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A STUDY OF THE KNOWLEDGE AND PRACTICE OF FAMILY PLANNING IN DAWAKIN TOFA LOCA L GOVERNMENT AREA, KANO STATE.

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Abstract
Many studies on family planning have primarily focused on women with little attention paid to influence of men's knowledge and involvement in family planning practice. This research addresses this gap through investigating the knowledge and practice of family planning among people who are married or ever married in the Dawakin Tofa Local Government Area of Kano State. The main objectives of this paper are to find out the knowledge and level of family planning practice among the people in the study area. Health Belief Model was used as the theoretical framework of the study, and the data were collected through quantitative and qualitative methods and a multi-stage cluster sampling technique was adopted for selection of the respondents. Also, 355 were selected, including 5 health workers working in the study area. The research found that level of education, occupational status and husbands' permission played a vital role in family planning education and practice. The research recommended that people with lower level of formal education should be educated for the benefit of family planning and husbands should be encouraged to permit their wives to visit clinics for family planning.

Key Words: **Knowledge, Practice, Family, Planning, Family Planning.**

Introduction

Family planning has attracted global attention due to its importance in decision making about population growth and development issues. It is the practice that helps couples to achieve the desired objectives, such as avoiding unwanted pregnancies, regulating intervals between pregnancies, and controlling the time at which birth occurs in relation to the ages of the parents as well as determining the number of children in the family. Family planning promotes the survival of infants as it supports birth spacing and reduces high-risk pregnancies. Achieving adequate birth spacing could reduce maternal and child mortality, particularly in rural communities with myriads of socio-economic problems. The World

Health Organization (2013) stated that family planning allows individuals and couples to anticipate and attain the desired number of children and the spacing and timing of their births. It is a process of controlling the number of children among couples. It is a lifesaver for millions of women and children in developing countries, including Nigeria, and it is one of the most cost-effective health interventions. The importance of family planning crucial because it goes a long way in helping individuals, parents, children, communities and governments in the area of health, the education of children and the social economic and political development of the society. For these reasons, governments, non-governmental organizations and individuals have found it necessary to introduce family planning Programs at federal, state and local government levels.

The Nigerian government in 2006 revised the National Policy on Population alongside emerging issues to improve the state of the economy and make progress in long–term sustainable development. The policy emphasized, among other priorities, the reproductive rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, to have the information and means to do so and the right to attain the highest standard of sexual and reproductive health, taking into consideration the social, economic and emotional needs of their living and future children and their responsibilities towards the community (Adams, 2012).

Family planning was introduced in Nigeria at a time when such a need was of paramount importance. It was to bring both psychological and economic relief to families. Interestingly, government and other non-governmental agencies have made concerted efforts to bring the knowledge about family planning to the people through advertisement on Television, Radio and other media. Family planning education was adopted in order to solve the problem of population explosion. Family planning should gear towards changing the people's attitude to family size. However, the people's attitude, to a large extent, is influenced by the social and cultural conditions of the environment as well as their views on the importance of children and their own need as status aspiration.

Statement of the Problem

Nigeria is the most populous country in Africa and the seventh most populous in the world, with more than 175 million people, an annual population growth rate of 3.2 percent and a total fertility of 5.5 per woman. Lack of family planning practice leads to maternal and infant mortality, high risk during pregnancies, risk during birth, too many young pregnancies before 18 years and after 35 years of age and less than 2 years' interval between one delivery and another. These problems are very common in rural communities where there is a low level of education, a high level of poverty and poor access of health care services, including family planning use. All these serve as sources of high population as well as mortality and morbidity in both children and mothers through short birth spacing and resources competition.

Traditionally, the majority of Nigerian cultures are highly patriarchal and value high fertility and male child preference. This perhaps could have a negative impact on the practicing of family planning services. Therefore, male dominance and patrilineal traditions support large family sizes and that men's reproductive idea, to a large extent, influences the reproductive behaviour of their wives. In addition, the present Nigerian economic situation does not help people to produce large families because it can lead to economic hardship, food shortage, inadequate housing, resource competition, and increase in the crime rate to mention but a few.

Objectives of the study

1. To find out the people's knowledge on family planning in the study area.
2. To find out the practice of family planning among the people in the study area.

Research Questions

1. What is the people's knowledge of family planning?
2. Do people in the study area practice family planning?

LITERATURE REVIEW

Family planning, according to Smith et al (2009), increases survival, improves the health of millions of people and helps to achieve national goals. It helps women to avoid unwanted pregnancies, illegal abortions and child bearing that will threaten their own personal health and that of children. Family planning involves two concepts – contraceptive use and family planning services, which are used by couples to bring about healthy sexual relationships among themselves without fears of unwanted pregnancies and sexually transmitted infections.

Free Encyclopedia (2013) reveals that family planning is for birth control and other techniques to implement such plans, which include sexuality education, the prevention and management of sexually transmitted infections, preconception counseling and management of infertility. It further conceptualizes that family planning is the educational, comprehensive medical or social activities that enable individuals to determine freely the number and spacing of their children and select the means by which this is to be achieved (Ndubisi, 2014).

According to the economic postulation of Malthus (1798), many countries are today experiencing population explosion that makes the available social infrastructures very deficient for the people. Food supplies to such populations have become big and unsolvable problems to the indigenous government, who mostly have resorted to receiving foreign aid from international organizations such as UNICEF, UNO, etc. This leads to third world nations grappling with endemic problems. It is true that some other countries share their food shortage experience not because of their own self-styled overpopulation problem, but because of famine, drought, flooding and the refugee influx.

THEORETICAL FRAMEWORK

The Health Belief Model (HBM)

The focus of the Health belief model is to assess the health behavior of individuals through the examination of the perceptions and attitudes someone may have towards disease and the negative outcomes of certain actions. The underlying concept of the model is that health behavior is determined by personal beliefs or perceptions about a disease and the strategies available to decrease its occurrence (Hoberaft, 2000). The whole range of intrapersonal factors affecting health behaviour influences personal perception. The following four perceptions serve as the main constructs of the model:

i. Perceived seriousness.
ii. Perceived susceptibility.
iii. Perceived benefits.
iv. Perceived barriers.

Perceived seriousness:

The construct of perceived seriousness refers to an individual's belief about the seriousness or severity of negative health behavior. While the perception of seriousness is often based on medical information or knowledge, it may also come from beliefs a person has about the difficulties negative health behavior would create or the effects it would have on his or her life in general. In relation to family planning practice, the Health belief model considers the personal feelings of seriousness of becoming pregnant, based upon the subjective assessment of medical and social consequences of pregnancy and child-bearing. Therefore, the theory seeks to increase awareness of how serious the outcomes of certain health behaviors can be in order to increase the quality of one's life. For example, a woman who is a student may become serious about getting pregnant within a short period of time because of fear of body changes, stress or bearing responsibility, which can affect her academic performance.

Perceived susceptibility:

A personal risk or susceptibility is one of the most powerful perceptions in prompting people to adopt healthier behaviours. The greater the perceived risk, the greater the likelihood of engaging in behaviours that decrease the stated risk. This is what prompts some women to practice family planning in an effort to decrease susceptibility to getting pregnant. It is only logical that when people believe they are at risk for contracting a disease or a problem, they will be more likely to do something to prevent it from happening. However, the opposite also occurs. When people believe they are not at risk or have a low

risk of susceptibility, unhealthy behaviours tend to result. For example, in a situation where a couple experienced a serious problem as a result of pregnancy, delivery or even economic hardship, they may easily accept and practice family planning.

Perceived Benefits:

The construct of perceived benefits is a person's opinion of the value or usefulness of a new behaviour in decreasing the risk of developing a disease or negative health outcomes. People tend to adopt healthier behaviours when they believe the new behaviour will decrease their chances of developing a disease. They have to believe that change in health behaviour will be of a certain benefit to them. Individuals must have rational thinking about how changing their behaviour will be of benefit to them to facilitate and maintain change (Graham, 2000). Therefore, perceived benefits are related to the perceived effectiveness, feasibility and other advantages of using family planning methods in the prevention of pregnancy. Indeed, having knowledge of the benefits of a family planning method may increase the number of people who accept to practice it.

Perceived Barriers:

Since change does not come easily, the last construct to the Health Belief Model is the issue of perceived barriers to change. This is an individual's own evaluation of the obstacles in the way of his or her adopting a new behavior of all the constraints. Perceived barriers are the most significant in determining behaviour change (Janz & Becker, 2012). In order to adopt new behavior, a person needs to believe that the benefits of the new behaviour outweigh the consequences of continuing the old. This enables barriers to be overcome and the new behavior adopted. Some barriers to adopt new behaviour and developing new habits may be the fear of not being able to maintain the new behavior or facing embarrassment in society after changing (Umeh & Rogan-Gibson, 2001). In relation to this study, perceived barriers are the negative consequences of using family planning methods. This includes factors such as the perceived side effects of contraceptives, spouse disapproval to get access to contraceptives.

Modifying Variables:

The four main constructs of perception are modified or influenced by other variables, such as culture, education level, past experiences, skills and motivation, just to name a few. These individual characteristics influence personal perceptions. For example, if a woman or her child experiences serious sickness or other social consequences as a result of lack of intervals between one birth and another, she may become more self-conscious and practise family planning easily due to lessons from that past experience.

Cues to action:

In addition to the four beliefs or perceptions and modifying variables, the Health Belief Model suggests that behavior is also influenced by cues to action. These events, people or things move people to change their behaviour. Examples are media campaigns, counselling from health care providers and advice from a partner, friends or other people within the community. Knowing a person who has gone through a health behaviour change and how it has benefited them can also act as a cue to action for others (Graham, 2000).

Self-efficacy:

In 1988, self-efficacy was added to the original four beliefs of the HBM (Rosenstock, Strecher & Becker, 1988). It is the belief in one's own ability to do something. People generally do not try to do something new unless they think they can do it. If someone believes a new behaviour is useful (perceived benefit), but does not think he or she is capable of doing it (perceived barrier), chances are that it will not be tried. Unless an individual believes that he is capable of engaging in certain beneficial health behaviours, it will not be performed.

In relation to this paper, husbands in the study area must take time to think about how their lack of participation in family planning issues could have negative outcomes. Unplanned pregnancies may result in unsafe abortions (perceived seriousness) by women, thus endangering their lives and those of their families. Husbands must give adequate thought to the serious consequences that could result from lack of participation in issues (susceptibility) and if they manage to overcome the barriers that prevent them from using family planning methods, the benefits will be realized eventually. Using this model,

family planning providers could develop messages that are tailored to target people, especially those that explain the practice and benefits of modern family planning methods. It is crucial that they understand that the benefits of family planning may not be felt immediately but eventually they will be experienced only if change in health seeking behaviours among people is adopted.

METHOOLOGY

Three hundred and Fifty five (355) respondents were drawn for this research to represent the entire population, which comprised 5 medical personnel and 350 individuals, who are married or ever married at DawakinTofa Local Government Area. The Multi- stage clusters sampling technique was adopted to select the respondents for the research. The political wards in the area were regarded as clusters, which selected by using the lottery method. In each household, 1 respondent was selected and in any household with more than one eligible respondent, the lottery method was used to select one for the research.

Table 1 The Socio-Demographic Characteristics of the Respondents

Sex	**Frequency**	**Percentage**
Male	200	57.1
Female	150	42.9
Total	**350**	**100**
Age	**Frequency**	**Percentage**
15-19	14	4.0
20-24	60	17.2
25-29	97	27.7
30-34	57	16.3
35-39	67	19.1
40-above	55	15.7
Total	**350**	**100**

Table 1 shows that 57.1% were male and 42.9 % of the respondent females. They are within the age group 25-29 (27.7%) and then followed by the 35-39 age range (19.1%). The data collected indicated that the majority were within the reproductive age and have the tendency of getting more children.

Result and Discussion

Knowledge of family planning and Level of Education

Knowledge on Family Planning	**Qur'anic**	**Primary**	**Secondary**	**Tertiary**	**None**	**Total**
Yes	52 (65.8)	20 (69)	102 (76.7)	84 (80)	3	261 (74.6)
No	27 (34.2)	9 (31)	31 (23.3)	21 (21)	1	89 (25.4)
Total	**79(100.00)**	**29(100.00)**	**133(100.00)**	**105(100.00)**	**4(100.00)**	**350(100.0)**

X^2 Value = 12.59 Table Value =9.49 P Value = 0.05 Cramer's V = .509

Table above presents the respondents' level of education and knowledge of family planning. The Table shows that 65.8% who attended Qur'anic Schools indicated that they have knowledge of family planning. Similarly, 69% who attended primary schools expressed that they have knowledge of family planning, and 76.7% who attended secondary education are also aware of it, while 80% of those who attended tertiary education indicated that they have more knowledge of it than others in the study area. The computed X^2 value is 12.59 while the table value under the 4 degree of freedom and P value of 0.05 is 9.49. The calculated value is higher than the table value, which means that the null hypothesis is rejected. This means that there is a relationship between knowledge of family planning and level of education. In order to determine the strength of the relationship, Cramer's V was obtained with a value

of .509, is a which weak relationship and confirms that people with a high levels of education have more knowledge of family planning than those with lower level of education.

Education helps people to accept and use innovations and new ideas, thereby helping them to pass information very fast. Education relates positively to levels of knowledge of Family Planning, as it offers better understanding among the people (Olawepo and Okedare, 2003). Therefore, with an improved level of education, there is an increase in awareness of. Accordingly, it is clear that there is a significant relationship between the level of education and knowledge of family planning, as indicated in the computed x^2 table above. Consequently, one may conclude that the level of education exposes people's knowledge of family planning.

This view was supported by a male couple who is a civil servant and also a degree holder where he responded that

My wife and I, have knowledge of family planning and agreed to practice it in order to have better life and good health for the mother and children (Male Respondent, 2017).

In her opinion a community health worker working at one of the health facilities said:

Most of spouses today especially the educated one have the knowledge and understand the benefit of family planning, some husbands take their wives to clinics or give them financial support. (Community Health Worker, 2017).

Family planning Practice Currently and Level of Education

Family Planning practice	**Qur'anic**	**Primary**	**Secondary**	**Tertiary**	**None**	**Total**
Yes	5 (4)	20 (20)	305 (47.6)	50 (83.3)	0 (0.0)	105 (30)
No	120 (96)	80 (80)	33 (52.4)	10 (16.7)	2 (1)	245 (70)
Total	**125(100.0)**	**100(100.0)**	**63(100.0)**	**60(100.0)**	**2(100.0)**	**350(100.0)**

X^2 value =10.18 Table value = 9.49 P value = 0.05 Cramer's V = .153

The cross tabulation table above shows that 83.3% of the respondents currently practicing family planning have tertiary education, while only 20% have secondary education and 4% Qur'anic Education.

The computed X^2 value obtained is 10.18 while the table x^2 value is 9.49. The calculated value is higher than the table value, which means that the null hypothesis is rejected. In other words, the current use of contraceptive is related to level of education. In order to determine the strength, the relationship, Cramer's V was obtained with a value of 1.53, which is a weak relationship. This reveals that highly educated people practice family planning more than those with the lower levels of education. Hence, with the above table, the hypothesis which says there is no significant relationship between level of education and family planning practice is rejected. This finding corresponds to Ekpo's finding (2011), where educational attainment had a statistically significant relationship with Family Planning practised by women.

This result supported by a female respondent who said:

I am practicing family planning because I am a primary school teacher with National certificate on education (N.C.E). Therefore, I must give interval between one birth and another, and even my husband permitted me to do it in order to be healthy and get opportunity to do my job. (Female Respondent, 2017).

Discussion

Research found that majority of the 80% who attended tertiary education and 76.7% who attended secondary school education have knowledge on family planning than those with lower level of education. This assertion is supported by NDHS (2013) report on knowledge of family planning, where reported that 72% of all women and, 90% of all men have knowledge on at least one method of family planning.

According to Health Belief Model Theory, under the perceived seriousness, the perception of seriousness is usually based on medical information or knowledge and may also come from the level of education a person has about the difficulties or negative health behavior or the effect would have on his or her life.

The research findings also show that people with higher level of education practice family planning more than those with the lower or no formal education in the study area. This is because Education helps people to accept changes easily and develop new ideas, thereby helping them to practice what they learnt very fast. Olawepo and Okedare (2003) posited that education relates positively to the practice of family planning among the people. Ekpo (2011), also revealed that educational attainment had a significant relationship with family planning practice. In addition, the Health Belief Model perceived susceptibility construct pointed out that the educational intervention information focused on maximizing healthy behaviors, increasing awareness, gathering more information and creating a new practice as healthy behavior related to family planning.

However, despite the higher percentage of those having knowledge on family planning still the percentage of people practicing is low as found during this research, where the finding show that only 30% of the respondents were practicing family planning in the study area. This finding is similar with many studies conducted in Nigeria by different researchers

Conclusion

The research made it clear that knowledge of family planning is not only enough for people to practice family planning because some have the knowledge but do not want to access and practice it due to lack of support from their partners and financial problems. The research also reveals that the number of people having knowledge of family planning is still low, more especially among those with low levels of education in the study area. In addition, most of the respondents with knowledge of family planning have secondary school certificates or obtained higher education certificates.

In DawakinTofa Local Government, the significant number of people are aware and ready to practice family planning either modern or traditional for the purpose of child spacing and improving the health care of mothers and their children. Media, medical personnel and friends played a vital role in educating people on family planning.

Recommendations

Knowledge of family planning is very important in practicing it in all societies. In view of this, the following recommendations were made on the research findings:

1. People especially those with the lower levels of or no formal education should be educated on the benefits of family planning to women health and the improvement of child health to avoid maternal and infant mortality in the community.
2. Sensitisation campaigns need to be encouraged in the rural community like DawakinTofa in order to increase the number of people with knowledge of family planning.
3. People in the study area should be encouraged to participate in health care programs, especially reproductive health, so that more proper understand can be achieved.
4. Husbands should be involved and educated in order to support their wives and give them permission to visit clinics to get knowledge on the benefits of Family Planning to themselves and their children.
5. Government and non-governmental organizations should be engaged in training and re-training programs for health workers working at family planning units, more especially at rural areas.

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