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ATTITUDE OF WOMEN TOWARDS FAMILY PLANNING IN SELECTED RURAL COMMUNITIES OF IBADAN,

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ABSTRACT

The immediate need to control the high fertility rates among women in the rural part of Nigeria has attracted the interest of scholars in the academic world. Lots have been done by international agencies and other stakeholders to encourage the use of family planning methods among women both in rural and urban areas of developing countries including Nigeria. This notwithstanding, there still exist a great challenge of unmet needs regarding family planning especially in the rural part of Ibadan as the desired attitudinal and behavioral changes towards family planning is yet to be achieved. This study attempts to examine the attitude of women from selected rural areas in Ibadan towards family planning using the Health Belief Model and Social Action as frameworks for explanation. The qualitative and quantitative methods of research were employed with a survey of 136 randomly selected mothers from 5 rural communities in Ibadan, 15 IDI', 5 KIIs and 5 FGDs. The Statistical Package for Social Sciences was utilized in analyzing the quantitative data, while the qualitative data were analyzed using content analysis.

The study revealed that the socio-economic status of mothers significantly influenced their attitude towards family planning. Most of the women had only primary education and more women had no formal education compared to those who had secondary and tertiary education, hence few of them displayed positive attitude towards family planning methods. Majority of the women hardly gave birth in hospitals and depended on their husbands to decide what ever method will be used to space or limit the number of children they will have. The study also revealed that women perceived benefits of family planning as measures: to control population, reduce infant and maternal mortality and also make mothers healthy and strong after child birth. However, these were learnt after they had given birth to more than four children in other places aside the hospitals.

The study recommends that couples in rural areas be encouraged to make effective use of contraceptives and adequately educated to appreciate the essence of utilizing family planning methods in order to give birth to quality children. Ante-natal and delivery cost should be highly subsidized in rural areas for women to be encouraged to give birth in the hospitals from the very first child and learn about family planning methods. It was also recommended that family planning programmes that will attract

couples to increase their knowledge and positively influence their attitudes towards practicing family planning especially in the rural parts of Ibadan be sponsored and supported by the government.

Key words: Family planning, Contraceptive use, attitude, perceived benefits, Perceived side effect.

INTRODUCTION/STATEMENT OF PROBLEM.

Family planning has overtime being a major phenomenon in the control of population both in the developing and developed world. This is because a nation's development is not only dependent on the resources she has, but also on the number of people to share from the resources. The population of the Nigerian society has no doubt increased continually, despite the challenges of maternal and infant mortality rates. This is observed to be prominent in rural communities than urban (Toure 2002). Also, acceptability and practice of family planning methods is more observed among educated people than among the uneducated that are more resident in rural communities. It is therefore not surprising that a significant difference was revealed in the attitude of women towards family planning with reference to their place of residence, rural and urban residence where the majority were illiterate (Toure 2002). ! Although contraceptive use in developing countries including the Sub-Saharan part of African was observed to have increased from 10 percent in the 1960s to 50 percent in the 1990s, population growth in this part of the world is still eminent (Robey et al 1994).

According to Robey et al 1994, many women in developing countries use family planning methods to prevent unwanted and unplanned pregnancies, however, unmet need for child-spacing and limiting the number of children to be born per couple is still posing a great challenge to the controlling population growth in Nigeria. This is because family planning methods are not practiced in such a manner that will commensurate with the intention to space and/or limit the rates of unwanted pregnancies and child birth. This to a large extent is not unconnected with the implication of patriarchy and marginalization of women experienced more in the rural communities of the Nigerian society. Women's decisions regarding family planning are usually undermined and overpowered by those of their husbands according to Onsuzi (2009). This is also aggravated by the level of dependency of women on their husbands due to lack of education and economic empowerment (Olutayo,

2005). Unfortunately, most men will not want to approve of family planning methods that will affect their enjoyment of the sexual relationship between them and their wife with or without sufficient knowledge of the family planning methods (Khurram et al.2009). Sometimes however, lack of spousal communication increases the barriers to family planning as some women do perceive some wrong opinion that their husbands do not approve of some family planning methods when in actual fact, they do (Toure 1996). Most importantly is the fact most health centres that educates women on family planning hardly create environments that will attract male spouses to such discussions so as to ease the spousal communication.

The high value for marriage especially on the part of the women also limits their independence and freedom as the fear of losing their husbands to other women in polygynous settings as theirs, makes the average rural woman succumb to the husbands views regarding reproductive health issues even when it does not go down well with the woman. (Abanihe 1994). More importantly is the inadequate knowledge and misconceptions which adversely influence people's attitude towards family planning and in turn the utilization of its methods in rural areas. Thus, inhibiting the fulfillment of the goals family planning in the reproductive health of rural women. Robey et al (1996) had already hypothesized that the fertility level in sub-Saharan Africa could be reduced by about one birth per woman on the average if it were possible to meet the unmet need for family planning.

Attitude towards family planning has been discovered to greatly influence the practice of family planning among individuals both in the urban and rural areas despite their knowledge of the methods (Khurram et al 2009). Also level of cost-effectiveness, accessibility and ease of administering modern family planning methods do not only influence the attitude of people towards utilizing contraceptive, but also goes a long way to affect their practice of the methods even when it seems essential.

Despite the fact that several publications on contraceptives and other family planning methods had existed for some time, the utilization of family planning method is still low in developing countries. Korra 2002 puts it that lack of knowledge of contraceptive use transforms to lack of use in developing countries. Although research has established some of the factors that serve as barriers to family planning have to include cultural influence, poverty and poor access, very few focus on women's self identified barriers and

attitude towards family planning. Furthermore women's attitude towards family planning as well as its measures goes a long way to influence their participation in adopting any kind of family planning measure to space their children and contribute to population control. Thus, studies that will bring to limelight the attitude of women towards family planning especially in rural areas become necessary in providing basis for planning intervention programmes on the control of population explosion.

OBJECTIVES OF STUDY

The general objective of this study is to examine the attitude of women towards family planning in the rural Ibadan metropolis. The specific objectives are to:

1. Document the socio-economic status of rural women in Ibadan metropolis

2. Examine the influence of socio-economic status of women on their attitude towards family planning.

3. Investigate women's views about the benefits of family planning

An Overview of Family Planning Utilization in Nigeria

It's being observed overtime in developing countries that women bear children over a short period of their lives. For the average woman in developing countries with relatively low fertility rates, such as Indonesia and Mexico, fifteen years elapse between first and the last birth, which is less than 20 percent of the mother's lifetime (Jan and Tabasaum, 2008). In Nigeria, with higher fertility and low expectancy, the average interval is nineteen to twenty years, or about 40 percent of a women's lifetime (Olorunfemi 2002). Thus, the size of the family is a matter of great importance not only for the country as a whole, but also for the welfare and health of the individual, the family and the community. Afolayan (2002) also maintained that the size of the family affects the quality of life of human being; every increase in family size results in decrease in per capital food and nutrition availability and this slows down the quality of nutrition and improvement of health standard.

However, available data indicates that Nigeria currently has one of the highest rates of maternity in the world. (Okonofua, 2009). It is also evident 40% of these maternal deaths are due to complications of unsafe abortion, and abortion is a response to an unwanted pregnancy that could have been prevented by effective contraceptive programmes. Yet (Okonufua, 2009) stressed further that contraceptive prevalence rate is less than 13%. This situation is further compounded by the persisting challenge of high fertility rate of about 5.8% and an annual growth rate of 2.8% in the face of a large population size of over 140 million persons.

However, to date contraception has not been well consolidated in Nigeria, with evidence from recent DHS data indicating that only about 13 percent of sexually active Nigerian women currently practice effective contraception. Part of the reasons as observed by (Inikori, 2009) include the persisting pronalist culture of the people, religious doctrines which discourage the use of contraception, poor availability and distribution of contraceptive and women's fear of contraceptive side effect. More importantly, is the perception that contraception could lead to infertility in the later part of one's life which is one major reason why Nigerian women have always proffered for not accepting effective contraception. (Adetona, 2006: Abanihe, 1999).

Hence, to overcome this barrier, studies in Nigeria have reported that by the very way contraception is perceived, community involvement and participation is the gold standard to the initiation of an effective debate towards acceptance as seen with programmes aimed at reducing maternal mortality. This according to Onowhakpor (2007) is further buttressed by the fact that community practices and cultural beliefs play a significant role in decision making vital to women's reproductive health.

Attitude of Women towards Family Planning

Contraceptive use is sti1llow in many developing countries, including Nigeria, where 23.7% of currently married women had ever used one (NPC and ICF Macro,2009). Over the past four decades, there have been numerous publications on contraceptives and other family planning methods. While culture, poverty and poor access have been widely understood as militating against their use (CDC, 2000; Leke, 2000; USAID, 2008; NPC and ICF Macro, 2009), studies presenting women's self-

identified barriers are relatively few. Much attention is given to eliciting clients' knowledge and utilization gaps regarding family planning methods, but specific attention to eliciting their knowledge gaps regarding the benefits of family planning is often deficient. Yet, identifying women's self-reported barriers and benefits is central to any intervention to promote their use especially in developing countries (CDC, 2000; USAID, 2008) fortunately; available literature shows that carefully conducted studies addressing these variables provide important guides for intervention.

For example, a study conducted among the Kanuris in Nigeria revealed that few Kanuri women used modern methods of family planning, the barriers being objection by their husbands, the fear of delayed return to fertility, damage to the reproductive apparatus and the belief that modem contraception was introduced to reduce Muslim populations (Mairiga et al, 2010). Also, the Suri people of people of Ethiopia prevent and delay pregnancies using natural family planning methods. The desired benefits are that women regain their strength following the injuries caused by pregnancy and delivery, and that attention can be given to the welfare of growing children. But these objectives are often countered by lack of access to modem family planning methods and the desire for many children within a socio-demographic context of threats to their tribal survival (Eyayou et al., 2004).

Similarly, Sarah (1994) found in the study that by data from the 1988 Ghana Demographic and Health Survey 77 per cent of cohabiting marital partners held similar attitudes towards family planning and that 73 percent of the concordant couples approved of contraceptive. However, only 61 percent of the wives correctly reported their husband's attitude. Although 76 percent of the couples agreed on whether they wanted more children, just 44 percent gave concordant responses on ideal family size. Regression analysis showed that urban residence, the wife's attitude toward family planning and discussion of family planning between spouses has significant independent effects on current contraceptive use.

La et al. (2003) examined in their study that most women had positive perceptions regarding their reproductive rights. Women's demographic factors were statistically significant to concepts and practices of sexual health, marriage and having a family, as well as awareness of and practice of screening

procedures for the early detection of cancer. The study encourages active participation of men to empower women to exercise their reproductive rights, as well as to enhance women's participation in public life and decision-making. Brochures on women's reproductive rights should be published to disseminate information to youth. Men, women and the elderly to increase awareness programmes about the reproductive rights of women should be encouraged, stressing the importance of sexual health through religious education as one of the best strategies for the elimination of all forms of discrimination against women. The health team should address the importance of reproductive right issues in health education or counseling at any clinical setting.

In these examples, any approach to promote family planning use must take into consideration the specific barriers and desired benefits identified in the communities, rather than only performed general lessons on family planning. Indeed, in many hospitals in Nigeria, a common practice is to deliver performed general messages on family planning methods of women attending antenatal clinics with little bearing on locally known and experienced barriers and benefits.

Benefits of Family Planning

The use of contraceptives and safe sexual practices can also help to curb the impending world population explosion. The Food and Agricultural Organisation (FAO) has projected that the world, and particularly the developing nations, currently face possible starvation if the population growth rate is not checked. Contraception over the years has been medically proven to be of tremendous medical advantage to its users. As a form of family planning, it reduces maternal mortality and improves women's health by preventing unwanted and high-risk pregnancies, thus reducing the need for abortion to terminate unwanted pregnancies.

In the developing countries of the world one of the most common causes of maternal death are complications during pregnancy and delivery. For each maternal death in a developing country, more than 30 women suffer injuries related to pregnancy and childbirth (Ponle, 2006). Medical records have shown the pregnancy is particularly dangerous to certain groups of women-with more than four children and women with existing health problems. If all high-risk pregnancies were prevented, maternal

mortality could be reduced by up to 25 percent. Contraception promotes survival of infants as it supports birth spacing and reduces high-risk pregnancies. Achieving adequate birth spacing could reduce child mortality by 20 percent or more, particularly in developing countries with myriads of socio-economic problems. The World Bank estimates for 1993 indicated that expanding contraceptive services to meet the needs of couples who wish to avoid pregnancy, but currently are not using contraception, could prevent as many as 850,000 deaths per among children under the age of five.

Adeleye and Akoria (2010) observes that family planning has also been found to help in reducing the economic and emotional burden of parenthood as it has provided as means for couples to have smaller, healthier families. It IS an uncontestable fact that families with fewer children can assign more resources to provide their children and educational opportunities. The status of women and their quality of life are also enhanced through the use of contraceptives, as assess to these contraceptives allows them to decide the number and spacing of their children (Shuaib and Ogboloh, 2010).

Similarly, mothers with smaller, healthier families are more likely to have increased opportunities for participation in educational, economic, and social activities. However, a cycle of low status and high fertility is perpetuated when girls leave school early to marry and bear children, as is the case in Africa and Nigeria in particular in any developing countries.

Thus, at this juncture, every indication points to the need to bombard the media with more education messages on the need for safe sexual practices. Men, in particular, should be made aware of the dangers of careless, promiscuous behaviour in this era of Acquired Immune Deficiency Syndrome (AIDs).

Social Action Theory

The social action theory of Max Weber will be useful in explaining the attitudes of individuals towards family planning. Weber (1947), in his analysis of the fundamental concept of sociology, maintains that the notion of action plays a central part in human interactions. He stated that the defining feature of action is its meaningfulness to the actors in an interactive process. Included in action according to him is that all human behavior in as much as the actor attaches a subjective meaning to it. For him, "individuals are creative actors, agents whose

actions determine both the structure of the society and the road which history travels". This means that the end product of society is determined by the actions of individuals within the society. Existing structural circumstances are constraints within which actors have to choose to act. Weber further stated that though these structural circumstances are there to shape and direct man's activities, what should be of interest is the actors perception of those constraints . To him, human beings have a unique ability to interpret the world around them and to choose to act in the light of those interpretations and meanings. The decision and choice to or not to utilize family planning methods according to Weber is therefore dependent on the interpretative meanings attached to the idea of family planning itself as well as the utilization of its methods. Thus, women who attach positive meanings or interpretation to planning their families will not only display positive attitudes towards family planning, but will also utilize the methods of family depending on the particular method they deem rational to utilize.

Health Belief Model

The Health Belief Model attempts to predict health behaviours by focusing on the attitudes and belief patterns of individuals. The model was originally introduced in 1950s by psychologists working in the United States Public Health Service. They assumed that people feared diseases, and that health actions were motivated in relation to the degree of fear (perceived threat) and expected fear-reduction potential of actions as long as that potential outweighed practical and psychological obstacles to taking action (net benefit). Since then, HBM has been adopted to explore a variety of long-term and short-term health behaviours including sexual risk behaviours and the transmission of HIV/AIDS, family planning nad other reproductive health issues The HBM attempts to predict health-related behaviours in terms of certain belief patterns. This model is used in explaining and predicting health behavior, as well as sick-role and illness behavior.

Perceived Threat: This includes perceived susceptibility and perceived severity of a health condition. Perceived susceptibility refers to an individual's perception of the likelihood of experiencing a condition that would adversely affect one's health. While perceived severity refers to how life threatening an illness condition is

perceived severity as the model entails could be applied to women attitude towards family planning as women are likely to display positive attitude towards family planning when there is a perceived threat to their health with another pregnancy.

Perceived Benefits: This is the belief of effectiveness of strategies designed to reduce the threat of illness. The perceived benefits of family planning by women will encourage and motivate them to practice family planning generally and specific method dependent on the benefits they perceive in that particular method. Such will go a long way too to affect their attitude towards such methods as well as family planning in general. Perceived benefits of taking action refers to taking action toward the prevention of disease conditions such as utilizing family planning methods to prevent further pregnancies and child birth which are perceived detrimental to the health of the women.

Barriers to taking action: However, action may not take place even though an individual may believe that the benefits to taking action are effective. This may be due to barriers related to the characteristics of a treatment may be inconvenient, expensive, unpleasant, painful or upsetting. As in the of barriers such as cost, affordability, accessibility, availability and ease of using family planning methods.These characteristics may lead a person away from taking the desired action (Rosenstock 1974)

Conceptual Framework: The fig below explains the socio-economic status and their attitude towards family planning. Women's socio-economic status which is reflected in their level of education, level of income and occupation influence their attitude family planning methods, the perceived benefits or advantages and the perceived disadvantages or side-effects. These have implication for their attitude and practice of family planning methods.

Conceptual frame work

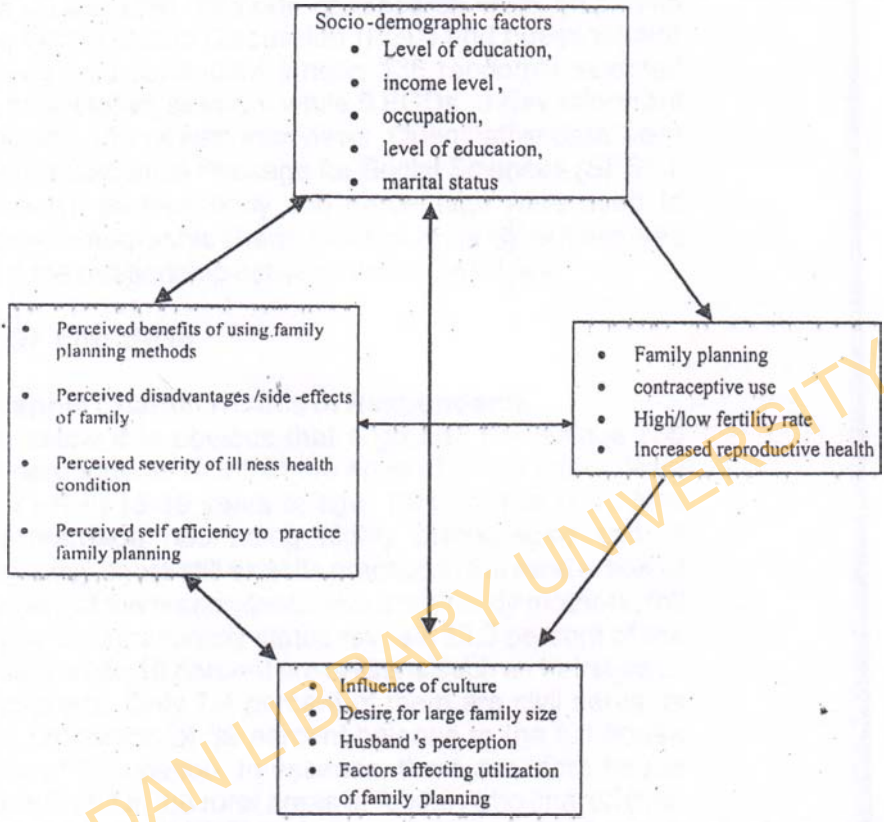

Fig 1; Conceptual framework of the Health Belief Model and the Social Action theory explaining the influence of women's socio-economic status on their attitude towards family planning.

Also, the perceived threat or severity of illness condition caused by further pregnancy and child birth do influence women's attitude and practice of family methods. The perceived severity of illness condition is also comparable to the interpretative meanings attached to the seriousness of such illness condition. The same applies to the attitudes of individuals towards utilizing family planning methods for whatever rational reason they deem fit. Furthermore, peoples, culture, desired family size, husband's expectation and availability of family planning methods are being influenced by their socio-economic status which could influence the level of rationality of

individuals. These further influence women's attitude towards family planning as well as its utilization.

METHODOLOGY

The study which is descriptive in design was carried out in some selected rural parts of Ibadan which included Mapo, Beere, Oje, Oja-Oba and Ita-Merin. Married mothers were selected from households within these communities for the study. The study population also included matrons, nurses and other necessary health personnel. Qualitative and quantitative methods of research were employed using interview, Focus Group Discussion (FGD) and questionnaire guide. The survey was conducted among 136 randomly selected women for the quantitative session, while 5 FGDs, 5 Key informant interviews (KIIs) and 15 in-depth interviews. Quantitative data were analyzed using the Statistical Package for Social Sciences (SPSS). Statistical tools such as frequency and percentage were used to analyze the socio-demographic characteristics while chi-square was use to determine the relationship between variables tables.

DISCUSSION OF FINDINGS

Socio-demographic Characteristics of Respondents.

From the table below it is obvious that a greater percentage (36 percent) of the respondents is within the ages of 25-29 years. Very few of them are within 15-19 years of age. This goes to show that although early marriage has being highly discouraged and is gradually fading away, there still exist its practice in the rural areas of Nigeria as 6 percent of the respondents who are already mothers, fall within these ages. Occupationally status reveals 35.3 percent of the women are traders while 18 percent are artisans such as hairstylists' and fashion designers. Only 7.4 percent of them are civil servants while the larger proportion of 39 percent belongs to the full house wives categories of occupation. In essence, there are more house wives and traders found in the rural areas of Ibadan who shared their views regarding their attitude towards family planning methods.

With reference to income, half of the women earned between N10, 000-N20, 000 per month, while almost a quarter of 23.5 percent earned less than N10, 000. About 15 percent earned between N21, 000-N30, 000 monthly and about 12 percent only earned above N31, 000. This goes to show to income level of women in rural Nigeria

which is reasonably low considering the fact that most of these cash will be spent on their children and immediate family. (Irobi 2007) the findings on the income level of rural Ibadan women confirmed the views of Aderinto, (2005)who stated that more of the people in these areas lived or earned below N20, 000 monthly and therefore lived on a low level of income.

Table 1. Socio-Demographic Characteristics of Women

S/N	Characteristics	Frequency	Percent
Age	15-19	6	4.4
	20-24	19	13.9
	25-29	49	36.9
	30-34	33	24.3
	35-39	35	25.7
	40-44	6	4.4
Occupation	Trader	48	35.3
	Artisan	25	18.4
	Civil servant	10	7.4
	Full house wife	53	39.0
Average Income	Below N10,000	32	23.5
	N10,000-N20,000	68	50.0
	N21,000- N30,000	20	14.7
	N31,000-N40,000	10	7.4
	Above N40,000	6	4.4
No of Children	>2	05	3.8
	2-4	24	17.6
	4-6	35	25.7
	6-8	72	52.9
Nature of marital status	Monogamy	43	31.6
	Polygamy	62	45.6
	Married but living apart	16	11.8
	Divorced	15	11.0
If Polygamy; how many wives	2 wives	81	59.6
	3-5 wives	43	31.6
	Above 5 wives	12	8.3
Occupation of Husband	Farmer	15	11.0
	Civil servant	31	22.8
	Artisan	19	14.0
	Transporter	71	52.2
Education Status	None	28	20.6
	Primary	69	50.7
	Secondary	17	12.5
	Tertiary	22	16.2

Source: Fieldwork, 2011.

From the table 1 above, it could be observed that the population growth in the rural areas is truly alarming as over half of the women have between 6 to 8 children. These numbers exceed the average number of 5.8 per women in Nigeria. A quarter of the women also were observed to have between 2 to 4 children while less than 4 percent of the women gave birth to less than two children less. It was obvious there that more women gave birth to more children, and the few who gave birth to less children are expecting mothers who still had plans to give birth to more depending on their husbands wish

Furthermore, the result indicates with reference to marital status that approximately 32 percent who belonged to monogamous status of marriage while 11.8 and 11 percent of the women are married but living apart and divorced respectively. However, more of the women are in a polygamous marital status as 45.6 percent of the total respondent belonged to this category. This is therefore corroborated the view that "man is polygamous in nature" especially in the African society. It should also be noted that over 70 percent of the respondents said they have husbands with more than two concubines,/wives outside themselves. Surprisingly men are still found to more than one wife even in a society where poverty has fully deepened and affected the socio-economic status of the common man or woman.

With regards to educational qualification, over half of the women have only primary education. 12.5 percent have secondary education, while 16.2 percent of the women have tertiary education. However, about 21 percent of the women had no formal education. Thus, aside from primary education more of the women lacked any formal education compared to the rest who had formal education. With this result, the level of education of women in the traditional core areas of Ibadan is relatively low and therefore affected their level of awareness towards family planning in the study area.

Furthermore, the content analysis revealed that the unit of social organization is the family, which is patrilineal and patriarchal. The man is the head of the family and its bread winners, while the woman is the procreator and house keeper who manages the house and perform all household chores, including nursing of the children. In a traditional core area like Beere, Oje, Mapo, and Oja-oba as well as Ita-merin that were studied, most women are either full house wives or a petty trader and sometimes, artisan workers that practices occupation such as Hair dresser, selling of building materials,

tailoring, herb sellers, circumcisers and traditional clothe weaver among others.

Socio-economic status and attitude towards family planning

The socio-economic characteristics of the respondents further revealed that most of the respondents are between the ages 18 to 50years due to the fact that early marriage is a major phenomenon in the area. Very few of them have tertiary education and half of them have only primary education. Thus there is the misconception that on the educated need to do family planning. A woman confirms this by saying.

> *It is only those that are educated that patronizes government and private hospital for delivery and do family planning not illiterate like me. God helps someone to take care of the children, no matter the number, and He also helps a tail-less cow to drive away flies, so I cannot stop the children that God is given to me by doing the family planning thing.*
> *(Married woman/IDI/28years/June 2010).*

Also the level of education and nature of marital status determine the number of children the woman will give birth and in turn their attitude towards family planning. As opined as one of the interviewed woman, she expressed thus:

> *I am 28 years old and have married for the past 7years with 5 children after my primary school, although my husband left me and I am now with another man whom I have not given a single child because he does not want. Also my present husband has already married before with eight children. So when he advised we use condom so that we do not continue to have more children since the burden is much to cater for 13 children and he is just a carpenter. Other I don't have any business with family planning.(Married woman/IDI/28years/June 2010).*

The above response revealed that the woman could still have given birth and is still ready to have more children for the current husband but for the burden of catering for too many children with the type of occupation he had. Such woman probably due to her level of education and self efficacy has left the decision of given birth to more children and the family planning method to be utilized solely to her husband who is probably as uneducated as she is considering his type of occupation. Also some women are able to continue giving birth as their occupation does not debar them from doing so; hence they do not practice any family planning method. Also, participation in family planning is determined by the husband and the birth of the expected number of children. This was confirmed by women during the FGDs

An interviewee also maintained that:

> *The nature of my work will not affect the type of family planning I will choose, I don't even have any form of family planning because I have just given birth to two children and I intend to give birth to not less than five before I can think of any family planning according to my husband*
> *(Married woman/FGD/39years/June 20, 2010).*

The level of income of women and their spouse also influence the practice of family planning a great deal as explained by the women. However some also expressed lack of awareness due to the fact that they had not been utilizing the modern health care centres due mainly to their level of income. A woman during the interviewed session confirmed this by saying:

> *The only time I have heard about family planning was when I gave birth to our sixth child which I had in a general hospital, because we have always used the traditional birth attendant when I want to deliver because they don't charge as high as that of General Hospital which my husband cannot afford and since the TBAs do not discuss family planning with us.*
> *(married woman/FGD/June, 2010)*

In the same vein, a respondent pointed to the fact that the size of the family and the sex of children born determine the attitude of women towards family planning as well as . A discussant during the FGDs confirms this by saying:

> *I did not think family planning was necessary at all when I was seeking to give birth to a male child after four girls. However, when I delivered a set of twins a boy and a girl, I had to do the family planning. I also wanted to stop because we were taking care of three of my siblings with six children.*
> *(married woman/ IDI/July, 2010)*

The discussion above reveals that the size of the family is a matter of great importance not only for the country as a whole, but also for the welfare and health of the individual, the family and the community. As explained by Tabassun (2008) the size of family affects quality of human lives. For an increase in family size results there will be decrease in per capita food and nutrition availability. Also, family size is seen to be related to education, where mothers education is high, the family sizes is smaller and infant mortality is low (Fopohunda and George, 2002). However, the increased number of children had was not only due to the fact that they needed male children, but also because they were not educated enough.

The level of education of women to a large extent affects the number of children they have in a life time as explained by a key informant who added that:

> *The high level of illiteracy and the syndrome that A man has the responsibility of caring for a woman has caused many woman not to be interested in working. Thus when a man comes back from work in the night, the only things, he thus is to pound on them, and within a short time they are pregnant not considering their financial capability of raising up the child.*
> *(A lady medical doctor/K.I.I./40years/June 20, 2011).*

Similarly, in another reaction by a key informant who is also a nurse usually called Doctor by the rural women added:

> *Most of the young girls in our area that do not go to school, usually have early marriages and by the time they are 18 years old, some of them must have been impregnated by their mates who are either learning carpentry, vulcanizer or load caring. Also women in this area see sex as a way of keeping a man, while the usage of condom is only meant for those involving in premarital sex for under-aged girls. Most often before these girls reach 26 years, they have given birth to 4-5 children whom are either given to grandma or end up becoming street beggars. (Nurse/ IDI/38 years/ June 2010).*

The result of the quantitative data which was done through regression revealed an association between income (P=0.002) occupation (P=0.002) both less than 0.005. it was obvious that income and occupation which are socio-economic variables influence the attitude of women towards family planning.

WOMEN'S VIEWS ABOUT THE BENEFIT OF FAMILY PLANNING

The benefits of family planning are enormous in the sense that family planning helps family to plan for their future and those of their children, it gives the parents enough time to take care of the child/children they already have and ensure the bringing forth of quality children. Family planning ensures adequate spacing of children with help the woman to recover fast and remain healthier and stronger after the birth of the previous child/children.it improves sexual relationships between partner, thereby promoting love and bonded which could in turn ensure marital stability and fidelity. It contributes to the reduction of maternal mortality and infant mortality rates and generally to societal development. Women were interviewed in order to gain insight into their views about the benefits of family planning as such knowledge could contribute to

influencing positively, the attitude of women towards its utilization. Contrary to expectation, majority could hardly provide concrete views as to the benefits of family planning as they stated that they hardly used hospitals due primarily to the cost which to them is hardly affordable. An interviewed woman has this to contribute

> *I hardly do family planning because my children are delivered at home so I cannot tell you the goodness or benefit but I know it makes people to waste time before having enough children.*
> *(married woman/IDI/31 years/ June 2010)*

The above response shows the misconception about family planning due probably to the level of Illiteracy. Child spacing which would enhance better health of child and mother, quality children and proper planning is now referred to as "wasting time in having enough children".

The few who responded stated that family planning ensure that children are well spaced and catered for and the husband will more time for their wives and family which will also promote happiness. This was confirmed by the response of a woman in one of the Focus Group Discussions who states:

> *My name is….. I am an NCE holder, I think that family planning will help parents to space their children properly so that they can have more time to plan for them and also save enough. It also helps the wife to meet the sexual needs of the husband and make him come home to them on time and have time for his family rather that going out to another woman and destroying the peace of the family. That is why I practice family planning.*

From the response above it could be deduced that the discussant who is literate has positive attitude towards family planning so that the benefit were mentioned to eve include economic growth which includes savings. A nurse who was also interviewed as a key informant points attention to poor practice of family planning being experience around as a result of poverty, illiteracy, fear, patriarchy and lack of adequate knowledge about the benefits by saying:

Most of our women here are not literate even their husbands too hence they hardly come for ante natal care. They don't even come to give birth to their babies here except when there are complications. They say they can't afford it because they are poor. Otherwise the benefits of family planning would be known to all the women in this community but will their uneducated husbands who don't come to the health centers with the women that manage to come allow them to practice family planning? I doubt it. Even the women will not agree except their husbands say so.

She explained further by stating the benefits of family planning:

Family planning improves women's health and that of their family; it ensures the birth of quality children, it improves the sexual lives of couples and reduces death both on the part of the mother and the child. It reduces poverty as couples will give birth to the number of children they can cater for. It reduces family disorganization due to infidelity because the same husband they are afraid to lose by getting pregnant and having more children will still go out when the women break down from incessant child bearing. There are so many benefits but these few are very important.

The above response simply summarizes the benefits of family planning although from an educated health professional not the rural women themselves.

SUMMARY OF FINDINGS

This study has examined the attitudes of rural women towards family planning in Ibadan, Oyo State. The areas studied included Oja-Oba, Beere, Mapo, Oje, and Ita-merin areas of Ibadan. Both quantitative and qualitative research methods were employed within one hundred and thirty-six available married women were surveyed using a questionnaire guide. In addition, 15 in-depth interview, 5 key informant interviews and 5focus group discussion were conducted among married women and health personnel's such are nurses, pharmacists and matrons in the selected regions.

Results of the study revealed a majority of the women, falling within a low socio-economic status with 50 percent having only primary school education and remaining as house wives. Also, half of the women earned between N10, 000 to N20, 000 per month, while almost a quarter of 23.5 percent earned less than N10, 000. Approximately 91 percent fall within the active reproductive ages of 20-39 years, 50 percent of the women have 6 to 8 children. It therefore calls attention to fact that there exist a high fertility rate among these women despite their low socio-economic status. This was also found to have influenced the attitude of women towards family planning as very few had interest in family planning as it was perceived to be an act meant for the literate. Very few of the women who were obviously had tertiary qualifications could boldly state the benefits of family planning. Women's Attitude towards family planning was observed to be influenced by poverty, perceived threat to health condition, perceived benefits and approval from husband. Women were also discovered to display negative attitude towards family methods because of the perceived side effect it will bring such

as stomach ache, abnormal menstruation, delayed fertility, pushing husbands that do not approve of the methods out to other women in a polygynous community like those studied and countless other factors.

RECOMMENDATIONS

Based on the findings, the study recommends the following:

1. Effective educational and counseling intervention geared towards improving the attitudes of providers and receivers towards family planning
2. Obvious and immediate barriers such as cost, lack of accessibility and availability, and ease of the utilization of family background should be minimized to attract people to its use. Men and women need better information about the usage of contraceptives and the side effects to expect once they do adopt a method.
3. Spousal communication about family planning should be increased and encouraged through mass media to promote husband-wife relationship on household decisions especially in family planning. Men should be adequately carried along during the talks and information in family planning during ante-natal and post-natal care. Such talks should also be presented in gathering that will attract many men.
4. Male involvement in reproductive health should be highly encouraged to also include larger issues of power, control and self image. Furthermore, it is important that men's perception of their own sexuality, including their fears and concerns be examined and addressed through adequate campaign and sensitization.
5. Reproductive health is important for improving the health and well being of both men and women. Men should no longer be seen as obstacles to improved health of their spouses but as full pledge partners who have their own needs and concerns as well as those of their spouse.

CONCLUSION

Family planning is not only strategic in the control of population growth, but also in the development of a nation. It has also contributed a great deal to the healthiness of mothers after child birth. It has also reduced maternal and infant mortality and has increased the quality of children produced. However, attitude that people especially uneducated individuals in rural areas have towards family planning methods, has not encouraged maximum patronage and utilization of family planning methods. Thus, urgent measures should be put in place to address this situation so as reduce the adverse consequences of population explosion and underdevelopment which is already permeating the rural areas in Ibadan community.