception. In conclusion, the high knowledge on family planning did not match with the high contraceptive practice in the study area. The study demonstrate that mere physical

access and awareness of family planning are not sufficient. In family planning, wives and husband should be encouraged to participate.

Odimegbu (2014) carried out a study on the study of knowledge and attitudes among women of reproductive age in Surere, LGA of Lagos state. A sample of one thousand eight hundred and thirty pregnant women was drawn from nine communities. It was discovered that 45% pregnant women were not aware but they do not practice. This suggested that, there is need to increase the dissemination of information on the issue of family planning in the rural setting in our country, Nigeria.

In a study conducted by Adeotu (2010) on the knowledge, attitude and practice (KAP) of family planning methods among women attending antenatal clinic in Jos, North-central Nigeria. This was a cross-sectional study involving 420 women who attended the antenatal clinic. The respondents were interviewed by the use of structured interviewer administered questionnaire. The results revealed that knowledge (88.1%) and acceptability (75.4%) of family planning methods were high, while modern family planning methods use was (44.0%). More women (39.3%) were aware of oral contraceptive pills. Common methods used were made condom (59.5%), oral contraceptive pills (47.0%) and injectable (27.1%) among others. Most of women (60.0%) received their family planning information in the hospital the desire for more children accounted for (36.5%) among those that refused use of contraceptive method after delivery. In conclusion, despite the high educational status, knowledge and acceptability of family planning methods in this study; the practice of these methods is still relatively low. More target and well-organized educational campaigns are needed to improve this trend.

A research study conducted by Shaheen (2006) on "A study of the awareness about family planning practices among Ismaili community" show that highly educated women have favourable attitude towards planning adaptation than less educated women she found that women living in nuclear family have more favourable attitude towards family planning practice. It shows that there is close relationship between economical stability and favourable attitude towards family planning. It is also found that women's involvement in socio-economic activities is not an important factor to adapt family planning practice.

A study conducted by Evelyn (2015), from the department of Adult Education and Human resources studies in Ghana city of Accra, on knowledge and practice of family planning among female basic school teachers in the city of Accra, Ghana. The research design used was on descriptive research design of the survey type, the population of the study is 40,407 female teachers, and sample of 176 female teachers, simple random sampling procedures was used. The instrument for data collection was on Likert type of questionnaire, on the subject matter, and semantic differential scale, this intents to bring out their personal details, level of knowledge, their attitudes towards practice of family planning, the study found out that knowledge and awareness about family planning is associated with the practice of family planning ($r = 0.747$: $P > 0.05$). It further showed that 77.6% were aware of family planning of which 71.3% are practicing one method or the other. Knowledge also correlates with the likeness of family planning among the female teachers ($r = 0.712$: $P < 0.05$). It concluded that Education on family planning must not be limited to only women and female teachers but to their spouses as well.

A study conducted by Olajide (2014) in Ogun State on "Attitude, Knowledge and Utilization of family planning methods Among Rural women in Ogun State Nigeria.

Revealed that the attitude, knowledge and utilization of family planning methods among rural women in Ogun State. Interview schedule was designed to obtain data from the respondents (rural women). Data was gathered from 120 rural women selected from the four zones of Ogun State Agricultural Development Program. (OGADEP). The data collected were analysed using inferential statistics and descriptive statistics such as frequency count, percentage and mean. The result shows that majority (80%) of the respondents were married; while most of them (68%) were within the age of 20 – 35 years. The respondents' sources of information on family planning were from friends and spouses (77%), radio (62%), market place (74%) and health centres (88%). Also (68%) of the respondents utilize pills, (48%) utilize condoms; while 20% of the respondents utilize prolonged breastfeeding as their family planning methods. Significant relationship existed between respondents utilization and knowledge of family planning methods. Correlation analysis showed a significant relationship between factors militating against the utilization of family planning methods and knowledge of family planning methods.

A cross sectional descriptive study of awareness and practice of family planning methods among 200 women of reproductive age attend gynaecology out patient department (GOPD) of Nepal medical college Teaching Hospital from 2009 – 2014, most of the respondents (93.0%) were aware of at least one of family planning methods out of ten methods, but only (65.0%) had ever used if and contraceptive prevalence rate was (33.5%) which was slightly higher than the national data as (28.5%). The best known method of temporary contraception was depo provera (78.0%) followed by oral contraceptive pills (74.0%) and condom (71.0%) and least known methods were vaginal foam tablets/jelly (34.0%) and natural methods (16.0%). Among permanent family planning methods,

awareness about female sterilization (81.0%) was more than male sterilization was quit low (12.0%) as it was newly introduced in the country. Regarding current use of contraception was depo provera (11.0% was the most widely used followed by oral contraceptive pills (4.5%) and condom (4.5%). 5.5% had undergone female sterilization while only 2.5% of male partner had sterilization knowledge of non contraceptive benefits of family planning methods was claimed by only (35.0%) of the respondents, (27.0%) reported awareness that condoms protect from Hiv/AIDs and Sexually Transmitted Diseases (STDs) while knowledge about various adverse effects was widerspread (52.5%). The most common source of Information on contraception was media (55.5%), both printed and electronic. This study also observed that with the increase in education, awareness also increase methods, they are ignorant about the details like duration of protection; return of fertility on discontinuation and non contraceptive benefits. The most common reason of discontinuation was on side effect. A wide knowledge gap was evident in this study, which was similar to the funding of studies done in other developing countries. Improved female education strategies and better problems. The uses of communications media suitable for the audience and adequate message is important in conducting effective family planning awareness activities. Efforts should be made to educate the public about the safety and convenience of modern, long-term, reversible methods of contraception among both healthcare professionals and the public.

A study conduct by Onuwa (2013) on “Knowledge, Attitude and Practice (Kap) of family planning amongst women in a High density low income Urban of Enugu State, Nigeria. A total of 334 Nigerian, non-pregnant women, living in a high density, low income Urban area of Enugu, Nigeria were Interviewed on knowledge, attitude and practice of

family planning. About (97.6%) were found literate, knowledge and approval of family planning was high (81.7%) and 86.2% respectively, but the practice of family planning was low, as only (20%) of the women were on a family planning method. The commonest methods for both ever use and current use were safe period/condoms, IUCD and injectables. The commonest source of family planning information was health workers, while the commonest single reason for non-proactive of a method was rejection by the husband. It is concluded that despite their high level of education/literacy, with the attendant high knowledge and approval rate of family planning, the socio-cultural influence of men on their wives is a major stumbling block to the use of modern family planning in this part of Nigeria. Policy makers should therefore, increase male involvement in family planning programs.

Family planning is regarded as an important prevention measure against maternal and child morbidity and mortality. A study conducted by John (2010) on "Knowledge, Attitude and Practice of family planning methods among women attending ante-natal clinics in Suleja LGA of Niger State. This was a cross sectional involving 440 women who attended the antenatal clinics. The respondents were interviewed by the use of structured questionnaire. The results revealed that, knowledge (88.1%) and acceptability (75.2%) of family planning methods use was (40.0%). More women (39.3%) were aware of oral contraceptive pills. Common methods used were male condom (59.5%), oral contraceptive pills (47.0%) and injectables (27.1%) among others. Most of the women (60.1%) received their family planning information in the hospital. Seventy five percent of the women agreed that both husband and wife should jointly decide for a family planning method. (68%) women would like to use contraceptive methods after delivery of the index pregnancy. In

conclusion, despite the high educational status, knowledge and acceptability of family planning methods observed in this study, the practice of these methods is still relatively low. Effective educational campaign are needed to improve this trend.

The government of India launched a family welfare programme, whose main objective is to spread the knowledge of family planning method and develop among the people and attitude favourable for adoption of contraceptive method. Several (KAP) studies have been conducted. The present study was conducted in Tezu village in implial city. The present paper is an effort to assess knowledge, attitude and practice of family planning (KAP) among the Meitei women of manipur India. The findings show that the maximum educational level of the respondents is matric. Since agriculture is the primary occupation, they are farmers which accounts for 50 percent. Their income ranges between 2000 – 3000. 48 percent of the respondents had the knowledge of tubectomy. As for the family planning method they are using 60 percent are satisfied. 44 percent of the respondents say that it is through friends they come to know about the different contraceptive methods. The percentage is high regarding the attitudes towards approval of abortion. 56% of the respondents agrees to use a method to delay/avoid pregnancy. 50 women were used and randomly selected. This study concluded that socio-demographic characteristics has influence on the practice of family planning method.

A rapid population growth is a burden on the resources of many developing countries. Unregulated fertility, which contributes to such situations, compromises the economic development and political stability of these countries. Contraceptive use is the lowest in yemen where I out of 5 married women of reproductive age use contraception and only I out of 10 married women use a modern method. The study conducted to evaluate the

Impact of Implementing an educational program of family planning upon Yemeni women at Sana's city. The study was on Quasi experimental research design. It was conducted in Al-sabeen Hospital, centre for childhood and motherhood which included a sample of one hundred and forty women (140), divided into two groups: study group and control group (Seventy for each group). It included three tools; social demographic data and women knowledge about family planning, women attitude towards birth control, and educational program about family planning. More than half of the control group (57.1%) of the control had preparatory education. The number of pregnancies was more than two fifth (41.4%) of the study group had three or more times while (58.6%) about two third for the control group. Unwanted pregnancy represented (64.3%) and (57.1%) respectively of both study group and control group – women's knowledge had a poor score on pretest, improve to good score on post-test, and remaining good score with slight decrease on follow up test, their attitudes score were slight positive attitudes on pretest, but increased on posttest and on follow up test. These was highly statistically significant differences between the women' knowledge about family planning in pretest, posttest and follow up test. Family planning program should involve men as well as women, design and implement a strategy to ensure all primary health care clinics provide counseling on family planning.

In a study conducted by Dangat (2013) in Hai district, Northern Tanzania, 65% of the Tanzanian population is under the age of 24 and almost 20% of the population is aged 15-24 years, important group faces many significant health challenges, such as early sexual debut, early pregnancies, risky behaviours and sexual transmitted infections. The objective of this study was to assess knowledge, attitudes and practices on family planning services among adolescents in secondary schools in Hai district in northern Tanzania. A cross sectorial study

was conducted between April and June 2011 among 36 randomly selected students into secondary schools using a self administered pre-tested questionnaire, median age of participants was 17 years (15-19 years). Two-thirds (67-4%) of the respondents had adequate level of knowledge on family planning services (FPS) and the most popular source of information was the radio (65.8%). Being in a lower class (X^2 = 8.6; P<0.02) and FPS most 71.2% (225/316) respondents reported that FPS should not be used adolescents and mentioned several reasons against it used. Less than 6% (18/316) of all respondents had used FP I their lifetime, with 44.4% (8/316) in the past month 33.3% (6/318) in the past year, and 22.3% (4/18) in the past 5 years. In conclusion, most secondary school students in Hai Districts do not practice family planning services despite of adequate level of knowledge on FPS. Interventions to improve utilization of FPS among secondary school students address barriers to low utilization of FPS in this study.

In a study conducted by Omishakin (2015) in Osun state, of Nigeria, this study investigated the knowledge, attitude and practice of family planning among healthcare providers in two selected health centres in Osogbo local government Osun state. The study was conducted to assess the level of knowledge and attitude of healthcare providers towards family planning, to determine the extent tov which the healthcare providers practices the family planning methods. The study sample was 50 healthcare providers that were purposively selected from primary health care centre. Oke-Baale and comprehensive health care centre, Isale-Agbara, both in Osogbo LGA, Nigeria. The data was collected through self-structured questionnaire. The data was analyzed using simple percentages and frequencies counts. The result showed that a good number (98%) knew about family planning while about 44% of them knew all the indicated different attitudes to family

planning methods such that 77.6% believed that family planning does not make users promiscuous contrary to 22.4% of the respondents that believed it makes them promiscuous. More than half (68%) of the respondents use family planning themselves. On the basis of these findings, it was concluded that intensive in-service training, seminars/conference and other forms of enlightenment programmes on all methods of family planning should be put in place, such that they will be able to practice methods best suitable for them.

A survey of 600 Atyap (Kataf) women aged between 15-49 by Avong (2009) in the study, perception and attitude towards Nigeria population policy, family planning programme and family planning in Kaduna State". Discovered that most of the respondents (98%) knew one form of modern method of family planning or the other but nearly all of them do not practice these modern methods of family planning due to fear of risk factors such as sterility, cancer, high blood pressure (HBP), weight increase, or weight loss, or fear of untimely death. A 34 year old undergraduate woman was reported to have made such remarks after been interviewed.

Contraceptive almost killed me if I were not educated. I`m sure I would have died (34 year old undergraduate women). The ascertain above corroborated what Hellandendu (2013) said in the study of violence against females. He observed of artificial fertility regulation techniques are perpetuated by economic; political and gender structure in contemporary societies most of which work to the detriment of women. This is so because most of the artificial contraceptives are directed towards women which have detrimental health effects.

Study conducted by Dauda and Oberiri (2016) in Taraba state, Nigeria, on the perception of married women aged 18-45 or the practice of family planning in Ardo Kola

local government o Taraba state of Nigeria. This study adopted the survey research design method with questionnaire as the instrument used for data collection. The research deployed multi-stage sampling techniques to select 5 wards out of the 12 wards in Ardo-kola, Jauro-ginu Lamido-Borno, Mallam and then sets questionnaire were distributed to 400 respondents gthat were randomly selected from the 5 wards. Data collected were analyzed using simple percentages, frequencies and micro soft excel chart analysis. The study reveals among other things that married women in Ardo-Kola LGA are aware of family planning/method but do not practice family planning because their husband are not favourably disposed to the practice. The study recommends that husbands in Ardo-Kola should be enlightened properly by healthcare providers on the benefits derivable from family planning, and the attendant socio-economic and health problems where the practice is ignored.

Summary

The act of giving birth is the most serious labour in the world. The explosive increase in the nation's population emanating from indiscriminate child bearing. Family planning is a means of by which individuals or couples space space the process of conception pregnancy and childbirth in intervals, mutually determined by both husband and wife in order to have desired number of children that then conveniently cater for many unplanned pregnancies remain unwanted.

Furthermore, a country like Nigeria already burdened with health and economic problems, rapid expanding population will seriously jeopardize the prospect for eradicating pervasive poverty, unemployment, ill-educated, and improving the standard of living of the people. Uncontrolled population growth has been recognized as the single most important impediment to national development.

Family planning services is one of the important strategies in reducing material morbidity and maternity nationwide. (www.safe.motherhood.org/htm2010). Contraceptives allow parents to choose the number they want to have and when to have them. Each year, national demographic health survey (2012) estimated on maternity mortality rate to 600,000 women died, out of 585,000 died during childbirth. And 215,000 pregnancy related complications. To break this vicious threat in our various society specifically in the rural setting, family planning is the best acceptable and practicable way to curb such ugly incidence.

Despite the recent increase in contraceptive use, Nigeria is still characterized by high level of fertility and a considerable unmet need of contraception Delano (2014), the total fertility rate in Nigeria 6.0 birth per women and considerably higher in the rural areas than the urban.

It is important to know why family planning is beneficial. The knowledge of family planning remains the key to attitude and practice of family planning. The reasons for family planning are, preventing unwanted pregnancy, reduced infant mortality, help in preventing veneral diseases like HIV/AIDs, enhance education, slowing population growth, and reducing adolescent pregnancies.

Literature were reviewed on the major variables, the study revealed four (4) theories in relation to this study, they are demographic transition theory by McLerory, the social ecological theory, theory of reasoned action by Ajzen, and health believe model. This study is out to assess knowledge, attitude and practice of planning among rural women in Kogi state.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

The purpose of this study was to assess knowledge, attitude, and practice (KAP) of family planning among rural women in Kogi State, Nigeria. To achieve the above stated Purpose, the research design, the population, sample and sampling procedure, instrumentation, validity of the instrument, pilot study, procedures for data collection and procedure for data analysis are presented and described in this chapter.

3.2 Research Design

Ex-post-facto research design was considered suitable for this study, since there would be no manipulation of information from the respondents by the researcher. Ex-post-facto research design is a method of testing possible antecedents of events that had happened which cannot be manipulated or controlled (Ademuwagun, 2012).

3.3 Population of the Study

The population of the study comprised of 72, 844 rural women of reproductive age (15 – 49years) in Kogi State, Nigeria. Based on the data collected by (World Population Women Data Sheet, 2014), the number of Women in Kogi state was approximately 1,104,117 out of which 72,844 estimate number were rural women of the three (3) already existing senatorial districts in Kogi State.

3.4 Sample and Sampling Procedures

For the purpose of this study, 384 respondents were used as the sample size based on Krejcie and morgan (1970) table for determination, which states that for the population of 70,000 and above, 384 considered adequate for the study. To arrive at the above stated sample size, multi-stage sampling procedure was used as follows:

Stage I – Stratified sampling procedure was used to divide the state into the already three existing senatorial districts, forming three (3) strata.

Stage II – Purposive sampling procedure was used to select two Local Government Areas as purposive sampling procedure According to Patton (2010) purposive sampling procedure is a type of non-probability sampling where the researcher conveniently selects a particular Local Government Wards that meets the characteristics for the study. Therefore, the Local Government Areas that were purposively selected are Omala, Ankpa (Kogi East), Okene, Adavi (Kogi Central) and Kaa and Ijumu (Kogi West). It was selected based on the fact that these local government areas have been categorized majorly on rural areas where the researcher could reach the respondents.

Stage III – Simple random sampling procedure was used to sample one ward from each selected Local Government Areas for the study. The researcher wrote the names of the wards of each local government area selected on pieces of paper, folded and put in a container and shaken thoroughly, without looking into the container, asked one of the research assistants to dip his hand and pick out a folded pieces of paper, and the name of the ward on that pieces of paper was written down. This procedure was followed until, a total of six (6) wards were randomly selected and used for the purpose of data collection as shown in table 3.1.

Stage IV – The researcher and his two instructed research assistants used purposive sampling procedure to administer the questionnaire to rural women of reproductive age (15-49 years) in each world sampled, starting with ward heads household. This procedure continues until required numbers of women of reproductive age in each ward were attained for this study.

Stage V – Proportionate sampling procedure was used to determine the sample size of the respondents. Proportionate sampling was employed due to the difference that existed in the number of persons per sampled local government areas. This sampling procedure was used to give fairness in the total number of respondents per ward.

Table 1: Proportionately Sampled Populations and Sample Respondents per LGAs Ward

S/N	Senatorial Distric	No. LGA`s	Population	Selected LGAs Ward	Population	Sample Size of Respondents
1.	Kogi East	9	24,912	Omala I	12,400	65
				Ankpa II	12,512	66
2.	Kogi Central	5	24,602	Okene	13,762	73
				Adavi-eba	10,840	57
3.	Kogi West	7	23,330	Kabba I	12,675	67
				Ijumu II	10,655	56
		21	**72,844**	**6**	**72,844**	**384**

Proportionate Sampling Procedure Formular

$$\frac{\text{Total population per war}}{\text{Population of the rural women in state}} \times \text{Sample size}$$

$$\frac{10655}{72,844} \times 384 = 56$$

3.5 Instrumentation

The Instrument used for data collection was a closed ended questionnaire developed by the researcher and the Instrument was divided into four (4) sections. Section A consisted of six (6) items on demographic characteristics of the rural women. Section B, consisted of ten (10) items on knowledge of family planning among rural women. Section C, contains ten (10) items on the attitude of rural women towards family planning. Section D, contains of ten (10) items on practice of family planning by rural women. Thus, a total of 36 items constituted the research instrument used for data collection. The research instrument was structured based on the 4 – point Likert scale as shown below:

Strongly Agreed (SA)	4 points
Agreed (A)	3 points
Disagreed (D)	2 points
Strongly Disagreed (SD)	1 point

The Likert scale used allows the respondents to choose options which best describe their feelings for each item in the questionnaire. Note that for each mean score of response to be positive or accepted must be 2.5 and or above, and any mean score of response which

is less than 2.5 is negative or not accepted. The critical value of 0.05 level of significance was used to test the formulated hypotheses.

3.6 Validity of the Instrument

To ascertain the face and content validity of the instrument, copies of the prepared questionnaire were distributed to five (5) jurors in the Department of Physical and Health Education, Ahmadu Bello University, Zaria. The observations and suggestions made by these jurors were implemented by the researcher and a clean draft of the questionnaire was produced for the purpose of pilot testing.

3.7 Procedures for Data Collection

Before the copies of questionnaire were distributed, an introductory letter from the Department of Physical and Health Education were given to the ward heads for the purpose of obtaining permission from them. The copies of the questionnaire were distributed to the rural women of reproductive age (15-49 years as indicated by W.H.O), with the help of two research assistants who were instructed for the purpose of data collection. The two instructed research assistants were graduates in health related fields. The two research assistants are fluent in speaking their local dialects and were used to interpret the items in the questionnaire for the purpose of clarity. The researcher employed systematic sampling procedure to number the households within the selected ward and this procedures continued until the required number of households were attained. In a household where there were more than one (1) women of reproductive age, the researcher and his instructed research assistants purposively administered a copy of questionnaire to the first woman they met. To collect data from respondents, a total of three hundred and eighty-four (384) copies of the

questionnaire were purposively administered to the rural women of reproductive age (15-49 years). Hence, out of 384 copies of questionnaire purposively administered, 379 (98.7%) copies were duly filled and returned, while five (5) (1.3%) copies of the questionnaire were not correctly filled and so these were not included. To be able to collect the data from the respondents, the researcher and his research assistants took three weeks and three days (11th April to 14th May, 2017).

3.8 Pilot Study

To further ascertain the internal consistency and reliability of the research instrument, pilot study was conducted by the researcher at Adogo ward in Ajaokuta local government area in Kogi State. The researcher met the Ward Head and obtained permission from him to conduct the pilot study. And 20 copies of questionnaire were administered to 20 respondents. To sample twenty (20) households, the researcher and his two research assistants systematically numbered 40 households starting from the Ward Head's household as his number one household. The researcher sampled and used only even numbered households, thereby administered a copy of the questionnaire purposively to the first woman of reproductive age that he first met. These 20 copies of questionnaire distributed to the respondents were filled and returned to the researcher on the spot. Thereafter, the retrieved copies of questionnaire were analyzed using statistical package for social sciences version 20 using Cronbach Alpha, Spearman Brown, and Guttman Split-Half on knowledge, attitude and practice. The result showed Cronbach Alpha .690, Spearman Brown coefficient .730 and Guttman split-Half .705 respectively. A research instrument, According to Becher (2015) any research instruments that is 0.5 or nearest to 1 is considered reliable and therefore, could be used for the purpose of data collection.

3.9 Procedures for Data Analysis

The data collected were analyzed using the following statistical tools.

1. Descriptive statistics of frequency and percentage was used to describe the demographic characteristics of the respondents.
2. Mean and standard deviation was used to answer the research questions.
3. One – Sample t-test was used to analyze the formulated hypotheses at 0.05 level of significance.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

The purpose of this study was to assess the knowledge, attitude and practice of family planning among rural women in Kogi State Nigeria. To achieve this purpose, three hundred and eighty four (384) copies of questionnaire were purposively distributed to the respondents. Out of these 384 copies of the questionnaire administered, three hundred and seventy nine (379) (98.7%) copies of questionnaire were adequately filled and returned. The data collected were analyzed and presented according to the order in which they were arranged in the questionnaire. The various responses were, therefore, grouped and tabulated towards ensuring an objective analysis and interpretation of the findings. Descriptive statistic of frequency and simple percentages were used to describe the demographic characteristics of the respondents, means and standard deviation were used to answer the research questions and one sample t – test was used to test the hypotheses formulated for the purpose of this study and the data collected was statistically analyzed, the results of which are presented and discussed in these chapters.

4.2 Results

Before the presentation of results and discussion of key findings, according to the formulated hypotheses the demographic characteristics of the respondents are presented in table 2.

Table 2: Demographic Characteristics of the Respondents

S/N	Variable	Option	Frequency	Percentage %
1.	Age Range	15 – 22 years old	56	14.8
		23 – 28 years old	95	25.1
		29 – 39 years old	105	27.7
		40 – 49 years old	79	20.8
		50 years old and above	44	11.6
		Total	**379**	**100.0**
2.	Level of Education	Quranic School Certificate	48	12.7
		Primary School Certificate	78	20.6
		SSCE	122	32.2
		NCE/ND	67	17.7
		B.Sc/B.Ed/HND	64	16.9
		Total	**379**	**100.0**
3.	Marital Status	Married	358	94.5
		Single	17	4.5
		Widowed	4	1.0
		Total	**379**	**100.0**
4.	Occupation	Housewife	76	20.1
		Trading	127	33.5
		Civil Servant	78	20.6
		Tailoring	35	9.2
		Farming	63	16.6
		Total	**379**	**100.0**
5.	Religious Affiliation	Islam	231	60.9
		Christianity	148	39.1
		Total	**379**	**100.0**
6.	Economic Status per month	Low income (N25,000-49,000 per month	133	35.1
		Middle income (N50,000 – 99,000)	187	49.3
		High income (N100,000 – 150,000)	59	15.6
		Total	**379**	**100.0**

A careful look at table 2 above shows that most of the rural women who responded (105, 27.7%) were in the age range of 29-39 years. Table 2 reveals that majority of the respondents had senior secondary certificate of education 122 (32.2%), 78 (20.6%) had primary school certificate, 67 (17.7%) had national certificate in education, 64 (16.9%) had degree and 48 (12.7%) attended Quranic school respectively. Furthermore, table 2 shows that most of the respondents were married (358, 94.5%), while 17 (4.5%) were single and 4 (1.0%) were widowed. Concerning occupation carried out by the respondents, most of them were traders (127, 33.5%), 78 (20.6%) were civil servants, 76 (20.1%) were full time housewives, 63 (16.6%) of the respondents were farmers, and 35 (9.2%) were into tailoring. Regarding religion affiliation, the table above reveals that many of the respondents (231, 60.9%), practiced Islam and on the other hand, 148 (39.1%) respondents were Christians. With regard to economics status of the respondents, the table also reveals that 187 (49.3%) respondents were middle income earners as from N50,000 to 90,000 base on salary scale. While 133 (35.1%); of the respondents earn N25,000 to N45,000 per month this are classified under low income earners. 59 (15.6%) of the respondents earn between 100,000 and above per month and they are categorized on high income earners.

4.2.1 Answering of Research Questions

Research Question One: What is the knowledge of rural women about family planning in Kogi State, Nigeria?

Table 3: Mean scores of Responses on the knowledge of Family Planning among rural women N= 379

Item	Mean	Std. Dev.
I have heard about family planning	3.4815	1.5764
I know that family planning helps me to have space between my babies	2.6991	1.0509
I am aware of withdrawal method, uses of pills, vasectomy, tubal ligation, sterilization, intra-uterine device, uses of diaphragm, uses of condom and use of calendar	3.6898	1.4896
I know that the use of condom can prevent the transmission of sexually transmitted infections	3.1713	1.4013
I know that uses of pills can help to prevent unwanted pregnancy	2.9907	.9835
I know about family planning through radio, television, friends, primary health care centres, husbands and newspaper	3.1204	1.3997
I know that mothers who do family planning have healthy babies.	3.3519	1.4977
My knowledge of family planning help me to limit the number of my children	2.8333	.9191
I am aware that family planning can improve mother's health	3.2593	1.2138
I know that family planning can control population growth of a country	2.6435	1.0451
Aggregate Mean	**3.1841**	

Observation of Table 3 shows the mean score of the responses on the knowledge of rural women about family planning in Kogi State, Nigeria. The aggregate mean score of the items is 3.1841 which was found to be greater than fixed mean of 2.5, indicated that the rural women have knowledge of family planning in Kogi state.

Research Question Two: What is the attitude of rural women towards family planning in Kogi State, Nigeria?

Table 4: **Mean scores of the attitude of rural women towards family planning**
N= 379

Items	Mean	Std. Dev.
My husband felt that we should not use any method of family planning	2.1031	1.1286
My husband felt that I chose condom as our method of family planning	2.8813	.7159
If the parent postpones the next child, the woman will have better health	2.7546	1.0997
I feel that the use family planning can help to reduce mortality rate	2.2144	.8146
I feel that the use of family planning can control population growth	2.1037	.1564
I don't want family planning because of the side effects	2.3113	1.17335
I feel that the use of family planning can reduce child morbidity	2.8981	.8304
I like family planning because it reduces unwanted pregnancy or abortion	2.5370	1.0777
I like family planning because it gives good health to the child	2.2193	.8338
I like using pills as my family planning method	2.2180	1.0203
Aggregate mean	**2.4241**	

Observation of table 4 reveals the mean score of the responses concerning rural women`s attitude towards family planning. The table shows that respondents attitude towards family planning was not positive as revealed by mean score of 2.42. Even though they had the knowledge of family planning, this knowledge was not translated into positive used.

Research Question 3: What are the practices of family planning among the rural women in Kogi State, Nigeria?

Table 5: Mean scores of responses on the practices of family planning among rural women N= 379

Items	Mean	Std. Dev.
I always go for family planning program	2.0166	.5171
My religion does not permit family planning	2.4124	.7634
The service providers are always not available to provide the service whenever I visit the clinic	2.2051	.7394
I use withdrawal method as my family planning method	2.7131	.8024
I use condom as my method of family planning	2.0039	.5886
I use calendar as my family planning method	2.0516	.8502
I obtain advice from friends on practice family planning	2.2315	.5307
I obey what my religion says about family planning, therefore do not practice	2.0194	.4119
I always read newspaper on the issue of family planning that encourages me to practice	2.3593	.8186
My culture sees family planning as a taboo, therefore, do not practice family planning	2.1511	.6121
Aggregate Mean	**2.2146**	

A careful look at table 5 reveals that rural women do not practice family planning as most of the mean score of responses were below 2.5 which is the fixed aggregate mean. However, the tables 5 indicate that despite their knowledge of family planning, they do not practice family planning methods.

4.3 Hypotheses Testing

Hypothesis one: There is no Significant Knowledge of Family Planning among Rural women in Kogi State, Nigeria.

Table 6: **One sample t-test Analysis on knowledge of Family Planning among rural women**

	Mean	Std. Deviation	t-value	df	P-value
Actual mean	3.1841	1.2577	3.201	378	0.021
Constant mean	2.50	0.00			

t (378) = 1.972, P < 0.05

Concerning the knowledge of family planning among rural women, table 6 reveals that the respondents indicated positive knowledge as shown by a p-value of 0.021 and t-value of 3.201respectively. Therefore, the formulated hypothesis that rural women in Kogi State, Nigeria do not have significant knowledge of family planning was rejected. The hypothesis was rejected because the t-calculated is greater than the t-critical. This means that rural women in Kogi State, Nigeria have positive knowledge of family planning.

Hypothesis Two: Rural women in Kogi State of Nigeria do not have significant attitude toward family planning

Table 7: One sample t-test Analysis on Attitude of Rural Women toward Family planning

	Mean	Std. Deviation	t-value	df	P-value
Actual mean	2.4241	.8762	1.291	378	0.18
Constant mean	2.50	0.00			

t (378) = 1.972, P $\leq$ 0.05

Concerning the attitude of rural women towards family planning, table 7 reveals that the respondents indicated negative attitude as shown by a p-value of 0.18 and t-value of 1.291 respectively. Therefore, the formulated hypothesis that the rural women do not have positive attitude towards family planning was retained because the t-critical is greater than the t-calculated. Hence, though they have knowledge of family planning, this knowledge has not being used to bring about positive attitude.

Hypothesis Three: Rural women in Kogi State of Nigeria do not have significant practice of family planning.

Table 8: One sample t-test analysis on practice of rural women toward family planning

Variables	Mean	Std. Deviation	t-value	df	P-value
Actual mean	2.2164	.6634	1.039	378	1.05
Constant mean	2.50	0.00			

t (378) = 1.972, P $\leq$ 0.05

From the above result of analysis presented, it shows that the probability value is less than 0.05 at 5% level of significance. The t-value value is 1.039 and the t-critical is 1.972 at degree of freedom 378 using two tailed significant level. The null hypothesis which states that "Rural women in Kogi State of Nigeria do not have significant practice of family planning" is therefore retained because the t-critical is greater than the t-calculated. This means that rural women in Kogi state, Nigeria do not practice family planning despite their positive knowledge

4.3 Discussion

The result of the findings on knowledge of family planning among rural women in Kogi state Nigeria was revealed positive using one sample t-test in testing the hypothesis one, the result of the test revealed that t-value of 3.201, while t-critical is 1.972 at 0.05 alpha level of significance with 378 as the degree of freedom, the null hypothesis was therefore rejected that rural women in Kogi State, Nigeria have significant knowledge of family planning. The findings revealed that knowledge of family planning is positive among the rural women in Kogi state, Nigeria. The findings is in consonance with Stanley (2010), and Temmerman (2012), on knowledge attitude and practice of family planning among married women in Jimma zone, Ethiopia mentioned that knowledge of family planning among married women in Jimma was positive with 70% (1,600) of women being aware of family planning. It is also similar to other studies such as Omishakin (2015), in Osun State, Nigeria. This study investigated the knowledge, attitude, and practice of family planning among health care providers in two selected health care centers in Oshogbo Local Government, Area Osun State. The study sampled fifty (50) healthcare providers purposively; the data was analyzed. The result revealed that a good number (98%) of the respondents knew about

family planning, while (44%) respondents knew of all the indicated different attitudes to family planning, while (22%) (65) of the respondents have fear of side effect.

The study also corroborates with John (2010) on knowledge, attitude and practice of family planning methods among women attending antenatal clinics in Suleja Niger state. The study revealed that knowledge of rural women towards family planning is still very positive but the practice and attitude is poor family planning methods despite their positive knowledge. The study also corroborates with Dauda and Oberiri (2016) on perception of married women aged 18-45 on the practice of family planning in Ardo-Kola LGA of Taraba state, Nigeria. This study adopted the survey research design method with Questionnaire as the instrument used for data collection. The result of the study revealed that married women in Ardo-Kola LGA are knowledgeable about family planning but do not practice family planning because their husbands are not favorably disposed to the practice. The study recommends that husbands in Ardo-Kola LGA should be enlightened properly by health care providers on the benefits of derivable from family planning.

The result is similar to Avong (2012) study relating to the reproductive health issues of Atyaps people in Kaduna State in which 98% of those interviewed knew one form of family planning or the other. The same goes for another study on Kaduna State Community Health Workers (CHEWS) by Onwuhafua (2015); virtually all the workers indicated having heard of family planning methods. Dogo and Bala (2014) discovered that awareness of family planning methods was very high among the military personnel in Ribadu Cantonment Kaduna State. This study is in line with Mbouda (2010) from Cameroon, the study reveals that knowledge and positive attitude has been identified but practice is poor, thus their attitudes do not influence their practice.

The result of the study on attitude of rural women towards family planning in Kogi state, Nigeria is Negative. One sample t-test was used to test the hypothesis two. The result of the test shows t-value of 1.291 while t-critica is 1.972 at 0.05 alpha level of significance with 378 as the degree of freedom. The hypothesis was therefore retained. Which stated that rural women in Kogi State, Nigeria do not have positive attitude towards family planning. The findings corrobates with Wahed (2013) study on attitude of women toward family planning method of Kwara resident in Bauchi state, using a sample of 320 respondents. This study revealed that women of Kwara resident have adequate knowledge of family planning but their attitude towards family planning is Negative.

The result of this finding is similar to Chingyayipe (2013) the findings revealed that women in Accra in Kenya have knowledge of family planning but their attitude is poor which influence their practice. The result of these findings is similar to Fogodi (2016) study on knowledge, attitude and practice of family planning among rural and urban women in Benue North, Benue state, Nigeria. This study revealed that women in urban areas have positive altitude than those in rural dwellers due to lack of appropriate knowledge of family planning.

The result of the findings on practice of family planning among rural women in Kogi state, Nigeria is poor. One sample t-test was used to test the hypothesis three. The result of the test shows t-value of 1.039 and t-critical of 1.972 at degree of freedom (378). The hypothesis was therefore retained, which state that rural women in Kogi state Nigeria do not have significant practice of family planning. This means that rural women in Kogi state, Nigeria do not practice family planning. The result of this findings corroborates with Olajide (2012), study on knowledge, attitude and practice of family planning among women of

reproductive age in ogun state. This study revealed that knowledge of family planning is positive but attitude and practice of family planning is Negative. This result of the findings is similar to Odimegu (2014) on knowledge and attitudes of women of reproductive age toward birth control in Surere LGA of Lagos State. The study reveals that knowledge of birth control is very high but the practice of birth control is relatively low. Also, this study is in line with Adeolu (2010), study on knowledge, attitude and practice (KAP) of family planning methods among women attending antenatal clinic in Jos, North Central Nigeria. This study reveals that despite the positive knowledge of family planning, practice of family planning methods is relatively low. The result of this findings also in consonance with Onuwa (2013), knowledge, attitude and practice (KAP) of family planning amongst women in a low income earner in urban area of Enugu state, Nigeria. This study found that knowledge and attitude is positive but practice of family planning was low. The result of this finding is similar to Dangart (2013) in Hai district, Northern Tanzania on (KAP) of family planning. The study revealed that knowledge and attitudes is very high with the respondents but the Hai district women do not practice family planning despite their adequate knowledge and positive attitude.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Summary

The purpose of this study was to assess knowledge, Attitude and Practice (KAP) of family planning among rural women in Kogi state, Nigeria. Three purposes, three research questions and three hypotheses respectively were formulated and tested for this study. Related literature was reviewed under the conceptual framework, theoretical framework and empirical studies. Ex-post-facto research design was adopted for this study. The population of the study comprised of 72,844 rural women of reproductive age 15 – 49 years within the three already existing senatorial districts in Kogi state of Nigeria where two wards were sampled from each local government area for the study. Samples of three hundred and eighty-four (384) respondents were sampled using proportionate sampling procedure. And three hundred and eighty-four (384) copies of questionnaires were purposively administered to the respondents, out of these; three hundred and seventy-nine (379) were dully field and returned. Data collected was analyzed with statistical package for social sciences (SPSS version 20) using frequencies, percentages, mean and standard deviation, one-sample t-test in testing the formulated hypotheses. Null hypothesis one was rejected while hypothesis two and three were retained. The findings of this study revealed that Rural women in Kogi state of Nigeria have significant knowledge of family planning. However, the attitude and practices of rural women in Kogi state towards family planning were negative indicating that even though the rural women have knowledge of family planning, it was not translated into positive used.

5.2 Summary of Major Findings

The following are the summary of the findings;

1. Rural women in Kogi state of Nigeria are knowledgeable about family planning (t=3.201; p value < 0.021).
2. Rural women in Kogi state of Nigeria have negative attitude towards family planning (t= 1.291; p=0.18).
3. Rural women in Kogi state of Nigeria do not practice family planning (t=1.039; p value=1.05).

5.3 Conclusion

Based on the findings of this study, the following conclusions were drawn;

1. Rural women in Kogi state of Nigeria are knowledge about family planning p value < 0.021.
2. Rural women in Kogi state of Nigeria has negative attitude towards family planning p=0.18.
3. Rural women in Kogi state of Nigeria do not practice family planning p value=1.05.

5.4 Recommendations

On the basis of the conclusions drawn, the following recommendations were made:

- Federal, State and Local Government health authorities should encourage women in sustaining their knowledge of family planning through community mobilization and enlighten programme.

- Federal, State and Local Government should organize community programmes for friends/relations where forums of free discussions on family planning can be held for a better understanding of the use of family planning methods.

- The health directorate in collaboration with the family planning unit should roll out more programmes such as organizing workshops and seminars to educate married couples on the benefits of family planning practices; this will bridge the gap between knowledge and practices of family planning.

5.5 Contributions to Knowledge

This study has made concerted effort to:

1. Established useful information on family planning which will continue to serve as source of information research findings.
2. Enable the client to benefit from the awareness programmes that are provided by the health educators in areas that are related to family planning.
3. The study established that rural women in Kogi state of Nigeria have significant knowledge of family planning.
4. The study sensitizes the policy makers in creating policies that would buttress family planning practices.

5.6 Suggestions for further studies

- This study was conducted in Kogi state of Nigeria. The study can be replicated in other states of the country.
- A research can be undertaken on the socio-economic and cultural deterrents to family planning practices among rural women.

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APPENDIX I

QUESTIONNAIRE ON "ASSESSMENT OF KNOWLEDGE, ATTITUDE AND PRACTICE (KAP) OF FAMILY PLANNING AMONG RURAL WOMEN IN KOGI STATE, NIGERIA.

Instruction: Please tick (√) the option which best describes your opinion.

Section A: Demographic Characteristics of Respondents

1. Age Range:

   (a) 15 – 22 years ( )

   (b) 23 – 28 years ( )

   (c) 29 – 39 years ( )

   (d) 40 – 49 years ( )

   (e) 50 – and above ( )

2. Level of Education

   a. Quranic School Certificate

   b. Primary School Certificate

   c. SSCE ( )

   d. NCE ( )

   e. B.ED ( )

   f. B.Sc ( )

3. Marital Status

   a. Married ( )

   b. Single ( )

   c. Divorce ( )

   d. Widowed ( )

e. Separated ( )

4. Occupation

a. House wife ( )

b. Trading ( )

c. Civil Servant ( )

d. Tailoring ( )

e. Farming ( )

5. Religious Affiliation

a. Islam ( )

b. Christianity ( )

6. Economic Status per month

a. Low income (N25, 000 – 49,000) per month ( )

b. Middle income (N50,000 – 99, 000) ( )

c. High income (N100, 000 – 150,000) ( )

Instruction

Please tick (√) against each statement on the space provided which describes your feeling or your opinion

SA – Strongly agree

A – Agree

D – Disagree

SD – Strongly disagree

Section B Knowledge of Family Planning by Rural Women in Kogi State.

S/NO	Item	YES		NO	
1	I have heard about family planning				
2	I know that family planning helps me to have space between my babies				
3	I am aware of the following family planning methods. Please tick (√) as many as you know on the following methods; a. Withdrawal method ( ) b. Uses of pills ( ) c. Vasectomy ( ) d. Tubal Ligation ( ) e. Sterilization ( ) f. Intra-uterine device ( ) g. Uses of Diaphragm ( ) h. Uses of Condom ( ) i. Uses of Calendar ( )				
4	I know that the use of condom can prevent the transmission of sexually transmitted infections.				
5	I know that uses of pills can help to prevent unwanted pregnancy.				
6	I know about family planning through; a. Radio ( ) b. Television ( )				

	c. Friends ( ) d. Primary Health Care Centres ( ) e. Husbands ( ) f. Newspaper ( )				
7	I know that mothers who do family planning have healthy babies.				
8	My knowledge of family planning help me to limit the number of my children.				
9.	I am aware that family planning can improve mother's health				
10.	I know that family planning can control population growth of a country.				

Section C: Attitude of Rural Women towards Family Planning in Kogi State

S/NO	Item	SA	A	D	SD
1	My husband felt that not to use any method of family planning				
2	My husband felt that I chose condom as our method of family planning				
3	If the parent postpones the next child, the woman will have better health.				
4	I feel that the use family planning can help to reduce mortality rate.				
5	I feel that that the use of family planning can control population growth.				
6	I don't want family planning because of the side effect				
7	I feel that the use of family planning can reduce child morbidity				
8	I like family planning because it reduce unwanted pregnancy or abortion.				
9	I like family planning because it gives good health to the child				
10	I like using pills as my family planning method				

Section D: Practice of Family Planning among Rural Women

S/NO	Item	SA	A	D	SD
1	I always go for family planning program				
2	My religion does not permit family planning.				
3	The service providers are always not available to provide the service whenever I visit the clinic.				
4	Mothers with higher level of education practice family planning methods.				
5	I use condom as my method of family planning.				
6	I use calendar as my family planning method				
7	I obtain advice from friends to practice family planning				
8	I obey what my religion says about family planning, therefore do not practice.				
9	I always read newspaper on the issue of family planning that encourages me to practice.				
10	My culture sees family planning as a taboo, therefore, do not practice family planning.				