

**ATTITUDE AND WILLINGNESS TO USE FAMILY PLANNING METHODS AMONG
MOTHERS OF UNDER-ONE AGE IN IBADAN NORTH LOCAL GOVERNMENT
AREA, OYO STATE**

BY

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CERTIFICATION

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DEDICATION

I dedicate this project work to my Faithful Father, Friend, Help and Confidant, God Almighty; who stood by me through this journey and supported me in all areas.

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ABSTRACT

The family planning program is a program designed to share knowledge of family planning and for people to develop an attitude favorable for contraception method adoption. The importance of family planning has come to be widely accepted by developing countries as a method of tackling related maternal health challenges and if done properly it can prevent unintended and high risk pregnancies that often lead to the deaths of mothers and babies. Though the awareness of contraceptive seems to have increased, there still exists a knowledge- attitude and practice gap among mothers, especially in sub-Saharan Africa. This study was meant to assess the attitude and willingness to use family planning methods among mothers of under-one in Ibadan North Local Government Area, Oyo state.

A descriptive cross sectional study was carried out among consenting Mothers of Under-One Age in Ibadan North Local Government Area, Oyo State. Multi-stage sampling procedure was used to select 195 mothers among 3 selected Primary Health Care centers. An interviewer administered semi-structured questionnaire, which included a 14-knowledge, 8-practice, 6-attitude, 7-willingness and 12-factors scales. This was used for data collection. Knowledge scores of ≤ 2 , >2 to 5 and ≥ 5 were rated as poor, fair and good respectively. Practice scores of ≥ 7 were classified as good while attitude scores of ≥ 4 were rated as good. Data was analyzed using descriptive statistics and Chi-square test at 5% level of significance.

Respondents mean age was 29.2 ± 7.3 . Mean knowledge, practice, attitude and willingness scores were 2.1 ± 0.7 , 1.4 ± 0.7 , 1.3 ± 0.4 and 1.2 ± 0.4 respectively. The level of knowledge of FP methods was high among respondents with 83.1% of the respondents having a knowledge of various FP methods. The major sources of information on FP identified were health workers, mass media, friends and neighbours with frequencies of 49.2%, 14.9% and 10.8% respectively. Respondents with poor, fair and good knowledge were 19.5%, 52.3% and 28.2% respectively. Thirty-seven (18.9%) of the respondents said "Yes" to "currently using any FP method" while 81.1% (158) of the respondents were not using any FP method. The FP methods used by the respondents were "Injectable" (43.2%), Condom (29.7%) and then Implants (27.1%). Majority (71.8%) had poor practice of FP methods, 81.0% of the respondents showed good attitude towards FP methods while 19.0% were willing to take up FP practices.

Willingness towards FP willingness was based on the positive attitude of service providers, majority of the respondents (92.8%) agreed that health workers do lay emphasis on the importance of FP.

The level of knowledge of respondents, level of usage and willingness rate towards family planning methods was relatively low. It was observed that the major source of information was the health workers, therefore their knowledge and skills have to be continuously enhanced and strengthened to deliver the right advice which in turn will increase the knowledge of mothers, thereby promoting an effective usage. Education and communication programs targeting mothers should be carried out at various healthcare settings to help mothers make informed decision about family planning method.

Keywords: Attitude, Willingness to use, Family planning methods, Mothers of under-one-age

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Glossary of Abbreviations

BI – Behavioural Intention

CPR – Contraceptive Prevalence Rate

FP – Family Planning

HIV – Human Immunodeficiency Virus

IBNLGA – Ibadan North Local Government Area

IUCD – Intrauterine Contraceptive Device

LAM – Lactational Amenorrhea Method

LG – Local Government

LMIC – Low and Middle Income Countries

MICS – Multiple Indicator Cluster Survey

M-U-1 – Mothers of Under-one

NDHS – Nigeria Demographic Health Survey

NPC – Nigerian Population Commission

PHC – Primary Health Care

PN – Post natal

SN – Subjective Norm

TRA – Theory of Reasoned Actions

UNEP – United Nations Environment Programme

WHO – World Health Organisation

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

In the year 2014, a global death of 290,000 women within the reproductive age was recorded as a result of preventable pregnancy related complications and sub-Saharan Africa accounted for 65% (179,000) of the deaths. It was deduced that women from low and middle income countries (LMIC) are more susceptible to death through pregnancy and unsafe abortion related complications compared to women in the developed countries (Wulifan, Mazalale, Kambala, Angko, Kpinpuo and Kalolo; 2018). There has been a 40% reduction in maternal mortality rate in LMICs over the last decade as a result of adherence to contraceptive use. Contraception adoption lengthens inter-pregnancy intervals and ultimately improves child survival and maternal health outcome (Cleland, Bernstein, Ezeh, Faundes, Glasier and Innis, 2006).

In 1900, the population of the world was estimated to be about 1.7 billion. By 1999, it had risen to 6 billion according to World Health Organization (WHO, 2005) estimate. Presently, 80% of the world population resides in less developed countries and this figure will rise to 90% by 2050 (WHO, 2005). UNEP (2017) recorded that Nigeria has a population of 195,875,237 million and an annual growth rate of 3.3% as reported by Nigerian Population Commission (NPC, 2007), this report declares Nigeria as the most populous country in Africa.

According to Khurfeld (2006), Nigeria is already facing a population explosion with the resultant effect that food production cannot match the growing population. In Nigeria today, the birth rates are higher than the world averages. Contraceptive Prevalence Rate (CPR) is still embarrassingly low in Nigeria. According to the report released by the International women's health coalition, the CPR among married women aged 15-49 years was 8% for modern methods and 12% for all methods (Nwachukwu and Obasi, 2008).

Family planning is an essential component of health care provided during the antenatal period, immediately after delivery and during the first year postpartum (WHO, 2009). Family planning helps people to have the desired number of children, which as a result improves the health of mothers and contributes to the nation's social and economic development. Poor family planning practice leads to short birth spacing between a birth and another pregnancy. The use of family planning methods has been studied to cause a substantial reduction in fertility and also contribute

a reduction in the proportion of unwanted pregnancies thereby reducing maternal deaths (Alege, Matovu, Ssensalire and Nabiwemba, 2016). Also, Contraceptive use has been studied to prevent unintended pregnancies, promote healthy birth spacing and reduce lifetime risk of maternal deaths (Solanke, 2016).

According to WHO (2013), post-partum period begins immediately after the birth of a child as the mother's body, including hormone levels and uterus size, returns to a non-pregnant state. Also, the terms puerperium or immediate postpartum period are commonly used to refer to the first 6 weeks following childbirth. Family planning (FP) is important throughout an individual's and couple's reproductive life. Postpartum family planning (PPFP) focuses on the prevention of unintended and closely spaced pregnancies through the first 12 months following childbirth. Effective family planning programs make the rapid spread of voluntary modern family planning methods possible in any country. Such programs help people achieve their personal reproductive goals (Robey et al., 1994).

1.2 Statement of Problem

Unfortunately, in the sub-Saharan Africa, Nigeria has one of the highest mortality ratios recording 58,000 deaths annually accounting for 19% globally which indicate 800 maternal death/100,000 live births (WHO, 2015). According to the numerous surveys carried out by the DHS, it has been recorded that 92-97% of women do not want another child within 2 years after giving birth. But due to unmet needs, out of 92-97%, only 35% of women had 2 years or less child spacing before the next birth, while 40% of women who intended to use a Family planning (FP) in the first year did not use one (Ross and Winfrey, 2001).

In a study to determine the contraceptive prevalence among women in Ogbomoso, Oyo state, Nigeria, the prevalence was found to be 15% and it was concluded that encouragement should be given to women especially by the health care workers so as to motivate them to employ the use of contraceptives (Adewale, Olugbenga-Bello, Salawu, Aderinoye and Agbaje; 2015). But in a recent study by the Multiple Indicator Cluster Survey (MICS), the prevalence of the use of contraceptive among women of reproductive age was 13.4% which is lower than the result gotten from the study in 2015 (MICS, 2017).

1.3 Justification of the study

The family planning program is a program designed to space knowledge of family planning and for people to develop an attitude favorable for contraception method adoption. The importance of family planning has come to be widely accepted by developing countries as a method in tackling related maternal health outcomes and if done properly can prevent unintended and high risk pregnancies that often lead to the deaths of mothers and babies (Fayehun, 2017). Though the awareness of contraceptive seems to have increased; there still exist a knowledge- attitude and practice gap among mothers especially in sub-Saharan Africa. This study was to assess the attitude and willingness to use family planning methods among mothers of under-one in Ibadan North Local Government Area, Oyo state.

1.4 Research questions

1. What is the level of knowledge of family planning methods among mothers of under-one (M-U-1) in Ibadan North Local Government Area (IBNLGA)?
2. What is the practice of family planning methods among mothers of under- one?
3. What is the attitude towards family planning methods among mothers of under-one in IBNLGA?
4. What is the willingness of mothers of under-one to use family planning methods?
5. What are the factors responsible for the use of family planning methods among mothers of under-one in IBNLGA?

1.5 Objectives of Study

The broad objective of this study was to investigate the Attitude and Willingness to use Family Planning Methods among Mothers of under-one in Ibadan North Local Government Area, Oyo state.

1.5.1 Specific Objectives

The specific objectives were to:

1. Assess the level of knowledge of family planning methods among mothers of under- one in Ibadan North Local Government Area (IBNLGA)?
2. Explain the practice of family planning methods among mothers of under- one.

3. Explore the attitude towards family planning methods among mothers of under-one in IBNLGA.
4. Examine the willingness of mothers of under- one to use family planning methods.
5. State the factors responsible for the use of family planning methods among mothers of under-one in IBNLGA.

1.6 Research Hypotheses

The following null hypotheses were tested

- There is no significant relationship between socio-demographic characteristics (age, level of education, religion, marital status, Number of children, employment) and the use of family planning methods among mothers of under- one in IBNLGA
- There is no significant relationship between knowledge and use of family planning methods among mothers of under- one in IBNLGA
- There is no significant relationship between attitude and use of family planning methods among mothers of under- one in IBNLGA
- There is no significant relationship between willingness and use of family planning methods among mothers of under- one in IBNLGA
- There is no significant association between factors responsible for family planning use and use of family planning methods among mothers of under- one in IBNLGA

1.7 Study Variables

Independent variables

- Mothers socio-demographic characteristics

Dependent variables

- Knowledge of family planning methods
- Practice of family planning methods being used
- Attitude towards family planning methods
- Willingness rate to use any of the family planning methods
- Factors associated with the use of family planning methods

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

Family planning is a practice which involves controlling the number of children in a family and the spacing between their births by means of artificial contraception or voluntary sterilization (Abdikadir, 2018). Childbirth is a process that refers to the total process through which an infant makes its way down the birth canal to the outside world (Stevens and Roe, 2004). It usually is an exciting phase in a woman's life, but it could come with mixed feelings especially if the baby was not planned for. Family planning according to World Health Organization (WHO, 2007) allows individuals and couples anticipate and attain their desired number of children and the spacing and timing of their births (Shaw, 2010).

Postpartum family planning (PPFP) is a program designed to help women decide on the family planning method they want to use, and to initiate the method, and continue the contraceptive method for 2 years or longer depending on the reproductive intentions of the woman or the couple (WHO, 2013). A major public health challenge among women of reproductive age especially in developing country is unplanned pregnancy also known as unexpected pregnancy. It has been estimated that of the 210 million pregnancies that occur annually worldwide, about 38% (80 million) are unplanned, and 22% (46 million) end in abortion (Lamina, 2015). An estimate of 200 million women in developing countries would like to delay their next pregnancy or stop bearing children altogether, but many of them still rely on traditional and less effective methods of contraception or use no method at all.

Oye-Adeniran et al. (2006) conducted investigation on community based contraceptive behaviour in Nigeria, using 2001 female respondents. The results established that of 2001 respondents, only 22.1% had ever used a contraceptive. Among those who had heard of ways of preventing or avoiding pregnancy, only 32.9% had ever used a method. Specifically, among those who have known about contraception, 73.7% in Southeast, 64.2% in Northeast, 58.1% in Northwest and 53.5% in Southwest had never used or tried any method. Among those who had ever used contraceptives, the most common method was the pill (Oye-Adeniran et al., 2006).

In another study by Osei, Birungi, Addico, Askew and Gyapong (2005) on contraceptive use among married women in Ghana using a sample of 2,500 women of reproductive age, the results of this study measured the usage level of the known contraceptive methods: IUCD, 1.9%,

combined pills 22.3%, mini pills 2%, male condom 11.1%, female condom 1.2%, injectables 54.7%, foaming tablets 4.1%, female sterilization 0.2%, and implant 1.0%. The injectable was the most commonly used. These findings also ascertained a low level of contraceptive methods in Ghana.

According to WHO fact sheet (2011), 214 million women of reproductive age in developing countries who want to avoid pregnancy are not using a modern contraceptive method. Reasons for this include:

- Limited access to contraception, particularly among young people, poorer segments of populations, or unmarried people
- Fear of health risks and side effects of contraceptives.
- Cultural and religious opposition
- Poor quality of available services
- Users and providers bias
- Gender-based barriers
- Lack of awareness about the available family planning methods, health benefits and side effects
- Opposition to use by partners or family members

A continuous learning process of modern family planning methods with having a positive attitude for these methods may increase the rate of usage of these methods and contribute towards the development of healthy communities.

2.1 Family Planning Methods

There are two major methods of family planning. These are the modern and the traditional methods. The modern methods as explained by a WHO handbook (2018) include hormonal contraceptive methods, implants, intrauterine devices, barrier methods, and female and male sterilization. While the traditional methods of contraceptive are calendar based, withdrawal methods, Lactational Amenorrhea Method (LAM).

2.1.1 Modern Methods

Hormonal methods contain either one or two female sex hormones that are similar to the hormones naturally produced by a woman's body and they work to stop the ovaries from releasing eggs.

The implants are small flexible rods or capsules, each about the size of a matchstick, that release a progestin hormone. Contraceptive implants are inserted under the skin of a woman's upper arm and provide continuous, highly effective pregnancy protection for 3 to 5 years, depending on the type of implant. Intrauterine contraceptive devices (IUDs or IUCDs) are small, flexible plastic devices that are inserted into the woman's uterus through her vagina and cervix. It works primarily by causing a chemical change that damages sperm and egg before they can meet.

Barrier methods are devices in form of male and female condoms that physically block sperm from reaching an egg, or chemicals (spermicides) that kill or damage the sperm in the vagina. The correct use of this method determines how effective this method would be to the people each time they have sex. Condoms are the only contraceptive method that prevents pregnancy and at the same time sexually transmitted infections including HIV.

The surgical methods are methods meant to provide life-long, permanent and very effective solution to getting pregnancy and it is irreversible in most cases. There are two methods related to the male specie and female specie which are vasectomy and female sterilization respectively.

2.1.2.1 Traditional or Natural Methods

The calendar method is one method whereby a woman monitors her pattern of menstrual cycle over 6 months, subtracts 18 from shortest cycle length (estimated 1st fertile day) and subtracts 11 from longest cycle length (estimated last fertile day). The couple prevents pregnancy by avoiding unprotected vaginal sex during the 1st and last estimated fertile days, by abstaining or using a condom. The withdrawal method suffices in that the man withdraws his penis from his partner's vagina, and ejaculates outside the vagina, and this keeps the semen away from her external genitalia.

The Lactational Amenorrhea Method (LAM) is a temporary contraceptive method which is based on the natural effects of breastfeeding on preventing fertility. It provides contraception for the mother and best feeding for the baby, it can be effective for up to 6 months after childbirth, as long as monthly bleeding has not returned and the woman is fully or nearly fully breastfeeding. Requires breastfeeding often, day and night. Almost all of the baby's feedings should be breast milk. It offers a woman the opportunity to continue on a method that can be used after 6 months. It works primarily by preventing the release of eggs from the ovaries

(ovulation). Frequent breastfeeding temporarily prevents the release of the natural hormones that cause ovulation.

2.2 Knowledge and Usage of Family Planning

In designing an adequate prenatal care to prevent unwanted pregnancies and illegal abortion, the knowledge and usage or non-usage of contraceptives is key (Afolabi, Ezedinachi, Arikpo, Ogunwale, Ganiyu, Abu and Ajibade; 2015). The use of contraceptive is not an issue openly discussed among young women and as a result of strong cultural and religious beliefs and this has exposed young women to increased risk of unwanted/unintended pregnancies (Nsubuga, Sekandi, Sempeera and Makumbi, 2016).

In a study to assess the knowledge of family planning practices, Tunde-Ayinmode (2013) carried out a study among 100 women in a teaching hospital in Ilorin where it was discovered that 88% of them had good knowledge about family planning but 27% of them had not used any method.

To identify the knowledge status of women about family planning methods, Adeyemi et al. (2015) conducted a study on contraceptive prevalence in Ogbomosho, Nigeria, using 560 women of reproductive age. From the result, it was recorded that only 49.7% (271) had ever used any of the FP methods while just 25.4% of the 271 used a method at the time of the study. The methods used were the traditional type (5.9%), natural type (3.0%) and modern type (91.1%). It can be inferred from these studies that FP methods were not practiced probably due to personal reasons not because of lack of information.

Both men and women need to have adequate information as regards contraceptive about its safety, effectiveness, affordability and the acceptable birth control method as this will help in child birth planning thereby reducing maternal health outcomes and infant mortality. As regards having the right knowledge of where to get the family planning methods, Stephen, Matovu, Ssensalire and Nabiwemba (2016), carried out a research on Knowledge, sources and use of family planning methods among women aged 15-49 years in Uganda: a cross-sectional study. The results show that majority of the women were less than 30 years of age (64.3%). Nearly three-quarters were married (73.1%), 51.1% had primary education and more than half (57%) were engaged in employment. On whom to trust as regards FP methods, the clinic providers with 60.4% was indicated, also friends (56.9%) and the media (51.3%) were the most trusted sources of contraceptive information. Government (27.6%) and private (21.1%) health facilities were the

main sources of modern FP methods. The results indicated that the knowledge of FP methods was universal (98.1%). While among the non-users of FP, injectables (50.4%), implants (22.8%) and pills (20.2%) were the most preferred FP methods.

It has been concluded that it is imperative for reproductive health programs to increase their efforts in improving women's knowledge of modern FP methods and also promote partner communication in order to raise contraceptive prevalence rate (Tengia-Kessy and Rwabudongo; 2006).

2.3 Attitudes towards family planning

Attitude refers to the positive or negative feelings or tendencies of an individual about an idea, an object or a symbol. According to Bohner, the attitude is anything that a person actually possesses and that he realizes later. Attitudes naturally affect beliefs as well. Behaviors and attitudes play an important role among the choice of using family planning methods and so it effects the change of fertility status and population rate indirectly. In order to promote the usage of an effective method, attitudes and behaviors play an important role on preference of choosing a family planning method. The identification of attitudes that affect the use of the family planning method by individuals is an important factor contributing to the scheduling of family planning services (Bohner et Wanke; 2002).

Various studies conducted have found that most women have the knowledge of the methods of family planning but have a lack of practice. This is because individuals have a negative and prejudiced attitude toward modern methods (Tanriverdi et al., 2008). It is known that positive or negative attitude affects the use of family planning method. After obtaining information about family planning methods, most people emotionally empower themselves with the information and ultimately turn their attitudes toward this information into positive or negative behavior (Çayan; 2009). Individuals' attitudes for family planning methods are influenced by some characteristics, such as economic factors, sociocultural factors, environmental factors, location, age, educational, traditional beliefs, religion, family type and level of knowledge. It is known that these factors have effects on turning the attitudes into behaviours.

Giman (2005) conducted a study among married women of reproductive age in Cambodia using a sample of 140 married women of reproductive age. The result of the survey revealed that regardless of socio-economic status, respondents showed positive attitude towards modern

family planning methods. About 68% of respondents had previously used some modern contraceptive methods and 56% were using contraception at the time of the study. Among the current users, the majority were pill users (44.6%) and only 8% were using male condom as a method of family planning. Implant, intra-uterine contraceptive device (IUCD) and female sterilization all were used by less than 1.5%. Among all respondents, 56% were using some methods of modern contraceptives while 44% were not using any method. Among the non-users, 32% did not intend to use them in the future either. Twenty-nine per cent (29%) of current users were concerned about using modern methods to their rumored side effects. However, there is likely no other choice or methods which do not have side effects. About 8% adopted modern family planning to avoid a lower standard of living brought about by the cost of child-bearing and difficulty in looking after many children among others.

2.4 Practice of Family Planning

A good number of researches have been conducted on attitude to and practice of modern family planning methods among women of reproductive age in many parts of the world including Nigeria. However, there is still a very low prevalence on the use of these modern FP methods especially among post-partum mothers which lead to inappropriate birth spacing among the number of births. Underwood (2000) in his study on Islamic precepts and family planning in Jordan, consisting 630 women of reproductive age reporting on the acceptability of specific modern methods, 65% said the pill was acceptable, 70% the IUCD, 16% tubal ligation and 63% injectables. Among women who were not using a contraceptive method at the time of the study, only 1% mentioned difficulty of selecting a method or lack of affordability as a reason for non-use. It can be concluded from the result of the study that contraceptive practice was in use but the barrier method was not practiced.

2.5 Factors influencing the use of Family Planning among Mothers of under-one

Several factors influence the use of family planning processes among women. In a study to identify factors influencing contraceptive use and non-use among women in Nigeria, Solanke (2016) identified that socio-demographic characteristics contribute greatly to the non-use of modern contraceptive use. Characteristics such as maternal age, parity, age at first birth, child mortality experience, fertility desire, ideal family size, maternal education, place of residence,

employment status, geographic region and remarriage significantly influenced the non-usage of family planning methods while parity, maternal education, fertility desires and geographical region significantly influenced modern contraceptive use.

Gender indicates the characteristics, positions and roles of man and woman in all social relationships. But in most studies on family planning, women are usually on the front line of factors that affect socioeconomic outcomes. For age, a commitment to supporting gender equality in economic outcomes has underlined women's empowerment. However, despite important advances toward equality, differences in the socioeconomic outcomes of men and women still persist. If the population is increasing by forcing natural resources and economic opportunity, the necessity of implementing effective and adequate family planning in the society is emerging. With industrialization, families have better economic opportunities and social security. Thus, aggravating living conditions and taking more roles in women's work life reduces the desire to have many children (Sensoy Korkut, Akturan, Yilmaz, Tuz et Tuncel; 2017)

A woman's desire to have a small family size in order to stay healthy, with more time to look after their children and to participate in the work force is also factor that promotes the use of family planning methods.

2.6.1 Benefits of Family Planning Methods

- According to Andrew Kaunitz (2011), effective contraception has been studied to provide both health and social benefits to mothers and their children, since these methods help to reduce unplanned pregnancies and unintended abortions and also provide an avenue for child spacing
- Family planning prevents closely paced and poorly-timed pregnancies and birth which has contributed majorly to the world's infant mortality rates (WHO; 2018)
- Family planning aids people in making informed choices about their sexual and reproductive health. It presents opportunities for women to have an educational pursuit and enjoy a public life including getting to work in non-family organizations
- A smaller family size encourages parents to invest more in the education of their children
- Family planning is a factor to reducing the population growth and the negative impacts on the economy, environment and regional development efforts

2.7 Conceptual Framework

The Theory of Reasoned Action (TRA)

TRA was propounded by Icek Ajzen and Martin Fishbein (1975 and 1980) to show how attitude impacts on behaviour. The components of TRA are three general constructs: Behavioral Intention (BI), Attitude (A) and Subjective Norm (SN).

TRA suggests that a person's behaviour intention depends on the person's attitude about the behaviour and subjective norms. To put the definition into simple terms, a person's volitional (Voluntary) behaviour, is predicted by his or her attitude towards the behaviour and how he or she thinks other people would view them, if they performed the behaviour (Ajzen and Fishgerbein, 1975). $BI = A + SN$

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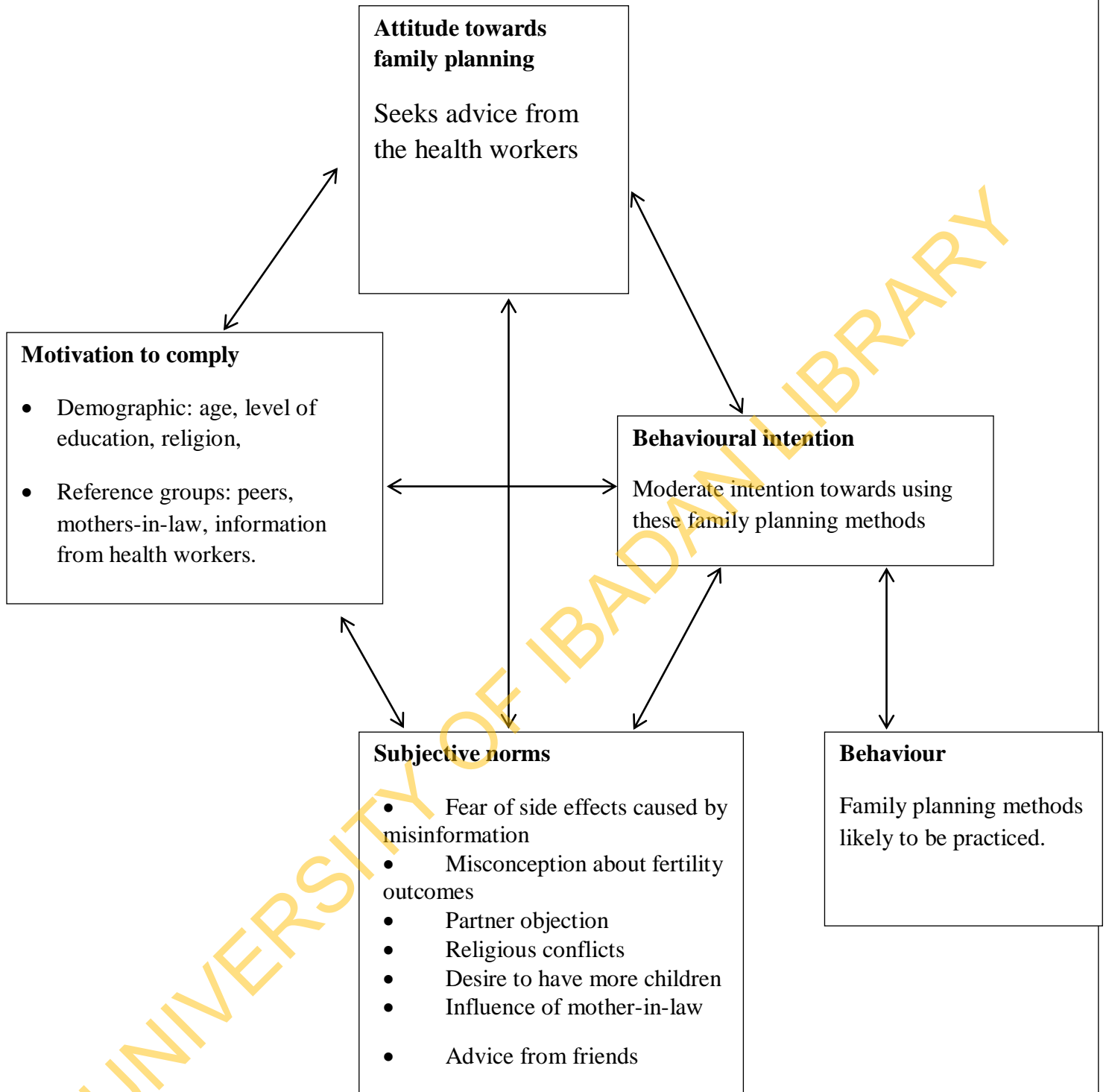


Figure 2. 1 - Theory of Reasoned Action (Ajzen and Fishgerbein, 1975)

CHAPTER THREE

METHODOLOGY

This section describes the type of research design that was employed for this study, research participants, sampling method, instruments, data collection procedures, validity and reliability of the test, statistical treatment and analysis of data and ethical issues.

3.1 Study Design

A descriptive cross-sectional survey was used. A cross-sectional study involves looking at data from a population at one specific point in time. The participants in this type of study are selected based on particular variables of interest.

An interviewer-administered questionnaire was employed to collate data from respondents. The questionnaire was translated to Yoruba which is the local language and translated back to English. The questionnaire measured the types, attitude, willingness of women attending post-natal clinic towards family planning methods and also the promoting or hindering factors in Ibadan North Local Government Area.

3.2 Description of The Study Area

Ibadan North Local Government (IBNLG) has an area of 27km² with a land mass of 132,500km². As at the 2006 census, it had a population of 308,119 people (Brinkhoff, 2017). It has a population density of 2,626 persons per square meter. The Local Government (LG) was one of the LGs carved out of the old Ibadan Municipal; it has its administrative headquarter at Bodija. It consists of 12 wards and is governed by an elected Chairman and 12 councilors per, one per ward.

It is bounded by Akinyele and Lagelu LG to the North, Egbeda LG to the East, Ibadan North West LG to the West and Ibadan North East LG to the South. It has a bustling academic and economy activities, with the presence of the first university in Nigeria. It has little or no farming activities but is a home for small, medium and large scale industries. It has the highest concentration of virtually all different tribes and ethnic groups in the country (Wikipedia).

The study was carried out among Primary Healthcare Clinics (PHCs) in Ibadan North Local Government (IBNLG). There are 16 Primary Healthcare Clinics (PHCs) in Ibadan North Local Government (IBNLG) - check table 3.1 to see the list - but Three (3) PHCs were selected for the study. The study was carried out among women attending the post-natal clinic in the selected PHCs in the local government.

Table 3.1: List of Primary Health Centres (PHC) In IBNLGA

S/N	PHC	ADDRESS/LOCATION
1.	Agbowo PHC	Apata Transformer Bus stop, the road beside Hamdala Hospital.
2.	Agodi-gate health Clinic	Staff Clinic, Council secretariat.
3.	Ago-tappa PHC	Behind the Group Medical Hospital, Mokola.
4.	Ajose Health Clinic	NITEL area.
5.	Ashi Health post	Baale's compound, Ashi.
6.	Barika PHC	Opposite U.I Second Gate, around L. Adisa house.
7.	Basorun PHC	Iyana Oluwo-nla area, shortly after Pharmalot Pharmacy, Basorun
8.	Bodija PHC	Ilupeju-Bodija, around Mount Olive Primary School.
9.	Idi-Ogungun PHC	Bus Stop Gate, beside the Police Station.
10.	Mokola health Clinic	Beside Oba Akinbiyi High School, Mokola.
11.	Obasa health Clinic	Road opposite GT bank, Obasa.
12.	Oke-Are Health Clinic	Beere customary court area, Beere.
13.	Oke-itunnu clinic	The Blood of Jesus church, beside Aanu Hospital, Oke-itunnu.
14.	Sabo health Clinic	Suya corner area, Sabo.
15.	Samonda Health Clinic	Lighthouse Church Area Bus stop, Samonda.
16.	Sango PHC	Opposite Ibadan Polytechnic main gate.

3.3 Inclusion criteria

- Mothers of under-one children who attended PN clinic and willing to participate
- Mothers who were breastfeeding
- Women within the reproductive age (15-49).
- Mothers who gave consent to take part in the study

3.5 Exclusion criteria

- Mothers who did not have under-one children.
- Mothers who did not give informed consent to participate in the study.

3.6 Sample size determination

The sample size for this study was estimated using Leslie Kish formula for single proportion which is:

$$n = \frac{Z^2 pq}{d^2} \text{ (Leslie Kish formula)}$$

Where:

N= sample size

$Z\alpha$ = standardized normal deviation which is a constant of 1.96 at 95% confidence interval

$$Z^2 = 1.96^2 = 3.8416$$

$p = 13.4\% = 0.134$ prevalence rate according to a study by Multiple Indicator Cluster Survey (MICS, 2017)

$$q = 1 - p = 1 - 0.134 = 0.866$$

$d = 0.05$ at 95% confidence interval = 0.0025

$$n = \frac{Z^2 pq}{d^2} = \frac{1.96^2 \times 0.134 \times 0.866}{0.05^2}$$

$$n = 177.03 = 177 \text{ samples}$$

Considering a non-response rate of 10% of 177 = 177 x 10% = 17.7 approximately is 18.

Therefore, 18 was added to the sample size calculated to make the sample size **195** in order to address issues of incomplete response.

3.7 Sampling technique

The eligible participants were selected by multistage sampling techniques as follows:

Stage 1: A simple random sampling was carried out among the 16 Primary Healthcare Centers (PHCs) in the LGA to select the 3 PHCs used for the study.

Stage 2: Proportionate sampling was carried out to determine the number of women from each PHC that were involved in the study.

3.8 Instrument for data collection – A Questionnaire

The method employed for data collection was the quantitative method of collecting data. This involved the use of interviewer-administered questionnaire. The questionnaire was developed using information obtained from literatures.

The instrument had five (5) sections. The first section was designed to elicit data on socio-demographics of the respondents; the second section documented the types of family planning methods known among the respondents; the third section assessed their perception towards family planning methods. Section four documented their attitudes towards family planning methods, section five documented their willingness towards the use family planning methods and section six identified the factors that promote family planning methods among women attending post-natal clinics in IBNLGA (Appendix II).

3.9 Validation of instrument

Validity of an instrument refers to the degree to which that instrument measures consistently and accurately what it is intended to measure in the context of the phenomenon of interest (Schmidt and Brown, 2012). Validity of a research is enhanced by improving face, content, construct, and criterion validity of the measuring instrument. To establish validity of the instruments, the researcher ensured validity of the instrument by reviewing relevant literatures.

The supervisor in charge of this study gave a valid template of how the instrument should be and also made useful corrections and suggestions before the administration of the questionnaire to the study participants.

3.10 Reliability of instrument

Reliability of an instrument is a measure of the consistency in which the instrument will measure what it is supposed to measure (Mugenda, 2000). An instrument is reliable if it gives similar results after several administrations under similar conditions.

In establishing the reliability of the instrument, the researcher applied the Pre-test technique. The questionnaire was pretested among Mothers-of-under-one in PHC at Iwo-road, Ibadan North East LGA because it had the same characteristics with the purposed sample population of Ibadan North being urban Local Government. As mentioned above, 10% of the total sample size was administered and tested through measures of internal consistencies using the Cronbach's alpha. A co-efficient analysis of >0.80 confirmed its reliability being greater than > 0.5 .

3.11 Data collection procedures

For the study, serially numbered interviewer-administered questionnaire was used. The data was collected by the researcher with the help of two (2) research assistants who were trained prior to the time of data collection. The benefits and possible harms that may arise as a result of participating in the study were explained to the research participants. The informed consent form (attached to the questionnaire) was distributed to the potential participants after they had been given adequate information about the study. Then, after the questionnaires were filled, the researcher checked for completeness and errors before leaving the field.

3.12 Data Management and Analysis

Serial numbers were written on the copies of the questionnaire for easy entry and recall. A coding guide was developed along with the data collection tool in order to facilitate its analysis. Questionnaire was reviewed to ensure consistency and completeness. Cleaning, recording and coding of data for analysis were also be done. Using the coding guide, the data collected was carefully entered into the Statistical Package for Social Science (SPSS version 20) and analysed using descriptive statistics such as mean, median and mode and inferential statistics such as Chi-square. The results obtained from the SPSS analysis were summarized and presented in tables and charts.

3.13 Study limitation

A limitation for this study is that it was carried out in a PHC which offer various health services to mothers but the study was restricted to only Mothers-of-under-one who were receiving post-natal services at the selected PHCs in Ibadan North local government of Oyo state Nigeria.

3.14 Ethical approval

Ethical approval was sought and obtained from the Oyo State Ministry of Health research ethics committee before going to the field for data collection (refer to page 75). Informed consent was obtained from the participants. To ensure confidentiality of research participants, identifiers such as names and other information that can reveal the identity of research participants was not included in the research instrument. The nature of the study, benefits and objectives was explained to the respondents and they were assured that the information given would be treated with utmost confidentiality. Participants were also intimated about the opportunity to withdraw their consent freely at any point during the study. Confidentiality of each participant was maximally maintained during and after the collection of their information. Information gathered from the respondents was stored in the computer for analysis by the researcher while copies of the filled instruments were kept for maximum safety.

CHAPTER FOUR

RESULTS

4.1 Demography

One hundred and ninety-five (195) mothers were enrolled for this study, they were randomly selected from 3 Primary Health Care centers in Ibadan North Local Government Area: Agbowo PHC, Idi-ogungun PHC and Sango PHC.

Majority of the respondents were married (96.9%) while (3.1%) were single mothers. Age of respondents ranged from 17 years to 47 years with a mean age of 29.2 ± 7.3 . More than half of the respondents were of the age range of 20-40 (94.4%). The respondents were predominantly of Yoruba ethnic group (81.5%) followed by Igbo (12.8%) and Benue (2.6%), the other tribes represented were Hausa (1.0%), Ijaw (1.0%), Edo (0.5%) and Senegal (0.5%). Majority (58.5%) were Christians, 41.5% were Muslims (Table 4.1).

Six occupational groups were represented in this study: trader (42.1%) civil servant (6.7%), artisan (21.0%), self-employed (20.0%) and professionals (5.1%); some of the respondents were students (3.6%). Majority of the respondents (52.8%) had only secondary education, however, a small proportion of the respondents (1.0%) did not have any form of formal education. 37.4% of the respondents earn a monthly income between 10,000 - <30,000 naira (Table 4.1).

The socio demographic characteristics of the respondents' husbands showed that 43.1% had at least a secondary school education and majority (27.2%) of them are traders (Table 4.1).

Table 4. 1: Respondents Socio-demographic Characteristics (n=195)

SOCIO DEMOGRAPHY	FREQUENCY	PERCENTAGE (%)
AGE		
< 20	8	4.1
20-40	184	94.4
> 40	2	1.0
No Response	1	0.5
TRIBE		
Yoruba	159	81.5
Igbo	25	12.9
Hausa	2	1.0
Others	9	4.6
RELIGION		
Christianity	114	58.5
Islam	81	41.5
MARITAL STATUS		
Single	6	3.1
Married	189	96.9
EDUCATIONAL LEVEL		
No Formal Education	2	1.0
Primary	8	4.1
Secondary	103	52.8
Tertiary	80	41.1
No Response	2	1.0
HUSBAND'S EDUCATIONAL LEVEL		
No Formal Education	1	0.5
Primary	2	1.0
Secondary	83	42.6
Tertiary	95	48.7
No Response	14	7.2
OCCUPATION		
Trader	82	42.1
Civil Servant	13	6.7
Artisan	41	21.0
Self-Employed	39	20.0
Professionals	10	5.1
Students	7	3.6
HUSBAND'S OCCUPATION		
Trader	53	27.2
Civil Servant	30	15.4
Artisan	35	17.9
Self-Employed	49	25.1
Professionals	17	8.7
Students	3	1.5
Clergy	2	1.0
No Response	6	3.2
MONTHLY INCOME (NAIRA)		
< 10,000	21	10.8
10,000 - < 30,000	73	37.4
30,000 - < 60,000	34	17.4
>60,000	10	5.2
No Response	57	29.2

4.2 Knowledge of Family Planning

The level of knowledge of family planning methods is high among the respondents with (83.1%). Among the family planning methods identified were condoms (29.7%), oral pills (37.9%), safe period (10.3%), intra uterine devices (22.1%), withdrawal method (17.8%), vasectomy (0.5%), injectable (62.5%), implants (36.4%), emergency pills (0.5%) and lactational amenorrhea method (0.5%) (Figure 4.1).

The major source of information on family planning was from the health workers (49.2%), followed by mass media (14.9%), friends and neighbors (10.8%) and pamphlets (3.6%) (Table 4.3). Majority (72.3%) of the respondents had the knowledge that family planning is used to space pregnancies while 51.8% also knew it can be used to obtain the number of desirable children (Table 4.4a).

Majority of the respondents (75.4%) affirmed that family planning is necessary. Among the different benefits of using family planning methods known by the respondents were prevention of pregnancy related risks in women which had the highest frequency (30.3%) followed by its knowledge of it helping mothers make informed choices regarding when to have children (25.1%) and to slow population growth (12.3%). About 39% of the respondents agreed that family planning has side effects while 41% affirmed in the negative. Amongst the side effects identified by the respondents, irregular bleeding (25.1%) had the highest followed by weight gain (12.8%).

One hundred and seventeen respondents (60%) responded in the negative to the question ‘Can the side effects hinder your usage of family planning methods?’ while 20.5% responded positively (Table 4.4c). Deciding who should make the decision on when to use family planning methods, ‘Both husband and wife’ (59.0%) had the highest frequency, followed by ‘wife’ (17.4%) and then ‘husband’ (4.1%) (Table 4.4d).

The overall knowledge score of the respondents on family planning methods was found to be fair (52.3%) with a mean score of 2.1 ± 0.7 and with the range of 0-8 (Table 4.5).

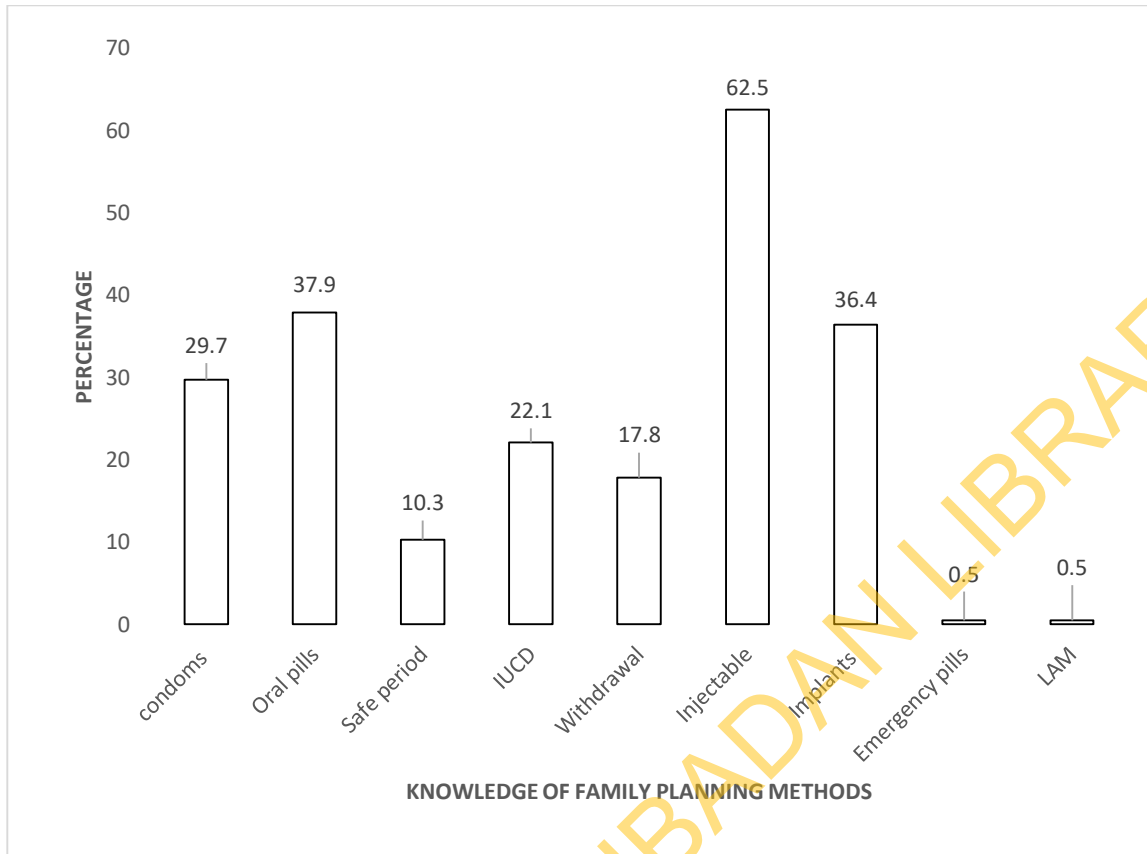


Figure 4. 1 – Knowledge of Family planning methods among respondents

Table 4. 2: Respondents' level of awareness of Family planning methods (n=195)

Know of any family planning method	Frequency	Percentage (%)
Yes	162	83.1
No	31	15.9
No response	2	1.0
Total	195	100.0

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Table 4. 3: Respondents' sources of information on Family planning methods (n=195)

Sources of information on FP methods	Frequency	Percentage
Health workers	96	49.2
Mass media	29	14.9
Pamphlets and posters	7	3.6
Friends	13	6.7
Neighbors	8	4.1
Family members	4	2.0
Religious leaders	2	1.0
No response	36	18.5
Total	195	100.0

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Table 4. 4a: Respondents' knowledge on definition of family planning (n= 195)

Knowledge on definition of FP	Frequency	Percentage (%)
Family planning is used to achieve the desired number of children	101	51.8
Family planning is used for birth spacing	40	20.5
No Response	54	27.7
Total	195	100.0

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Table 4. 4b: Respondents' knowledge of family planning methods

Variables	Frequency	Percentage (%)
Need for Family planning methods		
It helps to prevent pregnancy related risks in women	60	30.8
It helps to make informed decisions regarding when to have children	88	45.1
It helps to slow population growth	36	18.5
It empowers mothers	16	8.2
It enhances female education	19	9.8
It reduces adolescent pregnancies	7	3.6
Side effects of Family planning methods		
Irregular bleeding	51	26.1
Weight gain	36	18.4
Weight loss	8	4.1
Heavy period	17	8.7
Libido changes	4	2.0
No response	79	40.7

Table 4. 4c: Respondents' knowledge on effects of FP and when it should be used (n=195)

Variables	Yes (%)	No (%)	No response (%)	Total %
Can the side effects hinder your usage of family planning methods	40 (20.5)	117 (60.0)	38 (19.5)	100.0
When Family planning should be used*				
Want to delay next pregnancy	149 (76.4)	14 (7.2)	32 (16.4)	100.0
When the desired number of children is achieved	53 (27.2)	103 (53.8)	37 (19.0)	100.0
To prevent STD/HIV	21 (10.8)	134 (68.7)	40 (20.5)	100.0
To prevent unwanted pregnancy	153 (78.5)	6 (3.1)	36 (18.4)	100.0

***Multiple responses included**

Table 4. 4d: Respondents' knowledge on who should decide Family planning usage

Who should decide	Frequency	Percentage (%)
Both Husband and Wife	115	59.0
Wife	34	17.4
Husband	8	4.1
Mother-in-law	1	0.5
Your mother	1	0.5
No response	36	18.5
Total	195	100.0

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Table 4. 5: Respondents overall Knowledge score towards Family Planning (N= 195)

Score	Frequency	Percentage (%)
Poor (0 -2)	38	19.5
Fair (3-5)	102	52.3
Good (6-8)	55	28.2
Total	195	100.0%

Mean = 2.1±0.7

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4.3 Practice of Family Planning Among the Respondents

Majority of the respondents (67.2%) responded to “never have used any family planning method” and just 32.8% “have used any family planning method”. 18.5% of the respondents ticked “Yes” to “currently using any FP method” while majority (64.6%) of the respondents ticked “No” to currently using a FP method. The family planning method mostly used by the respondents was ‘Injectable’ (8.2%), followed by Condom (5.6) and then ‘Implants’ (5.1%) while 76.4% of the respondents were not using any FP method. Among the 32.8% respondents who ever used family planning, 10.8% have used family planning for >12 months, 4.1% for 7-12 months and 8.7% for <6 months. For future practice, 48.7% of the responded ‘yes’ to ‘still want to use FP’ while 27.7% responded otherwise.

Table 4. 6: Respondents overall Practice score towards Family Planning (N= 195)

Score	Frequency	Percentage (%)
Poor (0 -3)	140	71.8
Fair (4 – 6)	27	13.8
Good (7 – 9)	28	14.4
TOTAL	195	100.0

Mean = 1.4±0.7

4.4 Respondents attitude towards Family Planning

A majority (56.9%) of the respondents ‘disagreed’ to the statement that ‘It promotes unfaithfulness’, while a small proportion (27.7%) ‘Agreed’ and some (14.4%) were undecided. Also most of the respondents (50.8%) ‘disagreed’ to the statement that ‘Family planning methods are harmful because of their side effects’ while a small proportion (35.9%) of the respondents ‘agreed’ to the statement. The statement that ‘Family planning methods are actually effective in planning families’ was ‘agreed’ to by most of the respondents (84.1%) while it was ‘disagreed’ to by twenty-one respondents (10.8%). Majority of the respondents (89.2%) ‘Disagreed’ to the statement that ‘My role in family planning conflict with my moral/cultural/religious beliefs’ and 4.6% of the respondents ‘agreed’. There were one hundred and forty-eight respondents (75.9%) who ‘disagreed’ that ‘It reduces sexual pleasure’, a small proportion (7.2%) ‘agreed’ while thirty-two respondents (16.4%) were ‘undecided’. The final statement which is ‘I think family planning is similar to abortion’ was ‘disagreed’ to by one hundred and seventy-two respondents (88.2%), 6.7% were undecided; however, nine respondents (4.6%) ‘agreed’ to the statement (Table 4.7).

Table 4.7: Respondents Attitude towards FP (N= 195)

Statements	Agree (%)	Disagree (%)	Undecided (%)
It promotes unfaithfulness	54 (27.7)	111 (56.9)*	28 (14.4)
Family planning methods are harmful because of their side effects	70 (35.9)	99 (50.8)*	25 (12.8)
Family planning methods are actually effective in planning families	164 (84.1)*	21 (10.8)	9 (4.6)
My role in family planning conflicts with my moral/cultural/religious beliefs	9 (4.6)	174 (89.2)*	12 (6.2)
It reduces sexual pleasure	14 (7.2)	148 (75.9)*	32 (16.4)
I think FP is similar to abortion	9 (4.6)	172 (88.2)*	13 (6.7)

***correct statements**

Table 4.8: Respondents overall Attitude score towards Family Planning (N=195)

Score	Frequency	Percentage (%)
Poor (0-3)	37	19.0
Good (4-6)	158	81.0
Total	195	100.0%

Mean=1.3 ± 0.4

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4.5 Respondents willingness towards Family Planning

94.5% of the respondents (186) reported 'No' to the statement 'Willing to wear the vaginal ring', while a small proportion (4.6%) reported 'Yes'. A majority of the respondents (95.4%) reported 'No' to the statement 'Comfortable feeling the ring during intercourse' while a small proportion (4.1%) of the respondents responded 'Yes' to the statement. The statement 'Accept to use a monthly form of FP' was reported 'No' to by most of the respondents (64.1%) while it was agreed to ('Yes') to by sixty-nine respondents (35.4%). Majority of the respondents (54.4%) reported 'Yes' to the statement 'Willing to stop the FP method and return to fertility' and 42.6% reported 'No'. One hundred and forty-seven respondents (75.4%) reported 'Yes' to 'Need prescription before I start FP', a small proportion (23.1%) reported 'No'. The statement which is 'Want a good spacing in between my childbirths' was agreed to ('Yes') by 97.9% of the respondents, however, three respondents (1.5%) reported 'No'. The final statement which is 'Ready to stop bearing children' was reported 'No' to by one hundred and thirty-one respondents (67.2%), however, sixty-two respondents (31.8%) reported 'Yes' to the statement. (Table 4.8).

Table 4. 9: Respondents Willingness towards family planning methods (n=195)

Statements	Yes (%)	No (%)
Wiling to wear the vaginal ring	9 (4.6)	186 (95.4)
Comfortable feeling he ring during intercourse	8 (4.1)	186 (95.4)
Accept to use a monthly form of FP	69 (35.4)	125 (64.1)
Willing to stop the FP method and return to fertility	106 (54.4)	83 (42.6)
Need prescription before I start FP	147(75.4)	45(23.1)
Want a good spacing in between my childbirths	191 (97.9)	3 (1.5)
Ready to stop bearing childbirth	62 (31.8)	131(67.2)

***Multiple responses included**

Table 4. 10: Respondents overall Willingness score towards Family Planning (N= 195)

Score	Frequency	Percentage (%)
Poor (0 -2)	158	81.0
Good (3- 5)	37	19.0
Total	195	100.0

Mean= 1.2±0.4

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4.6 Factors responsible for the use of Family Planning

Attitude of Service Providers on Family Planning was assessed as a factor influencing family planning usage. Majority of the respondents (92.8%) agreed that health workers 'do lay emphasis on the importance of FP'. Assessing the distance of the health facility as a factor, 35.9% of the respondents responded 'Yes' to 'it takes 30 minutes or more from my house to the clinic' while 63.6% responded otherwise.

Assessing the socio-economic and religious factors associated with FP usage, 96.9% of the respondents responded 'No' to religious leaders determining the use of FP, majority of the respondents (95.4%) responded 'No' to 'Using any FP method is against my religious beliefs'. 94.4% of the respondents responded 'No' to 'It is a taboo to use FP methods in my family'. 88.7% of the respondents responded 'No' to 'FP services are expensive?'

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Table 4. 11: Factors responsible for use of Family Planning methods (N=195)

Factors	Yes (%)	No (%)	Undecided (%)
My husband determines if I use any FP method	88 (45.1)	106 (54.4)	1 (0.5)
My religious leader determines if I use any FP method	5 (2.6)	189 (96.9)	1 (0.5)
Using any FP method is against my religion belief	6 (3.1)	186 (95.4)	3 (1.5)
FP services are expensive	4 (2.1)	173 (88.7)	18 (9.2)
It is difficult to maintain any FP method I start with	15 (7.7)	165 (84.6)	15 (7.7)
It takes 30 minutes or more from my house to the clinic	70 (35.9)	124 (63.6)	1 (0.5)
It is a taboo to use any FP methods in my family	8 (4.1)	184 (94.9)	2 (1.0)
The health workers do not explain the importance of FP	11 (5.6)	181 (92.8)	3 (1.5)
In the last few months, have you heard about FP on any mass media	162 (83.1)	33 (16.9)	0(0.0)
In the last 12 months, I have not visited the clinic to receive FP	126 (64.6)	69 (34.4)	2 (1.0)

4.7 Test of Hypotheses

Hypothesis One: There is no significant difference between socio-demographic characteristics (age, level of education, religion, marital status, Number of children, employment) and use of family planning methods.

Chi square test (X^2) was used in testing this hypothesis at 95% confidence interval ($p < 0.05$). It was found that there is no statistical relationship between respondents' use of FP and age ($X^2=5.328$ p-value=0.149), tribe ($X^2=2.612$ p-value 0.455), educational level ($X^2=4.393$, p-value 0.734). Therefore, we fail to reject the null hypothesis (Table 4.11).

Hypothesis Two: There is no significant difference between knowledge and use of family planning methods.

Chi square test (X^2) was used in testing this hypothesis at 95% confidence interval ($p < 0.05$). It showed that the knowledge of respondents has an influence on use of FP ($X^2=15.36$, p-value=0.000). Also, respondents' source of information and use of FP at 95% confidence interval ($p < 0.05$) has a significant association ($X^2=34.142$, p-value = 0.000). Consequently, the null hypothesis was rejected (Table 4.12).

Hypothesis Three: There is no significant difference between attitude and use of family planning methods.

Table 4.13 indicates the cross tabulation of respondents' attitude and use of family planning at 95% confidence interval ($p < 0.05$). Respondents' attitude and use of family planning has no significant difference ($X^2=0.03$, p-value = 0.860). Therefore, we fail to reject the null hypothesis.

Hypothesis Four: There is no significant difference between willingness and use of family planning methods.

Chi square (X^2) at confidence interval of ($p < 0.05$) was used to test the statistical significance. It was found that there is statistical relationship between respondents' exclusive breastfeeding intention and attitude ($X^2=0.052$, p-value = 0.819). Therefore, the null hypothesis is hereby rejected (Table 4.14).

Table 4.12a: Relationship between Respondent's FP Practice and Socio-demographic characteristics

Variables	Family Planning Practice		Total(%)	X^2	df	p-value
	Good (%)	Poor (%)				
Age						
17-20	2 (20.0)	8 (80.0)	10 (100.0)	5.33	3	0.149 ^a
21-35	42 (26.2)	118 (73.8)	160 (100.0)			
36-47	14 (58.3)	10 (41.7)	24 (100.0)			
Tribe						
Yoruba	48 (30.2)	111 (69.8)	159 (100.0)	2.61	3	0.455 ^a
Igbo	6 (24.0)	19 (76.0)	25 (100.0)			
Hausa	0	2 (100)	2 (100.0)			
Others	1 (11.1)	8 (88.9)	9 (100.0)			
Religion						
Christianity	31 (27.2)	83 (72.8)	114 (100.0)	0.14	1	0.709
Islam	24 (29.6)	57 (70.4)	81 (100.0)			
Marital Status						
Single	1 (16.7)	5 (83.3)	6 (100.0)	0.41	1	0.523 ^a
Married	54 (28.6)	135 (71.4)	189 (100.0)			
Level of Education						
None	1 (50.0)	1 (50.0)	2 (100.0)	4.39	7	0.73 ^a
Primary	2 (25.0)	6 (75.0)	8 (100.0)			
Secondary	25 (24.3)	78 (75.7)	103 (100.0)			
College of Education	7 (36.8)	12 (63.2)	19 (100.0)			
ND/HND	14 (31.1)	31 (68.9)	45 (100.0)			
BSc.	6 (40.0)	9 (60.0)	15 (100.0)			
Postgraduate	0	1 (100)	1 (100.0)			

^a Fishers Exact Test p-value reported (due to Chi-Square assumption violation)

Table 4. 12b: Relationship between Respondent’s FP Practice and Socio-demographic characteristics

Variables	FP Practice		Total (%)	X ²	df	p-value
	Good (%)	Poor (%)				
Occupation						
Student	1 (14.3)	6 (85.7)	7 (100)	7.35	7	0.392 ^a
Trader	23 (28.0)	59 (72.0)	82 (100)			
Artisan	9 (22.0)	32 (78.0)	41 (100)			
Civil servant	6 (46.2)	7 (53.8)	13 (100)			
Professional	4 (40.0)	6 (60.0)	10 (100)			
Self employed	10 (25.6)	29 (74.4)	39(100.0)			
Unemployed	1 (100)	0 (0.0)	1 (100.0)			
Monthly income (Naira)						
<10,000	7 (33.3)	14 (66.7)	21 (100.0)	0.26	4	0.63 ^a
10,000 - <30,000	21 (28.8)	52 (71.2)	73 (100.0)			
30,000 - <60,000	12 (35.3)	22 (64.7)	34 (100.0)			
60,000 & above	3 (30.0)	7 (70.0)	10 (100.0)			
Number of children						
1-3	46 (27.2)	123 (72.8)	169 (100.0)	1.9	2	0.389 ^a
4-6	9 (37.5)	15 (62.5)	24 (100.0)			

^a Fishers Exact Test p-value reported (due to Chi-Square assumption violation)

Table 4. 13: Relationship between Knowledge and Respondents' use of Family planning

Knowledge about contraceptive	Ever use contraceptive		Total N%	X^2	df	p-value	Hypothesis
	Good (%)	Poor (%)					
Poor (0-2)	1 (2.6)	37 (97.4)	38 (100)	15.36	2	0.000	*rejected
Fair (3-5)	36 (35.3)	66 (64.7)	102 (100)				
Good (6-8)	18 (32.7)	37 (67.3)	55 (100)				
Total	55 (28.2)	140 (71.8)	195 (100.0)				

**Significant*

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Table 4. 14: Relationship between Attitude and Respondents' use of Family planning

Attitude towards contraceptive	Use of Family Planning		Total (%)	χ^2	df	p-value
	Good (%)	Poor (%)				
Poor (0-3)	10 (27.0)	27 (73.0)	37 (100.0)	0.03	1	0.860
Good (4-6)	45 (28.5)	113 (71.5)	158 (100.0)			
Total	55 (28.2)	140 (71.8)	195 (100.0)			

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Table 4. 15: Relationship between Willingness and Respondents' use of Family planning

Willingness to use FP method	Use of Family Planning		Total(%)	X^2	df	p-value
	Good(%)	Poor(%)				
Poor (0-2)	44 (27.8)	114(72.2)	158 (100.0)	0.05	1	0.819
Good (3-5)	11 (29.7)	26(70.3)	37 (100.0)			
Total	55 (28.2)	140 (71.8)	195 (100.0)			

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Table 4.16: Relationship between different Factors and use of Family Planning by respondents (n=195)

Variable	Use of Family Planning		Total N (100%)	X ²	df	p value
	Good (%)	Poor (%)				
My husband determines if I use any FP method						
Yes	22 (25.0)	66 (75.0)	88 (45.1)	3.19	2	0.20 ^a
No	32 (30.2)	74 (69.8)	106 (54.4)			
My religious leader determines if I use any FP method						
Yes	2 (40.0)	3 (60)	5 (2.6)	2.93	2	0.231 ^a
No	52 (27.5)	137 (72.5)	189 (96.9)			
Using any FP method is against my religion belief						
Yes	2 (33.3)	4 (66.7)	6 (3.1)	0.12	2	0.941 ^a
No	52 (28.0)	134 (72.0)	186 (95.4)			
FP services are expensive						
Yes	3 (75.0)	1 (25.0)	4 (2.1)	11.69	2	0.003 ^{a*}
No	52 (30.1)	121 (69.9)	173 (88.7)			
It is difficult to maintain any FP method I start with						
Yes	4 (26.7)	11 (73.3)	15 (7.7)	3.81	2	0.149 ^a
No	50 (30.3)	115 (69.7)	165 (84.6)			
It takes 30 minutes or more from my house to the clinic						
Yes	22 (31.4)	48 (68.6)	70 (35.9)	3.26	2	0.196 ^a
No	32 (25.8)	92 (74.2)	124 (63.6)			
It is a taboo to use any FP methods in my family						
Yes	2 (25.0)	6 (75.0)	8 (4.1)	3.08	3	0.380 ^a
No	51 (27.7)	133 (72.3)	184 (94.4)			
The health workers do not explain the importance of FP						
Yes	3 (27.3)	8 (72.7)	11 (5.6)	0.04	2	0.978 ^a
No	51 (28.2)	130 (71.8)	181 (94.4)			
In the last few months, have you heard about FP on any mass media						
Yes	47 (29.0)	115 (71.0)	162 (83.1)	0.31	1	0.579
No	5(38.5)	8 (61.5)	13(6.7)			
In the last 12 months, I have not visited the clinic to receive FP						
Yes	25 (19.8)	101 (80.2)	126 (64.6)	12.34	2	0.002 ^{a*}
No	29 (43.3)	38 (58.7)	67 (34.4)			

^a Fishers Exact Test p-value reported (due to Chi-Square assumption violation)

*Significant

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

This study has been able to provide data on the attitude and willingness to use family planning methods among mothers-of-under-one in Ibadan North Local Government Area of Oyo State. This chapter discusses the results presented in the previous chapter; it also presents the conclusions and recommendations.

5.1 Discussion

From this study, it was recorded that the highest age range of respondents was between 21-35 years, which is within the child bearing age, so also 12.3% of the respondents' age group falls between 36-47 years; this can be attributed to the fact that the age range is close to the menopause stage. In entirety, the study group age-ranged 17 – 47 years which according to WHO falls into the reproductive age range of 15-49 (WHO, 2006).

Majority of the respondents from this study were from the Yoruba ethnic group. This was expected because in a Yoruba geographical area like Ibadan, it is expected that the population of residents will be dominated by the Yoruba ethnic group. Our respondents were predominantly Christians; this is in keeping with the predominant religion in the community, previous studies conducted in Ibadan including those of Moronkola, Ojediran and Amosu (2006), and Dirisu (2014) similarly revealed the same religious affiliation and ethnic group predominance.

This study comprises of many occupational groups such as Artisans, Civil servants, Traders, Students, Professionals, Self-employed and Unemployed, with most of the respondents being Trader. This was also observed in a study assessing awareness of family planning by Omolase, Faturoti and Omolase (2009). This can be attributed to the Trading heritage cherished by the Yoruba women.

Notably, most of the respondents had secondary school education as their highest form of educational qualification while the highest form of educational qualification among the husbands' was tertiary education; this might actually result in spousal dependence among respondents financially and emotionally which may play significant role in decision making and socio-economic status of respondents.

The level of awareness about family planning among respondents was 83.1%, a data which is similar with the finding from a study in Ibadan, Nigeria by Obisesan (1998) where majority of respondents' level of awareness was 94.3% but higher than the finding of Adinma *et al.*, (1995) in which 76% of their respondents were aware of family planning methods.

This study showed that knowledge of the respondents had a significant relationship with the use of family planning. The knowledge of family planning showed that 28.2% of the respondents had good knowledge. This finding is lower than a study conducted by Ayele *et al.*, (2018) where the study participants had good knowledge of 42.3%. Most of the respondents had the knowledge of at least one modern form of family planning and one traditional method of family planning with the most common being “injectable” and “withdrawal” methods respectively. These methods were considered to be easy and safe and had little or no side effects.

Though about 18.0% of the respondents had no knowledge about family planning, about Eighty-two percent of the respondents had already heard about family planning, with the main source of information being the health workers (49.2%), this corroborates with the study by Omolase *et al.*, (2009) where health workers were also the major source of information (47.2%) but in variance with a study by Nwachukwu *et al.*, (2008) where the common source of information was the mass media. This implies that the health workers will play a major role in improving the knowledge of family planning and awareness of various family planning among mothers, alongside their respective advantages and disadvantages.

As detailed in Table 4.4b, it can be seen that most off the respondents had a good knowledge of the benefits of family planning as 45.1% asserted that “it helps to make informed decisions regarding when to have children” and 30.8% implied that it helps to prevent pregnancy related risks in women” and also as observed from the definition, 51.8% implied that family planning is necessary because it helps with the prevention of unwanted pregnancy.

Although as many as 32.8% of women who had used or is currently using family planning claimed to have knowledge of the beneficial/side effects of the various methods of family planning, the high no-response rate added to the number of women who admitted having no knowledge of the side effects. This gives a clear picture of the ignorance of these women of the side effects of their chosen family planning method; this observation was also reported in a previous study by Adinma and Nwosu.

This study showed a 14.4% prevalence of good family planning practice, the result is similar to a study conducted in Ogbomoso by Adewale *et al.*, (2015) where practice rate was recorded to be 15%; but it is extremely low when compared to a study by Nansseu *et al.*, (2015) in Cameroon where a high practice rate of 65.3% was gotten. The practice rate is also similar to the study conducted by MICS (2017) where a prevalence of 13.4% was recorded among women of reproductive age.

The most used family planning method in this study was determined to be condoms and injectable similar to a study in Nepal where condoms were mostly used followed by injectable and contraceptive pills (Tamang *et al.*, 2017) and another study in South West Nigeria by Omokhodion *et al.* (2017) where condoms were recorded to be the most used contraceptives.

This can be attributed to the perceived constraints to the use of family planning methods which included significantly insufficient knowledge, fear of complications from side effects, low literacy level and socioeconomic status. It can be concluded that there is a knowledge-practice gap concerning family planning methods practice among mothers in Ibadan; a claim supported in a study by Obisesan (1998).

Attitude refers to the positive or negative feelings of an individual about an idea. This study showed that the respondents have a good (positive) attitude towards use of family planning though there is no significant association between the attitude and use of family planning methods. This is in contrast to a study in Pakistan by Ghulam *et al.*, (2015) where their attitude towards family planning was poor; the women only intended to use family planning after completing their family size of 5-6 children despite their low economic situation.

Despite the high attitude rate generated in this study, the study indicated a poor practice. The high positive rate might be due to the fact that married women consider family planning to be effective in planning families and would not be hindered by the associated side effects. Nevertheless, the attitude-practice gap could be influenced by environmental factors, traditional belief, knowledge and most importantly the cost. As observed in this study, there is a significant relationship between the cost of family planning and its usage. The cost benefits and usage of family planning methods should be studied and addressed so as to enable the communication of accurate family planning-related-messages during counselling and training, as this will help to

further increase positive attitude towards family planning methods which will lead to a more effective usage.

With more than half of the respondents having a good attitude towards the usage of family planning methods, the willingness to use as observed by this study was poor (19.0%). This result differs greatly from a study conducted in India by Mothilal *et al.*, (2017) to assess the willingness and acceptance of post-partum sterilization, which is a modern family planning method, of which the willingness rate was 79.6%. In a study by Bhavya and Mathada (2016), the willingness to use modern family planning method was more among the 15-29 years' mothers compared to 30-34 years' mothers; which was as a result in differences among literacy level and adequate counselling sessions which was enjoyed more by the younger age group; it was also observed that the willingness to use contraceptive methods among women in nuclear families was high (96.2%), suggesting that the family structure is a factor for willingness for family planning use. Though, 48.7% of the respondents currently not practicing any of the family planning methods expressed the willingness to do so in future based on the prescription from their health workers and the associated side effects. It can be inferred that proper counselling by health workers help increase the willingness rate of mothers to use family planning methods.

Pertinent to observe in this study, is that a substantial number of respondents considered their husband's approval as a determinant of their family planning usage. This may be as a result of the high reference given to the husbands among the Yorubas where this study was conducted. This finding is similar to that of Moronkola *et al.*, (2006), where the husband's approval was significant to family planning usage. According to Ayele *et al.*, (2018) there was a significant relationship between age and the practice of family planning but this study contrasted the previous studies revealing that age was not statistically significant with family planning use. Accessibility and affordability are major factors highlighted in this study; it was observed that a substantial number of the respondents spent more time accessing the health clinics and some could also not afford the family planning services. It is interesting to note that low affordability issue was mainly highlighted by the women as their husbands earned limited incomes and they were dependent on the income (Ghulam *et al.*, 2015).

In the study by Adedini *et al.*, (2018), it was repeatedly mentioned that religious leaders have the power to inhibit or facilitate effective adoption of contraceptive methods to support family health, this is similar to this study though there was no significant relationship between religious leaders' involvement and use of family planning. Therefore, it is important to prioritize advocacy to religious group as this will enhance a positive attitudinal and willingness rate towards adoption of family planning methods.

5.2 Implication of the study findings for health promotion and education

Health education is a process of deliberate and purposeful use of health information and policy measures aimed at making people take informed health decisions and/or improve their health status (NDHS, 2013).

This study has investigated the attitude and willingness to use family planning methods among mothers-of-under-one in Ibadan, with emphasis laid on knowledge, use, attitude, willingness and factors influencing use of family planning methods. Knowledge has been established to be the important factor for practice, a reduced knowledge influences poor practice, from this study, respondents had fair knowledge of family planning methods, despite a high level of awareness and attitude with an observed negative willingness towards the family planning methods.

An implication of this finding is the need to intensify efforts towards improving the quality of information and education on family planning methods, as an individual who is well informed will not hesitate to seek health care. So also, the more knowledgeable people are about their reproductive health, its benefits and consequences, the more likely they are to access family planning methods.

Education and communication programs targeting mothers should be carried out at various healthcare settings to help them choose wisely their desired family planning method. Also, family planning and birth spacing interventions should be carried out to focus on alleviating fears about side effects.

Additionally, family planning programs should be broadened so as to include family planning messages directed at men. Because, it appears that in most of the families, the mother alone does not take the decision regarding family size. The men should be educated on family planning practices and advantages of having a small family, this will lead to an increase in knowledge and

ultimately contribute positively to the uptake of family planning services by women. To achieve this, the workplace setting can be utilized to design and implement this educational intervention. On a broader spectrum, family planning activity in Nigeria should be improved upon through a wider dissemination of information on family planning using the social media, mass media, public lectures and the electronic media. Health care workers need to be trained on the various peculiarities of family planning methods and how best to disseminate the information, so as to aid grass-root coverage.

It should be noted that not having adequate knowledge of health matters is not enough; there is the need to empower people with resources that will make it easy for them to adopt health promoting innovations (Green and Kreuter, 1999). This implies that for mothers to fully adopt family planning practices, there should be adequate social support system to encourage and motivate them and also health facilities should be accessible and affordable.

5.3 Conclusion

Based on the objectives of this study, the following were the conclusions made from the study results:

1. The level of knowledge of family planning among respondents was very high.
2. This study revealed several perceptions such as severe side effects of family planning which influenced the poor practice of family planning among the respondents.
3. Despite the poor practice of family planning recorded among the respondents, there was a relatively high attitude towards the use of family planning among respondents.
4. From the study, it was observed that the willingness rate and level of usage towards family planning methods were very in comparison with many studies.
5. The study revealed factors such as attitude of health workers played a major role in the uptake of family planning among mothers. It was observed that the frequent emphasis laid on family planning by health workers influenced the positive attitude of mothers towards family planning.

5.4 Recommendations

In view of the study findings, the following recommendations were made:

1. This study has highlighted knowledge, educational level and monthly income as major factors influencing usage of family planning methods. These factors should be considered in designing more effective family planning methods for mothers to select from.
2. This study has shown that knowledge precedes practice, therefore the media should be better involved in enlightening and promoting the use of Family planning services among the populace. This will lead to a more increased coverage.
3. As this study slightly revealed an involvement of husbands in uptake of family planning services, sensitization of men should be increased. This will lead to a positive attitude change towards FP among husbands and will enhance the need for them to support their wives to access appropriate family planning services.
4. Family service providers should be trained to provide accurate, unbiased and essential counselling services to all clients in general including the young, unmarried, and uneducated in order to promote acceptance of family planning methods. This will eventually reduce the rate of unplanned pregnancies and also improve maternal and child health outcomes.
5. A small concentration of adolescents was among the respondents. Therefore, peer education should be taught by those focusing on family planning such as Nigeria Urban Reproductive Health Initiative among adolescents after being trained by trained personnel on family planning.
6. Since the major source of information was the health workers, their knowledge and skills have to be continuously enhanced and strengthened to deliver the right advice which in turn will increase the knowledge of mothers, thereby promoting an effective usage.

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APPENDIX I

INFORMED CONSENT

Dear Respondent,

I am a post graduate student at the department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan. The purpose of this study is to gather information about the “Attitude And Willingness To Use Family Planning Methods Among Mothers Of Under-One In Ibadan North Local Government Area, Oyo State. Please note that your participation in this study is entirely voluntary. Each questionnaire has been given a CODE NUMBER to conceal your identity. All information that would be collected during this study will be treated with utmost confidentiality.

Your participation in this study is very important as it would help to determine the willingness rate of mothers to use family planning methods. Please also note that there are no right or wrong answers to the questions asked or the statements made. The time needed to complete this questionnaire is approximately 20-25 minutes. Your willingness to be interviewed implies you have given consent to participate.

Thank you for cooperating.

Serial Number _____

APPENDIX II: QUESTIONNAIRE

SECTION A: SOCIO - DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS.

Instruction: Kindly respond to the following as appropriate as possible

1. Age as at last Birthday: _____
2. Tribe: 1. Yoruba [] 2. Igbo [] 3. Hausa [] 4. Others (Specify) _____
3. Religion: 1. Christianity [] 2. Islam [] 3. Traditional [] 4. Others (Specify) _____
4. Marital Status: 1. Single [] 2. Married [] 3. Divorced [] 4. Widowed [] 5. Separated []
5. Highest level of education: 1. None [] 2. Primary [] 3. Secondary [] 4. College of Education [] 5. ND/HND [] 6. BSc./Bed/LLB/B.Tech [] 7. Postgraduate []
6. Husband's highest level of education: 1. None [] 2. Primary [] 3. Secondary [] 4. Tertiary Education [] 5. Others (Specify) _____
7. Occupation 1. Trader [] 2. Civil Servant [] 3. Student [] 4. Artisan [] 5. Self-employed [] 6. Unemployed [] 7. Others (Specify) _____
8. Husband's occupation 1. Trader [] 2. Civil Servant [] 3. Student [] 4. Artisan [] 5. Self-employed [] 6. Unemployed [] 7. Others (Specify) _____
9. Monthly income: _____
10. Husband's monthly income: _____
11. Number of children: _____

SECTION B: KNOWLEDGE OF FAMILY PLANNING METHODS AMONG MOTHERS OF UNDER-ONE

Instruction: Kindly respond to the following as appropriate as possible

12. Do you know of any family planning method?
 1. Yes 2. No if No, go to Section C.
If yes, mention 5.
 - 1) Condom [] 2) Oral pills [] 3) Safe periods (calendar method) []
 - 4) IUCD [] 5) withdrawal method [] 6) vasectomy [] 7) Injectable []
 - 8) Implants [] 9) Emergency pills [] 10) Lactational Amenorrhea method []
 - 11) Norplant [] 12) Diaphragm [] 13) others.....

13. What is/are your source(s) of information on family planning methods?

1. Mass media (radio and television) [] 2. Pamphlets and posters [] 3. Family members
4. Friends [] 5. Neighbours [] 6. Health workers [] 7. Religious leaders []
8. Community group [] 9. Others (Specify) _____

14. What is Family planning?

.....

(Family planning allows people to obtain their desired number of children and determine the spacing of pregnancies.)

15. Is family planning necessary? 1) Yes 2) No

15a) If yes, give 2 reasons.

- 1) It helps to prevent pregnancy related risks in women
2) To reduce infant mortality []
3) To prevent HIV/AIDS []
4) It helps to slow population growth []
5) It reduces adolescent pregnancies []
6) It empowers people
7 It enhances education. []
8) It helps to make informed choices regarding when to have children []

Others

15b. If no, give 2 reasons.

- 1) It has many side effects []
2) It makes women infertile. []
3) It causes diarrhea in breastfeeding babies. []

16. Mention 3 types of modern family planning methods you know?

- 1) Condom [] 2) Oral pills [] 3) Safe periods [] 4) IUCD [] 5) Vasectomy []
6) Norplant [] 7) Diaphragm [] 8) others

17. What 3 types of natural family planning methods do you know?

- 1) Abstinence [] 2) withdrawal method [] 3) Safe period [] 4) Lactation
Amenorrhoea Method [] 5) Others.....

18. Are there any side effects to any of the family planning methods? a) Yes b) No

18a) If yes, mention 3 side effects. (If No, move to question 23)

- 1) Irregular bleeding []
- 2) Libido changes []
- 3) Weight gain []
- 4) Depression []
- 5) Headaches []
- 6) Nausea []
- 7) Abnormal hair growth []
- 8) Heavy period []
- 9) Mood swings []
- 10) Skin discolorations []
- 11) Breast tenderness/swelling []
- 12) others

18b. Can the side effect hinder your usage of family planning methods? 1) Yes 2) No

19. Who should make the decision to start family planning methods?

- 1) Husband 2) Wife 3) Mother-in-law 4) Your mother 5) Both Husband and Wife 6) Religious leaders

20. When should family planning methods be used?

S/N	QUESTION	YES	NO
	When wife's health is in danger		
	Want to delay next pregnancy		
	When the desired number of children achieved		
	Wants wife to finish education		
	To prevent STD/HIV		
	To prevent unwanted pregnancy		

SECTION C: PRACTICE OF FAMILY PLANNING METHODS AMONG MOTHERS OF UNDER-ONE

Instruction: Kindly respond to the following as appropriate as possible

- 21. Have you used Family planning method before? a) Yes b) No
- 22. Do you currently use any FP method? a) Yes b) No if No, move to Ques 26,

23. Which one are you using currently? (Tick all mentioned)
- 1) Condom [] 2) Oral pills [] 3) Safe periods (calendar method) [] 4) IUCD [] 5) withdrawal method [] 6) vasectomy [] 7) Injectable []
- 8) Implants [] 9) Emergency pills [] 10) Lactational Amenorrhea method [] 11) Norplant [] 12) Diaphragm [] 13) others.....

24. Why do you use the FP method?

25. Years of usage?

26. Do you still want to use it in future? a) Yes b) No

27. Which method(s) will you adopt?

- 1) Condom [] 2) Oral pills [] 3) Safe periods (calendar method) [] 4) IUCD [] 5) withdrawal method [] 6) vasectomy [] 7) Injectable [] 8) Implants [] 9) Emergency pills [] 10) Lactational Amenorrhea method [] 11) others

28. Why the method in question 30?

.....

.....

SECTION D: ATTITUDE OF MOTHERS OF UNDER-ONE TOWARDS FAMILY PLANNING

Instruction: Kindly respond either Agree, Undecided and Disagree to the following

S/N	Statements	Agree	Disagree	Undecided
29.	It promotes unfaithfulness			
30.	Family planning methods are harmful because of their side effects			
31.	Family planning methods are actually effective in planning families			
32.	My role in family planning conflict with my moral/cultural/religious beliefs			
33.	It reduces sexual pleasure			
34.	I think FP is similar to abortion			

SECTION E: WILLINGNESS OF MOTHERS OF UNDER-ONE TOWARDS FAMILY PLANNING (FP)

Instruction: Kindly respond either “Yes” or “No” to the following

Are you willing to do the following?

S/N	Statement	Yes	No
35.	Willing to wear the vaginal ring		
36.	Comfortable feeling the ring during intercourse		
37.	Accept to use a monthly form of FP		
38.	Willing to stop the FP method and return to fertility		
39.	Need prescription before I start FP		
40.	Want a good spacing in between my childbirths		
41.	Ready to stop bearing children		

SECTION F: FACTORS RESPONSIBLE FOR THE USE OF FAMILY PLANNING METHODS AMONG MOTHERS OF UNDER- ONE

Instruction: Kindly respond either “Yes” or “No” to the following

S/N	STATEMENTS	Yes	No
42.	My husband determines if I use any FP method		
43.	My religious leader determines if I use any FP method		
44.	Using any FP method is against my religious belief?		
45.	FP services are expensive		
46.	It is difficult to maintain any FP method I start with		
47.	It takes 30 minutes or more from my house to the clinic		
48.	It is a taboo to use FP methods in my family		
49.	The health workers do not explain the importance of Family planning		
50.	In the last few months, have you heard about family planning on any mass media?		
51.	In the last 12 months, I have not visited the clinic to receive FP		

52. Have you ever had an unplanned pregnancy? a) Yes b) No
a) If yes, do you want to experience it (unplanned pregnancy) again? a) Yes b) No
b) If no, do you ever want to experience it? a) Yes b) No

53. Why?

.....
.....
.....

THANK YOU FOR YOUR RESPONSE

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APPENDIX III

IFITONILETI TI ALAYE

Ẹyin Olùkópa wa Owon,

Mo jẹ akèékó látí ile ìwé giga Yunifàsiti tí Ilẹ̀ Ibádán ni ẹka tí àtí n risi eto nípa idanilekoo ati igbega eto ilera, ti o wan i Kolejeji tí ati n se itoju pélu oogun, Ni abala Tí ohun risi eto ilera àwọn ara ilu, Mo nse iwadi lori **ISEWAHU ATI ITARA LATI LO ILANA IFETOSOMOBIBI LARIN AWON IYA OMOTI ODUN ORI WON KO TO OOKAN NI AGBEGBE IJOBA IBILE IBADAN NORTH IBADAN**, ni orilede Naijiriya. Kikopa nínú iwadi yí jẹ tí eyi ti oti okan yin wa, ati fi ohunka idanimọ si ara awon iwe ibeere kookan lati dabobo idanimọ yin. Gbogbo àlàyé tí ẹba si se fún mi ninu iwadi yi ni yí o wa ni ipamọ larin emi àtí ẹyín, mi ko sini se afihan ẹ fún ẹnikeni.

Kikopa yin ninu iwadi yí se pataki pupọ nitoriwipe yi o se iranlowo fun oluwadi lati mo osuwon ti itara awon iya omode nipa lilo ilana ifetosomobibi. E jowo eni lati se akiyesi wipe ko si idahun ti o to tabi eyi ti koto ninu gbogbo idahun eyikeyi ti ẹba fi esi si awon ibeere ti a ba bi yin. Didahun si awon ibeere yi ko ni gbayin ni akoko pupọ, nitoriwipe ko ni gbayin ju ogun tabi ogbon iseju lo. Ki a to maa te siwaju, o tunmo siwipe e ti fi aramo lati kopa ninu iwadi yi pelu gbigba lati kopa ninu iforowanilenuwo.

A dupe lowo yin fun ifowosowopo yin.

Ohunka Idanimọ _____

APPENDIX IV: IWE IBEERE

IPIN A: ÀLÀYÉ LORI ETO IGBESIAYE OLÙKÓPA.

1. Ojọ ori ni ojọ ibi to kẹhin: _____
2. Èyà: 1. Yoruba [] 2. Igbo [] 3. Hausa [] 4. Others (Specify) _____
3. Èsin: 1. Christianity [] 2. Islam [] 3. Traditional [] 4. Others (Specify) _____
4. Şe o ni iyawo tabi ọkọ : 1. Single [] 2. Married [] 3. Divorced [] 4. Widowed []
5. Ipele giga ti èkó: 1. None [] 2. Primary [] 3. Secondary [] 4. Tertiary Education []
5. Others (Specify) _____
6. Ipele giga ti èkó ti ọkọ: 1. None [] 2. Primary [] 3. Secondary [] 4. Tertiary Education []
5. Others (Specify) _____
7. Işé 1. Trader [] 2. Civil Servant [] 3. Student [] 4. Artisan [] 5. Self-employed [] 6. Unemployed [] 7. Others (Specify) _____
8. Işé ti ọkọ 1. Trader [] 2. Civil Servant [] 3. Student [] 4. Artisan [] 5. Self-employed []
6. Unemployed [] 7. Others (Specify) _____
9. Oya owo oşoşu: -----
10. Oya owo oşoşu ti ọkọ: -----
11. Iye ọmọ meloo: _____

IPIN B: ÌMỌ NIPA ILANA IFETOSỌMỌBIBI LARIN AWỌN ÌYÁ ỌMỌ TI ỌDUN ORI WỌN KO TO OOKAN

12. Se o mọ ilana awon eto ifetosomobibi?
1. Bẹni 2. Bẹkọ Ti ko ba mọ, bọsi apakan C.
13. Ti o ba jẹ bẹni, şe akojọ won.
1) Condom [] 2) Oral pills [] 3) Safe periods (calendar method) [] 4) IUCD []
5) withdrawal method [] 6) vasectomy [] 7) Injectable []
8) Implants [] 9) Emergency pills [] 10) Lactational Amenorrhea method [] 11) Norplant []
12) Diaphragm [] 13) others.....
14. Kini awon orisun ti alaye re?

1. Redio ati telifisiyonu [] 2. Awon iwe pelebe [] 3. Awon ebi [] 4. Ore []
 5. Awon aladugbo [] 6. Awon osise ilera [] 7. Awon olori esin []
 8. Egbe agbegbo [] 9. Awon omiiran _____

15. Kini ifeto somo bibi?

Ifeto somo bibi wa fun awon eniyan lati ni atele nomba omo ti won fe julọ ati lati pinnu oyun nini.

16. Se ifetosomobibi se pataki? 1) Beeni 2) Rara

17. Ti o ba je be, fun idi meji.

- 1) O se iranlowo lati dabobo awon ewu ti o ni ibatan si oyun awon obirin
- 2) Lati dinku iku awon omo ikoko
- 3) Lati dena arun kogboogun
- 4) O se iranlowo lati fa fifale idagbasoke eniyan
- 5) O dinku oyun awon omode
- 6) O fun awon eniyan ni agbara ati imudarasiko.
- 7) O se iranlowo lati se awon ipinnu nipa alaye nipa akoko lati ni awon omode.

18. Ti ko ba si, fun idi meji.

- 1) O ni opolopo awon atako.
- 2) O n so obinrin di agan.
- 3) O n fa igbuuru ni awon omo inu omo.

19. Daruko awon iru-iso ti ifetosomobibi?

- 1) Condom 2) Oral pills 3) Safe periods 4) IUCD 5) vasectomy 6) Norplant
 7) Diaphragm 8) others

20. Iru ilana adaye ba ifetosomobibi wo lo mo?

- 1) Abstinence 2) withdrawal method 3) Safe period 4) Lactation Amenorrhea
 Method

21. Se atako wa si ilana eyikeyi ifetosomobibi? a) Beeni b) Rara

22. Ti o ba je be, daruko meta. (Ti ko ba si, lo si ibeere 23)

- 1) Fifun eje ni alaibamu []
- 2) Ayipada ibalopo []

- 3) Ere-ọpa []
- 4) Ibanuḡe []
- 5) Ẹfọri []
- 6) Inu rerun []
- 7) Ajeeji idagba irun []
- 8) Nkan osu wuwo []
- 9) Isusaro Isesi []
- 10) Iwadii awo-ara []
- 11) Ireje igbaya []

23. Tani eni ti o ye ki o se ipinnu lati bere liana ifetosomobibi?

- 1) Oko 2) Iyawo 3) Iya-oko 4) Iya Iyawo

24. Nigba wo ni o ye ki o se ipinnu ifetosomobibi?

- Nigbati ilera iyawo ba wa ninu ewu
- Ti wọn ba fe lati daduro oyun tókàn
- Deede nomba ti o fe fun omo
- Fe ki iyawo lati pari eko
- Lati dena STD/HIV
- Lati dena oyun ti a ko fe

IPIN C: IWỌPỌ ILANA IFETOSOMOBIBI LAARIN AWỌN ÌYÁ ỌMỌ TI ỌDUN ORI WỌN KO TO OOKAN

25. Se o n lo ifetosomobibi? a) Beḡeni [] b) Rara [] Ti ko ba si, lo si nomba 29,

26. Eyi wo ni o n lo lowolowo?

- 1) Condom [] 2) Oral pills [] 3) Safe periods (calendar method) [] 4) IUCD []
- 5) withdrawal method [] 6) vasectomy [] 7) Injectable []
- 8) Implants [] 9) Emergency pills [] 10) Lactational Amenorrhea method [] 11) Norplant [] 12) Diaphragm [] 13) others.....

27. Eḡe ti o fi n lo ona ifetosomo bibi na?

28. Odun ti lilo?

29. Se o tun fe lati lo o ni ojo iwaju?

30. Ona wo ni iwọ yoo gba?

- 1) Condom [] 2) Oral pills [] 3) Safe periods (calendar method)[] 4) IUCD []
 5) withdrawal method[] 6) vasectomy[] 7) Injectable[] 8) Implants []
 9) Emergency pills[] 10) Lactational Amenorrhea method[] 11) others

.....

31. Idi ti ona ti o mu ninu ibeere 30?

.....

.....

IPIN D: IWA AWỌN ÌYÁ ỌMỌ TI ỌDUN ORI WỌN KO TO OOKAN SI IFETOSOMQBIBI

S/N	Gbólóhùn	Bẹni	Rara	Alaiwadi
32.	O n gbe aisododo laruge?			
33.	Şe awon ona ifetosomọ bibi je ipalara nitori awon ipa egbe won?			
34.	Awon ona ifetosomobibi ni o munadoko ninu iseto awon idile?			
35.	Ipa mi ninu awon eto ifetosomobibi gbogun ti igbagbo mi?			
36.	O din ku idunnu ibalopo?			
37.	Ifetosomobibi je iru kan si iseyun?			

IPIN E: ITARA AWỌN ÌYÁ ỌMỌ TI ỌDUN ORI WỌN KO TO OOKAN SI IFETOSOMQBIBI

S/N	Gbólóhùn	Yes	No
38.	Mo setan lati wo aginal ring?		
39.	Mo ni itura ni itara oruka nigba ajosepo? ?		
40.	Mo gba lati lo ilana ifetosomobibi osoosu?		
41.	Mo setan lati dawo ilana ifetosomobibi duro lati pada si iroyin?		

42.	Mo nilo ilana dokita ki n to lo ilana ifetosomobibi.		
43.	Mo fẹ aaye ti o dara laarin awọn ibimọ mi		
44.	Emi ko setan lati dẹkun ibinmọ		

IPIN F: AWỌN OKUFA OJUŞE FUN LILO ILANA IFETOSOMOBIBI LAARIN AWỌN İYÁ OMỌ TI ODUN ORI WỌN KO TO OOKAN

S/N	Gbólóhùn	Bẹni	Rara
45.	Şe o ti ni oyun ti ko ni ipileşẹ tẹlẹ?		
46.	Şe o fẹ lati ni iriri rẹ lẹkansi (unplanned pregnancy)?		
47.	Ọkọ mi lo ni ipinnu bi mo ba lo ilana ifetosomobibi?		
48.	Lilo eyikeyi ilana ifetosomobibi lodi si igbagbọ ẹsin mi?		
49.	Awọn ọna ifetosomọ bibi jẹ gbowolori?		
50.	O gba to ogbon işeju tabi diẹ si lati ile mi lo si ile iwosan.		
51.	O jẹ eewọ lati lo awọn ọna ifetosomobibi ninu ẹbi mi		
52.	Awọn oşişe ilera ko şe itokasi lori pataki ti ifetosomobibi jẹ.		
53.	Ni awọn oşu diẹ ti o gbeyin, se o ti gbọ nipa ifetosomobibi ni eyikeyi media?		
54.	Ni iwọn odun kan to koja, mo ti lo si ike iwosan lati gba ilana ifetosomobibi.		

ĘSE ADUPE FUN AKOKO YIN TI Ę FUN WA.

APPENDIX V

Ibadan North Local Government Primary Health Board Approval letter

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Oyo Health Ethical Review Committee Approval letter

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