

**AWARENESS, ATTITUDE AND PRACTICE OF FAMILY PLANNING AMONG  
WOMEN OF CHILD BEARING AGE IN FEDERAL MEDICAL CENTRE OWERRI, IMO-  
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**ABSTRACT**

The purpose of the study was to ascertain the level of awareness attitude and practice of family planning among women of child bearing age attending ante natal at FMC Owerri. To accomplish the research purpose, three research questions was formulated. Descriptive design was adopted for the study. The sample size was 1000 women drawn from the total population of 20,000 who were attending ANC as at time of conducting the research. The instrument for data collection was a no eight item questionnaire; the data was collected and analyzed using frequency table, bar chart and pie chart. Finding among others revealed that 1000 respondents (100%) have heard about family planning, 995 ie 99.6% have had lectures up to 4 different times in family planning indicating high level of awareness of family planning among the responses 700 (70%) accepted family planning, 500 (50%) showed increased partner co-operation and 560 (56%) accepted and also health educate mothers on family planning which reflected a positive attitude of family planning. 200 (20%) started family after first birth, 350 (35%) after second birth and 450 (45%) after the fourth birth which showed that women's contraceptive use is positively related to parity. Above all the finding showed that there is high level of awareness and practice and positive attitude towards family planning by women attending ante natal clinic is Federal Medical Centre Owerri. The recommendations among others are, the Federal and State Ministries of health should improve the family planning clinics both in the urban and rural areas to increase access and choice. The male folk should be actively involved in family planning to improve compliance.

**KEYWORDS:** awareness, attitude, practice, family planning, women of child bearing age.**INTRODUCTION**

History is replete with man's conscious and concerted efforts to have healthy population by not allowing pregnancies at short intervals and by not allowing population out run food supply. This need to space out pregnancies or babies was even strongest in the far past when it was a taboo for a woman to become pregnant while nursing or breast feeding a baby especially in the under developed (developing world) like the sub-Sahara Africa. Anyiam (2008) opined that it is a truism that unexpected or unplanned pregnancy poses a major public health challenge in women of reproductive age especially in developing countries. It is also true that man's obedient to God divine command to increase and multiply and fill the earth has led to unexpected rapid growth in population, often times unhealthy, ruined, famine ridden population. The concern over these problems, immediate and remote continued till Malthus propounded that the rate of population growth could be checked by "preventive checks" self restrain in curbing

sexual passion, family planning and late marriages. It becomes pertinent here to state that the family is the functional unit of the society – the larger population. Maternal morbidity and mortality problems are compounded by exponential increase in population growth, industrial revolution, rise in human productivity and urbanization, ushered in by the agricultural revolution of the 15<sup>th</sup> century (Ezumike, 2010). Since the problem transverses periods and associated with poverty, under development, a great number of women in developing countries of sub Sahara Africa, who would like to delay their next pregnancies or even stop bearing children altogether find themselves relying on traditional methods (crude) or resigning to fate because they lack access to contraceptive or hit barriers for using contraceptive, wrongly though (Ijeoma, 2010). Otoide (2014), opined that unprotected intercourse is the primary cause of unwanted pregnancy, many of which are illegally terminated by abortion. Unsafe abortion accounts for 20 – 40% of material death in Nigeria.

To appreciate the role of over-population (population-meaning the number of people living in a specified geographical area), a brief chronicle of population trend is imperative. Anyiam (2008) opined that by the year 1000, world population was about 250 million with very low population growth rate. But from 1000 through 1900, population increased from 900 million to 1.6 billion (Anyiam, 2008). Currently, world population stands between 5.3 to 6.2 billion with growth rate of 6 (percent) per 100,000 live births. It should be pointed out above growth rate was low because population depended on human fertility alone. But with the technological and scientific discovery years of 1900s, epidemiological and demographic transitions brought about lowered death rates with a shift from fatal infections, to degenerative diseases, all these leading to longevity and more rapid growth rate thus compounding population problems (Ijeoma, 2010). This scenario used to be true of developed worlds alone, but today, globalization has made it equally existent in the developing sub-Sahara African countries, Nigeria inclusive. The epilogue bordering on population is pertinent because population explosion in the near future would be far feared than nuclear explosion. Secondly, the harp on population is important because statistics in Nigeria, for example, has shown that children are born every day without a corresponding level of improvement in health care delivery services thus a possible high maternal death rate and fairly reduced infant mortality rate courtesy of immunization (Ejifugha, 2010).

Maternal mortality rate in Nigeria is among the highest in the world. Ejifugha (2010), noted that maternal mortality rate in Nigeria ranged from 800 to 1500 deaths per 100,000 live births, and is among the highest in the world. WHO (1995), estimated that some 500,000 women would die yearly as a result of complications in pregnancy and child birth.

Giving skeleton to maternal mortality – graphic picture of how it results, Chiwuzie (1995) explained that the high level of maternal mortality in developing countries stems from a complex array of factors in addition to the inadequacy of health services. Such factors include social, cultural, economical, logistic problems, coupled with high fertility. Similarly, WHO, (1996), identified low socio-economic and political status, lack of local supplies/facilities, equipment and human customs and practices, as factors that adversely affect women's lives and may lead them to death. Furthermore, Fathalia (1998) opined that the cause of maternal mortality death are complex, arising from conditions such as; early marriage, lack of basic pre-natal care, inadequate health

facility/supplies, lack of basic family planning, poverty, poor socio-economic status, poor nutrition, illiteracy, pride in having many children. Fathalia, further grouped these into four: Medical factors, health factors, reproductive factors and socio-economic factors.

Ijeomah (2002), while discussing prevention of maternal death, opined that maternal mortality is worst than a hurricane wind, and its optimum prevention is only achieved if commenced before conception in the child bearing aged women while Akinsola (2006) suggested that special attention has to be given to the women during pregnancy, delivery and after delivery.

Akinsola (2006) further buttressed that death of the child-bearing age women is real and preventable, but arises from neglect, inadequate facilities, and socio-economic and cultural view points, especially in the developing countries, the government, International Agencies, and Non-governmental Organization (NGOs) launched the world wide safe-motherhood initiative (SMI) at an International Conference in Nairobi in 1987. Chiwuzie (1995) opined that SMI is a global effort to reduce maternal mortality and morbidity. This sorry and pitiable situations towards the maintenance of safe motherhood above, which scare women of child bearing age on the face, including the fact that efforts to have planned family has concerned men of different historical period and also the fact that even today with its blossomed learning/knowledge. Some religion reject family planning and this has aroused the researchers interest to work on the awareness, attitude and practice of family planning among women of child bearing age who attend ante natal services at Federal Medical Centre, Owerri.

#### **Purpose of the Study**

The purpose of this study is to describe the awareness, attitude and practice of family planning among women of child bearing age who attend ante natal in FMC, Owerri.

#### **Population of the Study**

The target population for the study consisted of all women of child bearing age (15-49) attending ante-natal clinic at FMC Owerri from January to June 2014 and January to June 2015.

Approximately an average of 20,000 pregnant women of ages 15-49 attended ante-natal clinic within January-June 2014/2015; the twelve months used for the study, 13,000 were old patients while 7000 were new patients.

**Table 1: Target Population**

S/NO	Age range	No of pregnant women (15-49)
1	Less than 15	Nil
2	15 – 24	7,000
3	25 – 34	9,000
4	35 - 49	4,000
	<b>Total</b>	<b>20,000</b>

### Sample and Sampling Technique

The sample consists of 1000 women of child bearing age (15 – 49) who use FMC Owerri for ante-natal services within the period of study and who responded to the questionnaire.

Ejifughha (2004) defined sampling as the process of selecting participants from the population and it is used when the population is large, human and material resources are limited and when time available is limited. In this study, random sampling method was used. Pandey (2011) defined random sampling as a method where all members or units of the population have equal and independent chances of being included. Ejifughha (2004) stated that larger population will take a lot of time and resources thus adversely affecting the quality of findings. He stated that when a population is in many thousands, 5% would serve; few thousands, 10% would serve; many hundreds, 20% would serve, while in few hundreds, 40% would serve. Since the target population is 20,000 the researcher used 5% of the target population, employing the formula below:

$$\frac{5}{100} \times \frac{20,000}{1} = \frac{100,000}{100} = 1000$$

**Table 2:**

S/NO	Age range	Population size	
1	15 – 19	6,000	300
2	20 – 30	8,000	400
3	31 – 39	5,000	200
4	40 - 49	1,000	100
<b>Total</b>		<b>20,000.00</b>	

**Stage 1:** First random sampling by balloting with replacement was used drawing 1000 from the 21,100 used by the researcher.

**Table 3: Distribution of Age of Respondents (n=1000).**

VARIABLE	FREQUENCY	PERCENTAGE
	N=1000	=100
Less than 15 years	0	0%
15-24 years	350	35%
25-34 years	550	55%
35-49 years	100	10%
<b>Total</b>	<b>1000</b>	<b>100%</b>

In the above table 350 (35%) women were between 15-24 years while ages between 25-34 years were 550

**Stage 2:** Also simple random sampling with replacement was used to draw 5 months used for the study.

**Stage 3:** 5 working days was sampled for the study.

**Stage 4:** Simple random sampling with replacement was used to draw 200 respondents each for the five working days to make a total of 1000 respondents (sample).

### Method of Data Collection

The project supervisor raised a letter of introduction to FMC Owerri in favour of the student to be allowed access and release of data; the researcher used 1000 copies of self administered questionnaire distributed face to face to mothers during ANC clinics between the months of January and June, 2014/2015. 1000 questionnaire were served at a time and all collected immediately for the 5 working days 100% return was recorded.

### Method of Data Analysis

The research design described attitudes, awareness and practice of family planning among women aged 15-49 years. Data collected were analyzed using descriptive statistics of frequency, percentage, as well as presentation of result on tables, bar chart and pie chart.

### Ethical Consideration

Nursing is an ethical profession which demand ethics at all levels of practice. The ability to conduct a research successfully is based on the researcher's knowledge of the fact that individuals involved in the research have certain right and privileges which should not be overlooked. The privacy of all the respondents were assured by entering that no name was written and the responses and answers kept anonymous.

(55%) and ages between 35-49 years were 100 (10%) respondents.

**Table 4: Affiliation of the Respondents.**

VARIABLE	FREQUENCY	PERCENTAGE
	N=1000	=100
Orthodox churches	700	70%
Pentecostal churches	270	27%
Islamic	30	3%
Traditional	-	-

In table 4 above 700 (70%) of the respondents were from orthodox churches 270 (27%) are from Pentecostal churches and 30 (3%) are Muslims.

**Table 5: Distributions of Parity of Respondents.**

VARIABLE	FREQUENCY	PERCENTAGE
	N=1000	=100
None	50	5%
1-4	550	55%
More than 4	400	40%
<b>Total</b>	<b>1000</b>	<b>100%</b>

In table 5 above 550 (55%) have had one to four issues, 400 (40%) have more than four children and 50(5%) are primigravids that have not had any birth.

**Table 6: Distributions of Responses on level of Education.**

RESPONSES	FREQUENCY	PERCENTAGE
	N=1000	=100
Non Formal Education	Nil	-
Primary School	70	(7%)
Secondary School	430	(43%)
Tertiary School	500	(50%)
<b>Total</b>	<b>1000</b>	<b>(100%)</b>

In the table 6 above, 70 (7%) have primary education, 430 (43%) have secondary education and 500 (50%) have tertiary education.

**Table 7: Ethnic Group Distribution of Respondents (n=1000).**

VARIABLE	FREQUENCY	PERCENTAGE
	N=1000	=100
Igbo	800	80%
Hausa	150	15%
Yoruba	30	3%
Others	20	2%

The table above shows that about 800 (80%) of the respondents are Igbos, 150 (15%) are Hausas, 30 (3%) are Yorubas while others are 20 (2%).

**Table 8:**

OPTION	FREQUENCY	PERCENTAGE
	N=1000	=100
Yes	1000	100%
No	0	0%
<b>Total</b>	<b>1000</b>	<b>100%</b>

Table 8 shows the frequency cum percentage of respondents, who have heard of family planning before.

From the table, all the respondents have heard of family planning i.e. 100%.

**Table 9: Frequency Distribution of Respondents who have had talks on family planning.**

OPTION	FREQUENCY	PERCENTAGE
	N=1000	=100
Yes	995	99.5%
No	5	0.5%
<b>Total</b>	<b>1000</b>	<b>100%</b>

Table 9 shows number and percentage of respondents who have had talks on family planning probably during ante natal clinic or elsewhere. 995 (99.5%) of respondents have not only heard of family planning before, but only 5 (0.5%) respondents have had lecture on it.

**Table 10: Frequency Distribution of the number of times the respondents had talk on family planning.**

VARIABLE	FREQUENCY	PERCENTAGE
	N=1000	=100
None	5	0.5
1-3 times	150	15
More than 3 times	945	84.5
<b>Total</b>	<b>1000</b>	<b>100</b>

From the above, 5 (0.5%) have not had talk on family planning, 150 (15%) have had talk 1-3 times, 845 (84%) have had talks more than 3 times. Thus, many have had talks on family planning.

**Table 11: Frequency Distribution of respondents on places where family services could be accessed.**

OPTIONS	FREQUENCY	PERCENTAGE
	N=1000	=100
FMC Owerri/Other Health Institution	1000	100
One's Local Church	0	0
Market place	0	0
<b>Total</b>	<b>1000</b>	<b>100</b>

From the above, all the respondents answered in the affirmative that family can only be accessed from FMC Owerri and other health institutions and not from churches or market places.

**Table 12: Table shows responses to positive attitude to family planning exhibited by women attending ante natal clinic at FMC Owerri.**

OPTIONS	FREQUENCY	PERCENTAGE	FALSE
	N=1000	=100	
Increasing Acceptance	700 (70%)	300 (30%)	0 (0%)
Increasing Partner Cooperation	500 (50%)	400 (40%)	100 (10%)
Encouraging others	560 (56%)	380 (38%)	60 (6%)
<b>Total</b>	<b>1760 (58.66%)</b>	<b>1080 (36%)</b>	<b>160 (5%)</b>

The table above shows the distribution and frequency of acceptance and positive attitude to family planning by respondents. While a total of 1760 responses affirmed it is very true there is increasing positive acceptance and (increase acceptance 700 (70%), partner cooperation 500 (50%), encouraging others 560 (56%). A total of 1080 (36%) responses upheld that it is true that respondents positive attitude to family planning is on the increase. However, a total of 160 (5%) responded that there is no positive attitude to family planning by respondents.

**Table 13: A table showing different times those who practiced family planning started it.**

VARIABLE	FREQUENCY	PERCENTAGE
	N=1000	=100
After the 1 <sup>st</sup> Child	200	20
After the 2 <sup>nd</sup> Child	350	35
After the 4 <sup>th</sup> Child	450	45
<b>Total</b>	<b>1000</b>	<b>100</b>

From the table, respondents who commenced family planning after they had their 4<sup>th</sup> babies were more, 450 representing 45%. This was followed by those who commence after their 2<sup>nd</sup> babies, 350 (35%). Lastly, that respondent whose first time of embracing family planning was after their 1<sup>st</sup> baby is 200 (20%).

**Table 14: A table showing respondents preference (choice) of family planning methods.**

Family Planning Methods	Always	Sometimes	Rarely
	N=1000	=100	
Oral Pills	300 (30%)	30 (3%)	250 (25%)
Condoms	150 (15%)	250 (25%)	50 (5%)
IUCD	200 (20%)	100 (10%)	—
Injectables	50 (5%)	1000 (100%)	20 (2%)
Norplant/Implant	50 (5%)	30 (3%)	—
Emergency Pills	600 (60%)	—	—
Natural Family Planning	5 (0.5%)	80 (8%)	—



Tubal Ligation	—	—	—
Vasectomy	—	—	—
Lactation Amenorrhoea	750 (75%)	—	—

From the table above, respondents who use Lactation amenorrhoea, Emergency Pills, Oral Pills, IUCD, Condoms, and natural Family Planning have the highest frequencies respectively. Lactation amenorrhoea was 750 (75%) followed by those who use emergency pills always 600 (60%). Thirdly responses that favoured oral pills, IUCD and condom always are 300 (30%), 200 (20%), 150 (15%) respectively, the least frequently used was natural family planning with 5 (0.5%) responses.

As for injectables, 50 (5%) Norplant/Implant, 50 (5%) tubal ligation and vasectomy there were no responses favouring their frequent use. The table also shows that the various methods used always have 2105 responses while 1110 and 320 responses indicated various methods sometimes and rarely respectively. The frequencies are apparently high because switch over from one method to another is a common practice.

**Table 15: Shows the respondents who are satisfied with the type of family planning method currently used.**

SATISFACTION	FREQUENCY	PERCENTAGE
	N=1000	=100
Yes	730	73
No	210	21
Not indicated	60	6
<b>Total</b>	<b>1000</b>	<b>100</b>

From the above table, 730 (73%) of women answered yes, showing that they are satisfied with the family planning method they are using, while 210 (21%) said no indicating that they are not satisfied while 60 (6%) did not indicate whether they are satisfied or not.

## DISCUSSION

In a study by Okonta and Ande (2003), on the knowledge and perception of Emergency contraception among Nigeria undergraduates, the accessible population was 6000, study sample 880 (14.66%). Based on percentage of responses that favoured exposure to gatherings were family planning was thought, majority of women who attended ante-natal, clinics have adequate knowledge of the benefits, gain of family planning and actually practice it.

The 3<sup>RD</sup> most respondent of responses of 300 or 30% represent those who use oral pills while those who use IUCD and condom had 200(20%) and 150(15%) respectively. Natural family planning method is the least used method having 5 (0.5%). Since multiple responses was allowed, among methods u' sometimes, use of emergency pills had the highest frequency, 400 or 40%, use of condom 250(25%) and lactation amenorrhoea 120 responses or 12%. The other methods IUCD 100 or 10%, natural family planning 80(8%) and the least used was oral pills 30(3%). Injectables 50(5%), Norplant/implants 50(5%), tubal ligation and vasectomy there were no responses at all in favor of them, be it under always, sometimes or rarely. Summation of the table shows that 2005(61%) responses use lactation amenorrhoea, emergency pills, oral pills, IUCD and condoms always, while 980 use the same methods sometimes, and 300 responses use oral pills and condoms rarely.

Total responses tend to be higher than sample number because of switch over effect. For example, use of

lactation amenorrhoea is a temporary one, can be use as long as lactation last.

The result showed a high level of practice of family planning among use women of child bearing age. The result was in support with a similar study done in rural Cambodia. 139 married women were selected randomly 248(56%) of the women were practicing family planning at the time the survey was conducted, with their main reason being fertility desire despite the side effect of some methods and to maintain their standard of living.

## CONCLUSION

From the beginning, it is observed that FMC Owerri plays its role as one of the standing tertiary hospital very well. No client comes into it and leaves without a talk on one or more health issues. This good news about family planning including spreading of the advantages and clearing of misconception are spread. With good educational background and exposure to health education, women of WCBA have gained appreciable level of education of family planning and other health issues. They are enthusiastic and encouraged other women to embraced family planning. The awareness and positive attitude and practice which women exhibit towards family planning, no doubt is as a result of exposure to health talks in big hospitals.

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