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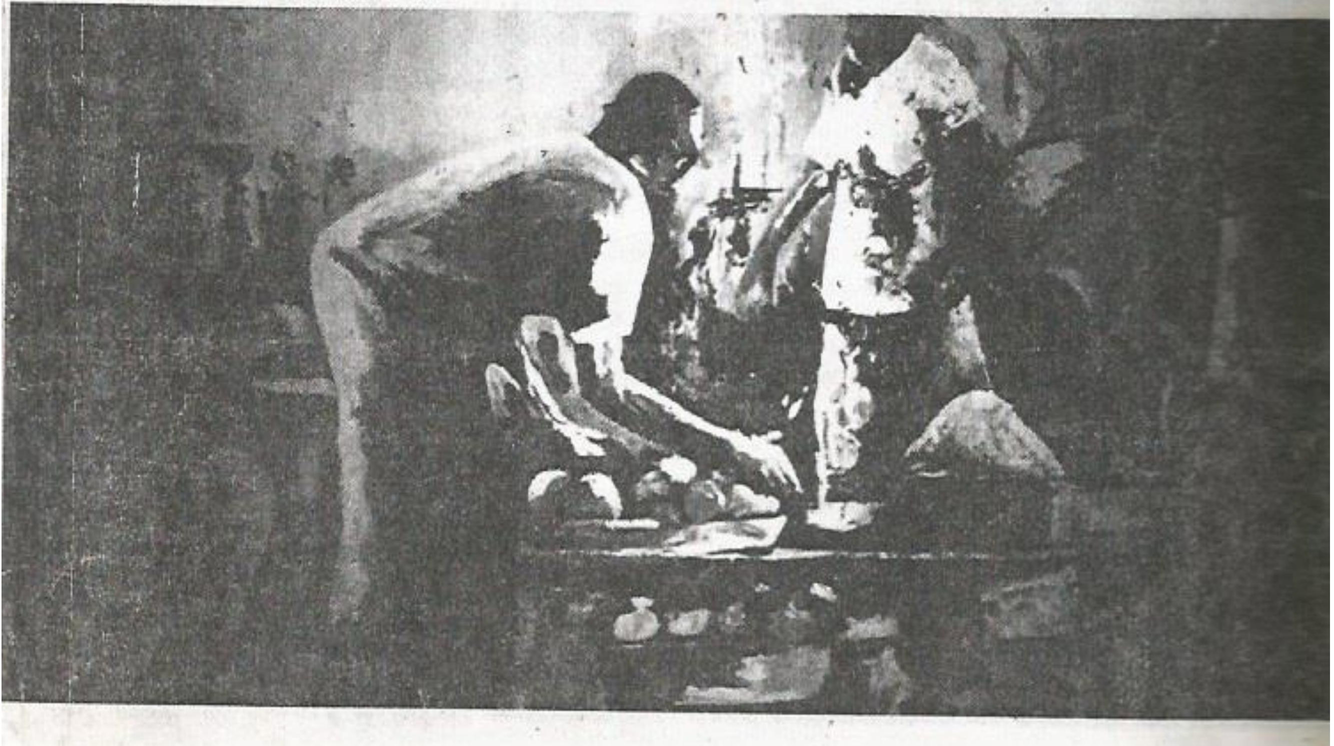

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KNOWLEDGE AND USE OF FAMILY PLANNING METHODS: A CASE STUDY OF EBONYI STATE UNIVERSITY, ABAKALIKI

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INTRODUCTION

When people have positive attitude towards family planning, they are more likely to adopt one or more of available family planning methods. The research is centered on knowledge; use and source of contraceptives especially among women of reproductive age [15 – 49]

Family planning is the various ways in which couples control the number of their children or spacing their birth for overall improvement of the family. Family planning has been misunderstood by many people in Nigeria to be legalized abortion. According to Onyia [2003]

> "*It simply means that couples should adopt measures to avoid frequent childbearing leading to too many children. Pregnancies should be spaced in such a way as to allow a mother to recover sufficiently from the telling effects of one birth before the other. This will also allow the parents sufficient time to give one baby, the necessary foundation before the next one is conceived.*"

Through family planning, couple can have the number of children they want and can afford. Birth therefore becomes a matter of choice rather than chance. Nwana [1997] noted that family planning as a concept involves voluntary limitation of birth by choice, either for the purpose of limiting family size or for spacing pregnancies.

Nigerian men, on average want even more children than Nigerian women. Indeed men's mean ideal number of children is about two children more than that of women [8.5: version 6.7]. Currently married men report a mean ideal number of children that is three children more than the ideal of currently married women [10.6 versus 7.3]. These findings are similar to those from the 1999 NDHS [NPC, 2000:95].

ORIGIN OF FAMILY PLANNING IN NIGERIA

The first move in modern times according to Ifedinugo [2004] to introduce and popularize the acceptance and practice of family planning was made by Margaret Sanger a nurse in New York City in 1912. History has it that Margaret Sanger lost one of her best friends through childbirth. Painful as it was she felt very bad because that was the deceased woman's 12th pregnancy, including the fact that her husband was earlier warned. After this ugly incidence Margaret Sanger decided to do something to reduce maternal death in her country by introducing a health programme that could enable the women to decide how/when and the frequency with which to have children. This method is called family planning. The Government of the day in United States of America was completely against the proposal, so she was jailed for initiating that programme. The reaction of the countrywomen compelled the Government to release Margaret Sanger. She opened the first family planning clinic in 1916 at New York City. Through the efforts of Margaret Sanger, the services spread to Britain and other European countries.

In his own contribution Ugboaja [1997] noted that the need for family planning

was identified in Nigeria in 1957 by some public – spirited individuals as a result of the incidence of tragic cases of septic abortions, which occurred in Lagos. This incidence compelled the then Lagos marriage guidance council to set up a Committee to look into the need for modern family planning practice in the country. The Committee found that illegal abortions were common among both married and unmarried women because of unintended pregnancies and recommended the need for modern family planning practice as a way of stemming the negative trend.

This development according to Oyebola [1990] led to the opening of the first Family Planning Clinic in Lagos in 1958. The clinic was resuscitated with fund from Pathfinder International, The Population Council and International Planned Parenthood Federation [IPPF]. The clinic provided family planning and contraceptive services to the Family Planning Council Federation of Nigeria [NPFN]. The Federal Ministry of Health departments all have family planning units. Ugboaja [1995] noted that Nigeria has witnessed a lot of expansion in family planning service delivery and also the training of family personnel.

STATEMENT OF PROBLEM

According to Demographic and Health Survey 2003, one third of women aged 25 – 49 reported that they had sexual intercourse by age 15. By age 20, more that three quarters of women, and by age 25, nine in ten women have had sexual intercourse. One quarter of teenage women has given birth or is pregnant. Early child bearing is more of a rural phenomenon with 30 percent of rural women aged 15 – 19 having been child bearing compared with 17 percent of urban women in the same age group.

The 2003 NDHS survey estimates infant mortality to be 100 per 1000 births for the 1999 – 2003 periods. This means that more children are surviving today than the days of our forefathers. A contraceptive survey carried out in 1992 by the Federal Office of Statistics showed that overall use of modern contraceptive methods is as low as 10.4%; it was also observed that there was no significant increase from the above figure over the years. The National Demographic and Health Survey [NDHS] which was carried out in 1990 by the Federal Office of Statistics and the National Integrated Survey of Households [NISH] both confirmed that the knowledge level is 83% while level of practice is 10.4%. The researcher is worried about this wide disparity, hence the present research.

THEORETICAL FRAMEWORK

A woman's desire and ability to control her fertility and her choice of contraceptive method are partly affected by her empowerment status and self – image. A woman who feels that she is unable to control her life may be less likely to feel she can make and carry out decisions about her fertility.

According to the contraceptive prevalence report of the Federal Office of Statistics [FOS] in 1992, contraceptive use among women of reproductive age in Nigeria is as low as 10.4% while the National Demographic and Health Survey NDHS which was carried out in 1990 by the Federal Office of Statistics and the National Integrated Survey of Households [NISH] both confirmed that the knowledge level is 83% while practice is 10.4%. This implies that a wide gap exist between knowledge of family planning one hand and actual practice on the other.

Knowledge of contraception among men is higher than among women. Knowledge of contraceptive method or any modern method for all men is almost universal, with 9 out of every 10 men knowing at least one method. The most well known modern method is the male condom [87%] followed by the pill [57%]. The mean number of methods known by all men is five, while currently married

men and sexually active unmarried men know an average of close to six.

The mean number of methods known is a rough indication of the breadth of knowledge of family planning methods. On the average, all women and currently many women know four methods each, while sexually active unmarried women know six methods.

Many researchers have attempted to give reasons for this wide disparity. Many attribute it to the fact that the aggressive media publicity was not matched with family planning providers and community distribution agents. There are rumors moving round about possible side effects. Oghide [1994] noted that most women who would have ordinarily become potential acceptors either decide not to practice at all or discontinue after some time because of rumors. The Governments have also been blamed for this wide gap between knowledge and acceptance because according to Ifedinugo [2004] the inability of the Governments to come out and support family planning programmes dealt a very big blow on the expansion of clinical services provision especially to the rural areas where we have a lot of women who are vulnerable.

ACCESS TO CONTRACEPTIVE CHOICES

The National Demographic Health Survey [1990] observed that only 6% of married women use a contraceptive method [3.5% use a modern method and 2.5% use a traditional method]. These levels of practice were low though reflected an increase over the past decade. Ten years ago just 1% of Nigerian women were using a modern family planning method. The report further Stated that the pill, IUCD and injectables are most popular modern methods used by couples. Each of these methods is used by about 1% of currently married women. However the single most widely used method is periodic abstinence or rhythm method used by 1% of married women.

Contraceptive acceptances among women vary according to level of education and areas of residence etc. According to the annual work programme of the Planned Parenthood Federation of Nigeria, certain groups of women are more likely to use some method than others. For instance, 15% of urban women use method that others. While 15% of urban women use methods as do 15% of women in the southwest zone of Nigeria. Similarly, contraceptive prevalence rate is higher among women who have complete secondary or higher education. The level of contraceptive use is much lower among certain classes of women. Specifically rural women tend to shy away from practicing family planning when compared to their urban counterparts, [4%]. Women in the North East and North West part of the country equally show a lot of reluctance in practicing family planning [1%] while women with no education recorded [2%] practice rate.

SAMPLE SIZE AND TECHNIQUE

Workers of Ebonyi State University are divided into two broad categories – academic and non – academic. These are further subdivided into junior and senior non – academic staff. Because of constraints of time and fund, this research rounded on only 10% of the entire population which is 118.

On the whole therefore, 118 staff drawn from the university population served as the sample for this study. Stratification for that purpose was aimed at improving the representativeness of the sample.

The selection of the 118 staff who served as the sample for this study was randomized. Four lists of the staff of the University were compiled as follows:

a. A list of junior academic staff

b. A list of senior academic staff
c. A list of senior non – academic staff
d. A list of junior non – academic staff

On the whole 10% of the members of each stratum were chosen to form the sample of this study through the method of systematic selection. In order to achieve a high degree of randomness using this method the researcher produced original lists of staff that were in random order

DATA COLLECTION AND ANALYSIS

The questionnaire was the only data – collecting instrument of this research work. The researcher ensured that the questionnaire was reliable and valid by testing and retesting the questionnaire before administering them to the main respondents of this research work.

Mean scores of response were used in answering the research questions. The hypotheses formulated for this study were tested with the use of the t – test statistics

RESULTS AND DISCUSSION

The study identified from the review of literature, the following variables of interest, which formed the basis for analysis;

i. Level of education
ii. Women interest
iii. Economic power and religious affiliations
iv. Elderly women

HYPOTHESIS ONE: LEVEL OF EDUCATION

The attitude of highly educated women does not significantly differ from the attitude of lowly educated women in family planning acceptance.

TABLE 1: OBSERVED AND EXPECTED FREQUENCY TABLE FOR LEVEL OF EDUCATION

Responses	*Observed [O]*	*Expected [E]*	*O – E*	$\frac{[O-E]^2}{E}$
Yes	21	14.6	6.4	2.8
No	4	10.4	– 6.4	3.9
Yes	18	17.5	0.5	0.0
No	12	12.5	– 0.5	0.0
Yes	13	17.5	– 4.5	1.2
No	17	12.5	4.5	1.6
Yes	17	19.3	– 2.3	0.3
No	16	13.7	2.3	0.4
	118		0	10.2

$X^2_c = 10.2$ while $X^2_t = 0.05$, 3d.f = 7.81. Since X^2 calculated is greater than X^2 tabulated, we reject H_0

HYPOTHESIS TWO: WOMEN INTEREST

The attitude of women towards family planning does not significantly differ from that of men

TABLE 2: OBSERVED AND EXPECTED FREQUENCY TABLE FOR WOMEN INTEREST

Responses	*Observed [O]*	*Expected [E]*	*O – E*	$\frac{[O-E]^2}{E}$
Yes	19	15.3	3.7	0.9
No	6	9.7	– 3.7	1.4
Yes	20	18.3	1.7	0.2
No	10	11.5	– 1.5	0.2
Yes	13	18.3	– 5.3	1.5

No	17	11.5	5.5	2.6
Yes	20	20.1	− 0.1	0.0
No	13	12.9	0.1	0.0
Total	118		0	6.8

Critical value of $X^2{}_{t\ at}$ 3d.f with 95% confidence interval is 7.81 i.e. X^2 to .05 [3df] = 7.81. Since calculated value [$X^2{}_t$ = 6.8] is less than the table value [$X^2{}_t$ = 7.81], we accept the H_0

HYPOTHESIS THREE: ECONOMIC POWER AND RELIGIOUS AFFILIATIONS

Acceptance of family planning by men is not a function of economic power and religious affiliations.

TABLE THREE OBSERVED AND EXPECTED FREQUENCY TABLE FOR ECONOMIC POWER AND RELIGIOUS AFFILIATIONS.

Responses	*Observed [O]*	*Expected [E]*	*O − E*	*[O − E]²/E*
Yes	21	14.8	6.2	2.6
No	4	10.2	- 6.2	3.8
Yes	17	17.8	− 0.8	0.0
No	13	12.2	0.8	0.1
Yes	13	17.8	-4.8	1-3
No	17	12.2	4.8	1.9
Yes	19	19.6	− 0.6	0.0
No	14	13.4	0.6	0.0
	118		0	9.7

The chi – square table value [$X^2{}_t$] at 0.05 level of significance and 3 degrees of freedom is 7.81
Since calculated value [$X^2{}_c$ = 9.7] is greater than tabulated value [$X^2{}_t$ = 7.81] we reject H_0 and accept H_A

HYPOTHESIS FOUR: ELDERLY WOMEN

The attitude of elderly women before menopause does not significantly differ from that of the women of younger generation.

TABLE IV: OBSERVED AND EXPECTED FREQUENCY TABLE FOR ELDERLY WOMEN

Responses	*Observed [O]*	*Expected [E]*	*O − E*	*[O − E]²/E*
Yes	16	9.7	6.3	4.1
No	9	15.3	- 6.3	2.6
Yes	8	11.7	− 3.7	1.8
No	22	18.3	3.7	0.7
Yes	13	11.7	1.3	0.1
No	17	18.3	− 1.3	0.0
Yes	9	12.9	− 3.9	1.2
No	24	20.1	3.9	1.2
	118		0	11.3

$X^2{}_c = 11.3$
$X^2{}_t\ 0.05\ (3df) = 7.81$
Since $X^2{}_c$ (11.3) > $X^2{}_t$ 0.05 (3df), we reject the H_0 and accept H_A

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