

## **Knowledge of Traditional Family Planning Methods among Married Persons in Ogbadibo Local Government Area, Benue State, Nigeria**

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### **Abstract**

Current global efforts are focus at regulating fertility in order to promote healthy living across generations. For developing societies like Nigeria, dependence on traditional family planning methods is necessary in attaining this feat. This is because traditional family planning methods (TFPMs) are known to be cost effective and readily available for use by community members. However, most married persons in Ogbadibo, Nigeria have consistently shown lack of knowledge of traditional contraceptive methods in the area. Adopting a descriptive research design involving 344 married people in three wards (Aioodo I, Orokam II, and Itabono I) of Ogbadibo, Benue State; this paper examines factors influencing the knowledge of TFPMs among married persons in the area. Through the lens of the fertility decision-making model, study results recognized that as communities of Ogbadibo modernize, the family structure is transformed in manners that knowledge; motivation; and assessment of fertility regulations become the bases for family planning decision-making. Majority of married people (75.5%) could not mention any TFPM that they know. Only 13.4% mentioned rhythm and withdrawal methods as the TFPM that they know. Television, radio as well as health personnel are main sources through which information and knowledge on TFPMs is disseminated in Ogbadibo Local Government Area. The study recommends that community leaders and elders should work to abolish traditional beliefs that are inimical to birth control and promote knowledge of TFPMs among married people; while advocacy should be intensify toward encouraging smaller family sizes in communities of Ogbadibo Local Government Area.

**Keywords:** Knowledge, Contraceptives, Traditional Beliefs, Traditional Family Planning

## Introduction

Attempts to regulate fertility started from the early men. Evidence from medical history indicates that our forefathers did space their children through traditional means (Alkema, Kantorova, Menozzi & Biddlecom, 2013). The traditional family planning methods (TFPMs) had been handed down from generation to generation. It is quite true that our world is increasingly devising and succeeding in the means of preventing and de-escalating unintended and unwanted pregnancies, unsafe abortions, injuries as well as maternal and childhood deaths. However, the comprehensive knowledge of these technologies particularly TFPMs and many other maternal health services specifically by married persons (MPs) seemed to be a sore point for many societies across the globe. Before the introduction of modern methods, Africans had methods of fertility regulation. Nigerian culture includes many myths, rituals and the use of known herbs in attempts to regulate women's fertility. Although many of these TFPMs have no harmful effects on a woman's health, some however, do have dangerous or counterproductive effects (Mairiga, Kullima, Bako & Kolo, 2010). In addition, the complete effectiveness of many of the traditional methods remains doubtful. The traditional methods of contraception include the lactational amenorrhea method, coitus interruptus (withdrawal method), calendar method or rhythm method, cervical mucus method and abstinence. Other form of TFPMs can be customs or beliefs which include some rituals and use of traditional medicine and herbs.

The knowledge and use of TFPMs seems to have received less research attention than other methods. The lack of substantive research on knowledge of these methods likely stem from the fact that TFPMs are considered as less effective and less often used than modern methods. Contraceptive efficacy is one of the most important aspects of method choice and promotion, and, with typical use, periodic abstinence and withdrawal (the two most commonly used traditional methods) are less effective than nearly all modern methods (Trussell 2004). There seem to be indications that familiarity of MPs towards TFPMs are either not reported or underreported by couples in large-scale surveys, including in the Nigerian Demographic and Health Survey (NDHS, 2018) data. However, several small-scale studies (Okpani & Okpani 2000; Kabonga et al. 2010; Mathe, Kasonia, & Maliro 2011; Adanu et al. 2012) focused specifically on family planning in sub-Saharan Africa have reported higher levels of TFPMs use. These discrepancies may result from different approaches to probing about TFPMs awareness which tend to be more detailed in smaller contraceptive use studies.

In Burkina Faso, including specific prompts for TFPMs resulted in 26% of MPs reporting their use compared to only 5% when using the questionnaire approach of the DHS that does not include such prompts (Rossier, Senderowicz, & Soura 2014). A similar underreporting of TFPMs was noted in the first large contraceptive surveys undertaken in Western countries in the 1970s, at the time when modern contraceptive methods were first being introduced on a wide scale (Sardon 1986; Santow 1993). These findings suggest that people in marriage often do not spontaneously recall TFPMs when asked about knowledge of current methods, leading to underreporting of actual levels of knowledge of TFPMs. They also suggest that many including MPs are not aware of alternatives including TFPMs to modern methods. A recent qualitative follow-up of a DHS survey in Ghana also reveals that a substantial number of MPs recorded as having an “unmet need for contraception” were in fact using TFPMs (Staveteig 2016).

In Nigeria, the report of recent Demographic and Health Survey (NDHS) is startling (NDHS, 2018). The report reveals adequately the components of modern contraceptive awareness but was more or less silent on that of TFPMs (Otache & Dauji, 2018). The critical challenge here is that there is a dearth of data on knowledge of TFPMs as the emphasis has always been on modern contraceptives. As glaring as these facts might seem, they are a stark reflection of the African experience where TFPMs orientation and education are relatively unknown and underreported particularly in marriage. This seeming low knowledge towards TFPMs by MPs may have serious consequences for maternal and childhood morbidity and mortality. This gave the impetus to this study especially in Ogbadibo Local Government Area (LGA) of Benue state.

The average Ogbadibo man and woman have a very strong traditional belief about maternal health especially in marriage that seems to influence what people should know about family planning even TFPMs (Otache, 2015). It is believed that once a girl has attained the age of puberty, whatever a man does to prevent conception will be severely punished by *Alekwu* (an unseen spirit being responsible for apprehending and punishing traditional law breakers or offenders) (Otache, 2018). Therefore in marriage, the man must not have any knowledge of prevention of pregnancy and when it occurs even at the wife's peril, he must not be seen trying to terminate it else he will pay heavily with his own life or that of his first son (Otache, 2018). It is also not clear whether what is known about TFPMs among MPs translates to uses of such products and services towards improving maternal health in the area. This is against the backdrop that knowledge may or may not necessarily result to acceptable use. Therefore, the study is set to unravel level of knowledge and factors affecting knowledge of MPs towards TFPMs as well

as suggest strategies for improving the knowledge of TFPs among MPs in Ogbadibo.

### **Origins of Family Planning (FP) in Human Society**

The World Health Organization (WHO) have conceptualized family planning (FP) as a way of thinking and living that is adopted voluntarily upon the basis of knowledge, attitudes and responsible decisions by individuals and couples in order to promote the health and welfare of family groups and thus contribute effectively to the social development of a country (Stewart, McNamee & Harvey, 2013). In a similar vein Mohammad, Mathew and Sinha (2017) harped that FP refers to practices that help individuals or couples to attain certain objectives including avoidance of unwanted births, bringing about wanted births, regulating the intervals between the pregnancies, controlling the time at which birth occurs in relation to the ages of the parent and determining the number of children in the family (Otache, 2015). In other words, FP is the means by which individuals or married men and women space the process of conception, pregnancy and childbirth at intervals mutually determined by both husband and wife in order to have the desired number of children that they can conveniently maintain (Otache, 2015). These definitions show that FP is the decision-making process by couples, together or individually, on the number of children that they would like to have in their lifetime, and the age interval between children. These conceptions are appropriate for this study as they mean that both halves of a couple have equal rights to decide on their future fertility. In planning their future children, partners need to have the right information on when and how to get and use methods of their choice without any form of coercion (Otache, 2015).

The modern stream of thought to limit or control birth had its origins in late 18th century British social philosophy as exemplified most prominently in the writings of the Reverend Thomas Malthus, who during the Industrial Revolution worried about the imbalance between the rapidly growing numbers of people in increasingly prosperous Western Europe and the problem of stagnating agricultural production (Otache, 2015). The modern manifestation of Malthusianism was the recognition in the decade following the end of World War II of the extraordinarily rapid growth in human populations in the developing regions of the world (Otache, 2015). Concern about rapid population growth was particularly notable in the United States, especially among a small elite that shared concerns about the shape of the postwar world and the institutions that would determine its development. John D. Rockefeller III was an exemplar and a leader of the population control movement,<sup>1</sup> whose primary concern was less the wellbeing of individuals than of entire societies, a well-being that, in the view of these

neo-Malthusians, was threatened by a growing imbalance between human numbers and a wide variety of natural and other resources, including food supplies. High on the list of concerns of the neo-Malthusians was the potential for political instability resulting from impoverishment and deprivation induced by rapid population growth in poor countries. One can date the beginning of the modern family planning movement from various starting points: Sanger's opening of the first birth control clinic in 1916; the nearly simultaneous establishment in 1952 of the first national population policy in India, the International Planned Parenthood Federation, and Rockefeller's Population Council; or the beginning of significant transfers of financial and technical assistance for population programs from industrial to developing countries in the mid- to late 1960s. My own preferred starting date is 1952, as it was then that the two streams that formed the torrent that was to become the family planning movement first began to merge (Otache, 2015).

### **Traditional Family Planning Methods (TFPMs) in Africa**

According to Hubacher and Trussell (2015), the definition of TFPMs varies. Basu (2005) argued that the term "traditional contraception (TFPMs)" implies a method used in the past and likely to be abandoned with the spread of modern contraception and the advance of socioeconomic development. This term may have been appropriate for describing the Western fertility transition, as when modern methods were introduced in these countries traditional methods had been in use there for a long time and were indeed largely replaced by newer methods. In contemporary developing countries like Nigeria, however, it is not clear how widespread the practices of periodic abstinence and withdrawal were prior to the introduction of modern contraception, and thus the designation of "traditional" may be less accurate in these settings. Further, it is uncertain whether the pattern of method switching seen in Western countries will play out similarly in these regions.

WHO (2010) have regarded TFPMs as natural family planning and described them as the methods of planning sexual intercourse according to the desired status of pregnancy by observing some signs occurring in women in the fertile and infertile periods of the menstrual cycle. These methods are based on periodic repetition of fertile and infertile periods, disposition of a single egg in each menstrual cycle, limited lifetime of the egg (it can be fertilized in a short time, only 12-24 hours after the release of it), limited lifetime (3-5 days) of sperms in cervical mucus and upper genital area, continuously monitoring and signing the duration of the cycle and/or the symptoms, and signs associated with the cycle by women, as well as being aware of the symptoms. TFPMs are also regarded as Fertility Awareness-

Based Methods (FABMs). Stewart, McNamee and Harvey (2013) comprehensively described that FABMs include all methods based on the identification of the fertile phase of the menstrual cycle. The several documented FABMs can be broadly classified as symptoms-based methods, calendar-based methods or combinations of these. These methods refer to all the local or natural means of regulating the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births in this study. It also involves the non-modern methods for consideration of the number of children married people wishes to have, including the choice to have no children and the age at which they wish to have them. In other words, in this method, married people rely on predicting times in the menstrual cycle when they should abstain from unprotected vaginal intercourse.

There is disagreement in the literature with regard to the methods that should be categorized as modern or traditional. For instance, many documents (National Demographic Health Surveys) have grouped withdrawal and the rhythm method/periodic abstinence (also known as the calendar method) as traditional, and these two methods account for the vast majority of use reported in the traditional method category. Other reported methods included as traditional in the NDHSs are generally lumped into an “other traditional” category. It is also difficult to consider users of folkloric methods (amulets, beads, herbs) to be contraceptive users. A core challenge in literature is whether the standard days method (SDM) and the lactational amenorrhea method (LAM) are traditional or modern methods. TFPMs provide an alternative means of contraception for women who prefer to avoid other methods and those with religious beliefs that discourage the use of other contraceptives. They do, however, require a thorough understanding of the female reproductive cycle and commitment to maintaining daily vigilance regarding physical changes, signs and symptoms.

TFPMs have received less attention than others. The lack of substantive researches on these methods likely stems from the fact that traditional methods are both less effective and less often used than modern methods. Contraceptive efficacy is one of the most important aspects of method choice and promotion, and, with typical use, periodic abstinence and withdrawal (the two most commonly used traditional methods) are less effective than nearly all modern methods (Trussell 2004). In a review of known TFPMs in Africa, Moroole, Materechera, Otang-Mbeng & Aremu (2020) asserted that there are more than 40 techniques of African indigenous contraception known across approximately 16 African countries. The authors considered six of these methods to be widely and commonly known in at least five countries. They include periodic abstinence, withdrawal, breastfeeding, the use of herbs, postpartum abstinence, and waist bands. The periodic

abstinence method is also known as calendar, moon checking and rhythm methods. In this technique, MPs avoid a pregnancy by abstain from sexual intercourse during the potentially fertile phase of the woman's menstrual cycle (Thapa, Wonga, Lampe, Pietojo & Soejoenoes, 1990). Periodic abstinence is the most common technique known by women of most social categories (Johnson-Hanks, 2002).

The withdrawal method referred to as *coitus interruptus* has been known as a contraceptive technique since biblical times (Rogow D and Horowitz, 1995). An important advantage of withdrawal vis-a-vis many other methods is its safety (Rogow D and Horowitz, 1995). Withdrawal might more aptly be referred to as a method that is almost as effective as the male condom, that is, at least when it comes to pregnancy prevention (Jones, Fennell, Higgins & Blachard, 2009). If the male partner withdraws before ejaculation every time a couple has vaginal intercourse, about 4% of couples will become pregnant over the course of a year (Hatcher, Trussell, Nelson, Cates, Stewart & Lowal, 2007). Whilst some couples indicated the use of withdrawal to avoid male sperms entering the women, some elders in Zimbabwe indicated that it was a taboo to splash sperms outside [(*Kurasa mbeu*) Jaravaza, 2013].

In Africa, lactation is widely recognized as a natural defence against pregnancy (Sridhar & Salcedo, 2017). The *lactational amenorrhea* method (LAM) is the specific name given to use of breastfeeding as a dedicated technique of contraception (Sridhar & Salcedo, 2017). Though lactational amenorrhea can rival efficacy of the best modern approaches, women must experience pregnancy to appreciate it (Potss & Bhiwandiwala, 1989). If the mother is nursing, she is delaying the return of fertility (Sridhar & Salcedo, 2017). Suckling induces a reduction in gonadotropin releasing hormone, luteinizing hormone and follicle stimulating hormone release, resulting in amenorrhea (Vekemans, 1997). Breastfeeding in Zimbabwe is known for child spacing (Jaravaza, 2013). LAM is unquestionably cost effective, as breastfeeding alone provides adequate nutrition and fluid intake through the first 6 months, and breast milk is considered a healthier option than its substitutes for infants in low-resource settings (Ntozi & Kabera, 1991 and Afifi, 2003). LAM is 98-99% effective during the first six months after childbirth in women practicing exclusive breastfeeding (Silberschmidt & Rasch, 2001).

There are several known medicinal plants that are the most easily accessible health resource available to many communities (Dar, Shahnawaz & Qazi, 2017) Various parts and extracts of medicinal plants have been recognized as contraceptive agents in different countries globally (Keshri, Lakshmi & Singh, 2003). Several *madawa* (medicine men) in Tanzania confirmed the existence of certain herbs and roots that might act as

contraceptives (ranging from indigenous trees to the juice of young papaya, to a cinnamon concoction) taken for several weeks after delivery of a baby (Keele, Forste & Flake, 2005). In Gambia, herbal preparations, usually taken orally, have probably been known as contraceptives for some time, as in much of Africa (Bledsoe, Hill, D'Alessandro & Langerock, 1994). Given that herbs vary widely in composition, and because there has been little systematic study of herbal contraceptives anywhere in Africa, no definitive statements about how these methods work or their effectiveness, if any, can be made (Bledsoe, Hill, D'Alessandro & Langerock, 1994).

In Zimbabwe, the known roots of medicinal plants are ground and soaked in water, before being taken by women every day for child spacing (Jaravaza, 2013). Women also collect the bark of *Ziziphus mucronata*, boil it and drink the liquid every evening to prevent pregnancy. It is also reported that a Zimbabwean women drink the seed of *mbanje* (*Cannabis sativa*) once a year to avoid pregnancy (Jaravaza, 2013). In South Africa, herbs are mixed and taken orally for three months before engaging in sexual intercourse to prevent pregnancy in women (Mothiba, Lebeso & Davhana-Maselesele, 2012). In Nigeria, herbs known to prevent pregnancy can be drunk in the form of soup, be ground into powder, mixed with cold pap and eaten or herbal powder is rubbed in an incision near vagina (Jinadu, Olusi & Ajuwon, 1997).

Postpartum abstinence refers to abstaining from sexual relations after child birth (Cleland, Ali & Capo-Chichi, 1999). This is a known common technique deep rooted in the cultures of different communities worldwide with varying duration (Dada, Akesode & Olanrewaju 2002; Cleland, Ali & Capo-Chichi, 1999 and Isenaiumhe & Oviawe, 1986). A major form of contraception in precolonial Nigerian societies was abstinence from sex during breastfeeding (Zaggi, 2014). The practice of postpartum abstinence is closely linked to child spacing in Tanzania and Ivory Coast with additional connections to lactation and child health in Ghana, Côte d'Ivoire, and Malawi (Nieto-Andrade, Fidel, Simmons, Sievers, Fedorova, Bell, Weidert & Prata 2017; Achana, Debpuur, Akweongo & Cleland, 2010; Mabilia, 2005; Desgrees-du-Lou & Brou, 2005 and Zulu, 2001). Postpartum abstinence in the D.R Congo is known in local terms as "separate beds" (Bertrand, Bertrand & Malonga, 1983). The period of abstinence varies from one cultural group to the next (Bertrand, Bertrand & Malonga, 1983). Many women, who live in Matemwe village in Tanzania, leave their husbands after birth of a baby (taking the child with them) and live in their maternal village for up to two years (Keele, Forste & Flake, 2005). One of the recognized common techniques of African indigenous contraception is the wearing of waist bands/belt, such as tying a rope containing traditional medicine around the waist (Wood & Jewkes, 2006). Women in South Africa reported that



traditional healers dipped a red string in a mixture of herbs and asked them to tie it around the waist as a contraceptive (Ncube, 2012).

The technique of a waist band could be found in Malawi after a study on traditional family planning (Maliwichi-Nyirenda & Maliwichi, 2010). In Uganda, herbs are tied in a belt and the belt is tied on the body so that the woman does not become pregnant (Kabagenyi, Reid, Ntozi & Atuyambe, 2016). Traditional beads are worn by women as waist bands or as armlets to prevent pregnancy in Nigeria (Ajayi, Adeniyi & Akpan, 2018). These items were usually soaked in recipes available as concoctions or decoctions, and thereafter, believed to possess certain spiritual powers to protect women from getting pregnant during sex (Sathiyaraj, Sivaraj, Thirumalai & Senthilkumar, 2012). The waist bands among the Yoruba of South-western Nigeria involve herbal materials wrapped with animal skins and worn before sexual intercourse (Jinadu, Olusi & Ajuwon, 1997). Other known but less common techniques of African indigenous contraception are the tying of an umbilical cord around the waist in Uganda and put in glass bottle in Mozambique (Agadjanian, 1999 and Ntozi & Kabera, 1991). Holy water or tea is taken in Zimbabwe and South Africa (Jaravaza, 2013 and Wood & Jewkes, 2006). Burial of menstrual blood is known in South Africa and Mozambique (Wood & Jewkes, 2006 and Mabilia, 2005). The placenta method is known in South Africa and Uganda (Mothiba, Lebesse & Davhana-Maselesele, 2012 and Ntozi & Kabera, 1991). Self-sterilization is commonly known in Uganda, Tanzania and Nigeria (Keele, Forste & Flake, 2005; Jinadu, Olusi & Ajuwon, 1997 and Ntozi & Kabera, 1991).

In Uganda, the baby's foot is inserted back in the opening of the womb after delivery, and the person inserting it says "let the productivity stop here" (Ntozi & Kabera, 1991). The last-born is carried in the first-born's baby carrier and placed on the eaves of the house (Ntozi & Kabera, 1991). The burial technique of dead children is practiced in South Africa to prevent the mother from conceiving again (Mothiba, Lebesse & Davhana-Maselesele, 2012). There is also knowledge of less common techniques of African indigenous contraception such as exposing testicles to heat, safety pin, eating soil, use of snail shell, milking rope, use of spear head, traditional ring, standard days and padlock on labia (Ajayi, Adeniyi & Akpan, 2018; Odivwri, 2016; Jaravaza, 2013, Mothiba, Lebesse & Davhana-Maselesele, 2012; Jinadu, Olusi & Ajuwon, 1997 and Ntozi & Kabera, 1991).

### **Changing Dynamics of Marriage and Family Planning across the Globe**

There is a dearth of research on the subjective meaning of the term "married persons". Although Edin and Kefalas (2005) do explore the meaning of marriage, they do so for a sample of poor women, and consequently, very little is known about what MPs means for other

populations. There is also the perceived underutilization of the life course approach to the conceptualization of MPs. For instance, Mitchell (2006b) argues for the “importance of situating family-related transitions and social change within their relative time and space” (p. 334). The transition to adulthood is the staging ground for decisions to marry, cohabit, or bear children; as such statuses are often seen as certifying one’s passage to maturity. The meaning of marriage can then be better assessed in terms of how it unfolds among the life circumstances and choices that young adults make in this crucial phase of their lives.

In most societies, it can be said that marriage is process that transforms the status of a man and woman, stipulates the degree of sexual access the married partners may have to each other (exclusive, preferred), establishes the legitimacy of children born to the wife, creates relationships between the husband’s and wife’s kin and specifies economic duties of husband and wife. Gough (1968) argued that

Marriage is a relationship established between a woman and one or more other persons, which provides that a child born to the woman under circumstances not prohibited by the rules of the relationship, is accorded full birth-status rights common to normal members of his society or social stratum.

This Definition is so complicated because in some societies sexual rights, economic responsibilities, or socialization of children are not derived from relationships in marriage. In our society, marriage does many things besides legitimize offspring from a sexual union yet the core of marriage is seen as being about consensual sexual intercourse. Among the Nuer of Sudan and certain Igbos of Nigeria, a woman can marry another woman and become the “father” of the children the wife bore. Some man, a kinsman, friend or neighbor impregnates the wife. There are cultures where ghost marriage is practiced for instance among the Nuer. If a man died without heirs left an unhappy and angry spirit, so a woman would be married to this deceased man’s “name”. These kinds of marriage are logical once you understand the social system and what’s at stake. A more understanding of the contemporary usage of the concept of MPs should encompass how people in a given society see it in terms of the functions marriage performs for society and understand what it is, rather than in terms of what it “ought” to be. This study conceptualizes married people as any two or more people engaged in any legally, religious, culturally or community-based recognized conjugal union that establishes rights and obligations between them.

### **Knowledge of TFPMs in Nigeria**

There is increasing delineation and identification of unmet needs as a separate category within FP and TFPMs in particular among scholars. This

is in order to focus on such married women whose attitudes resemble those of contraceptive users but practices do not. Prominent among factors responsible for such behaviour is lack of information or knowledge of services. The need for the knowledge of married men and women towards TFPMs is of paramount importance. Sexual health of married men and women in appears to be affected by poor knowledge of the available TFPMs (Babatunde, Olusola & Osakinle, 2019). Many married men and women appear to have a low level of information and many of them are shy to express themselves appropriately on the issues that relate to sex. These problems inevitably lead to a lower quality of care in sexual health. It is noteworthy here as studies devoted to knowledge as a critical component of FP are hard to come by. While empirical studies on knowledge of modern methods of contraception abound, a comprehensive study on knowledge of married people on TFPMs are rare and usually among small populations (Otache, 2015).

In their study Rossier and Corker (2017) sample 409,399 from the Demographic and Health Survey (DHS) Reports 2010—2103 of West, East and Central African countries and found that knowledge of periodic abstinence or withdrawal (key TFPMs) is lower than knowledge of modern methods. However, their study reveals that TFPMs' knowledge is fairly widespread in the region, especially in Central Africa, where knowledge of either traditional method is greater than knowledge of modern methods. The researchers opined that a lack of knowledge of TFPMs seems to contribute to lower rates of use among uneducated, very poor, and Muslim women.

In another study on "Contraceptive Knowledge, Attitude and Practice among Rural Women", Mustafa, Afreen and Hashmi (2008) sampled 81 cases at community based health facility in Karachi. They found that women illiteracy is one of the factors that affect the knowledge regarding contraception. Another factor responsible for knowledge of family planning methods are the exposure of messages through media. Electronic media play an important role in a society where literacy level is low. Fikree, Khan, Kadir, Sajan, and Rahbar (2001) stated that women were more likely to use contraceptives when messages of family planning were delivered through media. Religious affiliation also appears to affects the knowledge of contraceptive use. Religions differ in their stand on fertility regulation and among the major world religions, Catholicism and Islam are widely regarded as pronatalist in their ideology. However, the relationship between religion and contraceptive use is much more complex than expected (Yeatman & Trinitapoli, 2011). In one study conducted in India, it was discovered that even though the average number of children born to a Muslim or Christian couple is higher than that born to a Hindu couple, the acceptance of sterilization to limit family size was greater among Muslims and Christians

than Hindus. The strength of one's religiosity or degree of one's adherence to the norms of a given religion may exert an influence on ones' mode of life including knowledge of reproductive behaviour.

### **Theoretical Framework**

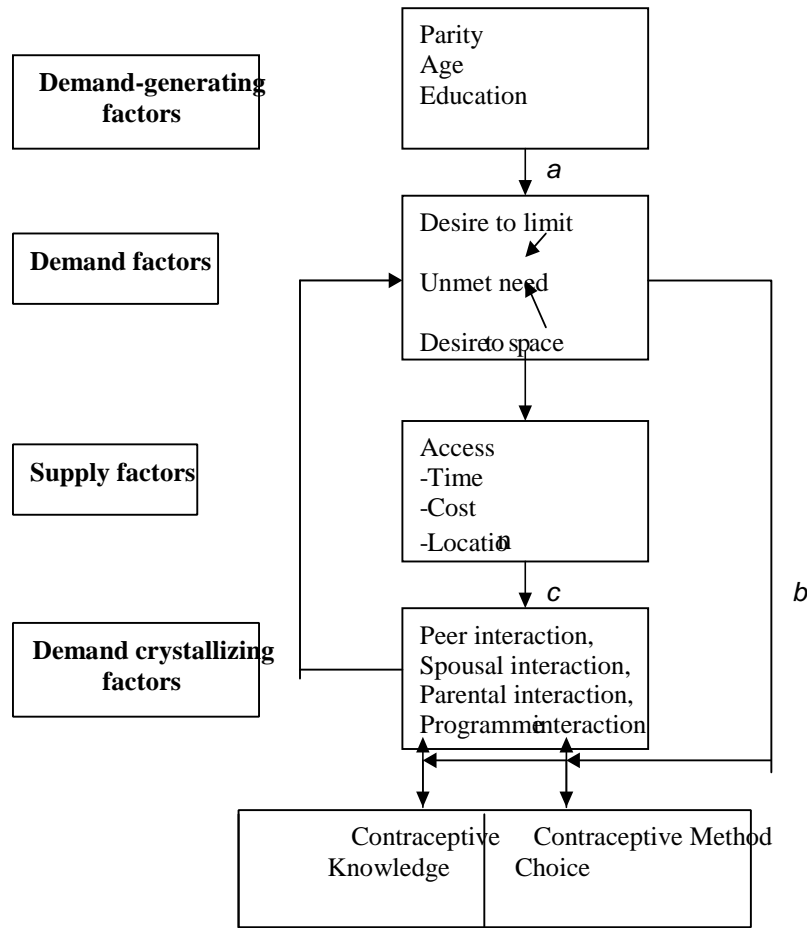
The fertility decision-making model (FDMM) presented by Bulatao and Lee (1983). The fertility decision-making theory is based on the notion that as society modernizes, changes occur including rational decision-making and changes on the structure of the family. Decision-making consists of three elements: knowledge, motivation and assessment of fertility regulation. The initial step involves being aware of the alternatives of influencing ones' costs of reproductive behaviour. However, knowledge alone would not be sufficient to influence fertility regulation although it is a precondition. Knowledge about contraceptives should be accompanied by perceptions about access and availability of methods in order for proper considerations to be given whether to adopt it or not. In order for MPs to adopt contraception, they should have a perceptive awareness of the availability and accessibility of the means of fertility regulation, so that they can translate these perceptions into action (Davis & Blake, 1956).

The second stage of the decision-making process involves motivation. Within a population, motivation is influenced by socio-economic, cultural and family life cycle patterns. The concept of motivation has been used widely in the economic models of fertility in which motivation is thus defined as the balance between supply and demand (Davis & Blake, 1956). The last stage in the decision-making process is assessment, which is the weighting of the positives and negatives of adopting contraception. A key purpose of the framework is to highlight how some elements act as intervening factors in influencing MPs' awareness of family planning services in the study area. Knowledge about contraceptive is considered to be of great importance regarding contraceptive intention and behaviour. If MPs are aware and trust their ability to have control, if they understand and believe that pregnancy at a young age is a serious matter and that it is beneficial to adopt contraception and realise they have parental support, they are considered more likely to obtain sexual and reproductive health services, including contraceptives, effectively. However, if MPs not well informed or not adequately acquainted with and do not believe in the above-mentioned items and think there are several barriers to obtaining sexual and reproductive health services, then they are considered less likely to adopt contraceptives even TFPMS.

The schematic presentation in figure 3 examines the relative roles of individual and social support factors as determinants of knowledge of contraceptive and choice of methods. Determinants are divided into four

general classes: (i) demand-generating factors such as education, age and other personal characteristics; (ii) demand components which are composed of desire to limit births and desire to space future births (iii) supply factors and (iv) demand crystallising components which are composed of factors that facilitate the implementation of the outcome such as spousal support, social (peer) support and parental support. In this specification, MPs' TFPM awareness is generated by individual socioeconomic characteristics indicated by the pathways a and b representing the extent to which demand fosters adoption of contraceptive methods in the absence of facilitating factors. Pathway c represents the role of crystallizing factors in fostering knowledge and the implementation of demand. In this framework, programme activities play a role in contraceptive method awareness and adoption that is similar to the roles of social, familiar and spousal support. The psychological, logistical and social constraints to contraceptive acquaintance and adoption are offset by programme activities that enhance service accessibility, improve the climate of information exchange and legitimize contraceptive behavior.

**Figure 1: Conceptual framework for the determinants of Knowledge of Contraceptive**



Source: Adapted from Davis & Blake (1956) with modifications

**Materials and Methods**

A social survey is used in this study as a specification of procedures for gathering information about a large number of people by collecting information from a few of them. Consequently, sample size considered convenient to handle by the researcher was used to facilitate primary data collection in order to generate empirical data for the research. Hence, the utilization of quantitative field research methods. From a projection of the population of 745,198 (NPC, NBS, 2021), sample size of 350 respondents determined by the online sample size determining calculator were selected. The software for this calculation requires a population, values for confidence

level and interval or marginal error to determine the sample size. 99% confidence level and a 5% marginal error were inputted.

$$1 + \left( \frac{\frac{z^2 X p (1-p)}{e^2}}{e^2 N} \right)$$

Where z= z-score from confidence level, p= population proportion, e= marginal error and N=total population.

$$1 + \left( \frac{\frac{2.58^2 \times 0.5(1-0.5)}{0.05^2}}{0.05^2 (745,178)} \right)$$

$$1 + \left( \frac{\frac{6.6564 \times 0.5(1-0.5)}{0.0025}}{0.0025 (745,178)} \right)$$

$$1 + \left( \frac{\frac{6.6564 \times 0.5(1-0.5)}{0.0025}}{0.0025 (745,178)} \right)$$

$$1 + \left( \frac{\frac{1.6641}{0.0025}}{1862.945} \right)$$

$$\frac{665.6}{1 + 0.000893263}$$

$$\frac{665.6}{1.000893263}$$

$$= 665.54 \times 0.5 = 332.77$$

This figure (332.77) was then approximated to the nearest half of hundredth (350).

The study used the probability sampling technique for convenience, cost, appropriateness, accessibility, usefulness and representativeness. The procedures involved simple random sampling techniques at two stages. This is suitable because population is segmented into wards. The first stage involved the selection of wards. This is to give the study an LGA-wide spread and for technical ease. There are 3 districts made up 13 wards in Ogbadibo LGA, these districts and their wards are presented in table 1 below:

**Table 1. Districts and their Wards in Ogbadibo LGA**

<b>Districts</b>	<b>Wards</b>
Otukpa	Ai-Oodo I
	Ai-Oodo II
	Ai-Oono I
	Ai-Oono II
	Ai-Oono III
	Olachagbaha
Owukpa	Ehaje I
	Ehaje II
	Itabono I
Orokam	Itabono II
	Orokam I
	Orokam II
	Orokam III
<b>Total</b>	<b>13</b>

Source: Independent National Electoral Commission, 2015

The study adopts 25% of the total wards to be included in the study. That means

$$\frac{25}{100} \times \frac{13}{1} = 3.25 \cong 3$$

Ogbadibo LGA is Using the fish-bow method, the study selects three wards—Aioodoo I, Orokam II, and Itabono I wards as the sampling frame. This selection is considered appropriate and a true representative of the entire population as each ward is given equal chance of being selected and at least a ward is chosen from each district. Given that there are twenty-two communities in these three selected wards, 16 respondents were selected from each community. The cluster area listing used by the Primary Health care immunization programme was followed with an interval five houses to select each respondent for the study (National Programme on Immunization, 2019). The justification for the adoption of these sampling methods is to ensure that all wards and their communities are given adequate consideration for the study.

The researcher developed a questionnaire as an instrument for data collection. The instrument is called Questionnaire on Knowledge of married people towards TFPMs in Ogbadibo (QKMP). Majority of the questions have multi-choice answers and respondents are expected to choose an option in most cases and on a few ones they are expected to choose more than an option. There are also open—ended items to elicit suggestions from respondents. The questionnaires were administered personally by the researcher with prior arrangement with the selected communities in



Ogbadibo, with the help of two research assistant. Individuals in the various selected communities were approached with appropriate consent request to participate in the survey. Those within each community that gave their consent were administered the research instrument. The socio-demographic and other research questions' data gathered through the research inventory in this study was processed using Statistical Package for the Social Sciences (SPSS) version 26.0 and then presented in tabular and chart forms, with manipulation in percentages. The formulae for simple percentages  $\frac{n}{N} \times \frac{100}{1}$  Where n= scores N= total scores. Statistical tools especially the Chi-Square were used to cross tabulate and establish relations as stated in the study assumptions. Information from the open ended questions in the questionnaire were transcribed and reported as added information in the appropriate subsection.

### **Results and Discussions**

The primary purpose of this study was to examine the 'knowledge, attitude and practices of married people towards traditional family planning methods in Ogbadibo LGA of Benue State Nigeria. A total of 352 respondents took part in this study. However, 6 of the respondents were unable to fill and return the research instrument. This brings the instrument returned rate to 98.0% which was considered adequate for analysis. Hence, data collected from returned 344 questionnaires were organized, classified, presented and analyzed using statistical tools such as frequency tables and charts with simple percentages to produce results in line with the research objectives. The first part presents and analyzes demographic, marital and economic characteristics of the respondents and the second part focuses on data that relate specifically to the research questions and the relationship between variables are tested. The results will form the basis for a comprehensive discussion and subsequently, summaries, conclusion and recommendations in the next chapter.

### **Socio-demographic and Economic Characteristics of the Respondents**

This section presents the data on sex, age-group, religious affiliation and ethnic group of the respondents. As shown in table 2, the sex distribution of the respondent indicates that the majority of respondents are females. 203 respondents representing 59.0% are females while 141 respondents representing 41.0% are males. This is not surprising considering the fact that issues of family planning in general is regarded traditionally as a female dominated agenda. However, times are really changing and males are becoming increasingly interested in such discussions.

The age distribution of the respondents reflects an increasing young population of married people in Ogbadibo. Out of the 344, majority (63.6%) of the respondents are in their late twenties and early thirties (26—35 years). These are the age cohorts when reproduction is at its peak. Also 45 respondents representing 13.1% were within 36—40 years, 30 respondents each representing 8.7% were within 18—25 years and 41—45 years respectively, while 20 respondents representing 5.8% are aged 46 years and above. The age distribution clearly reveals that most married people in Ogbadibo LGA are still within the active reproduction age bracket. Therefore, this study is apt with implications for interest in planning families for better quality of life and societal development. From table 2 also religious affiliation data of the respondents shows that the dominant religion of married people in Ogbadibo is Christianity. This is so because from the 344 respondents, majority (77.9%) is Christians. A considerable 18.6% still practice traditional worship of gods and 3.5% are Muslims. The importance of religious beliefs on the subject matter of this study cannot be overemphasized. One expects that the knowledge of MPs towards TFPMs in Ogbadibo LGA be influenced by the doctrines of the dominant religion.

Similarly, the ethnic group information of the respondents indicates that married people in Ogbadibo are mostly Idoma. From the data, majority (44.0%) is Idoma. The Igala ethnic group constitutes 23.8% of the respondents. A considerable 18.0% of the study participants are Igbo speaking while others including Yoruba, Hausa/Fulani, Tiv etc make 14.2% of respondents. Again, the significance of ethnic groups with diverse cultural beliefs on the subject matter of this study cannot be overemphasized. It is taken for granted that the knowledge of MPs towards TFPMs in Ogbadibo LGA will be influenced by the cultural practices of the dominant ethnic group. These demographic information as presented above are closely related to the marriage related behaviours of the Ogbadibo inhabitants as shown in the next subsection.

From the table, the marital status distribution of the respondent indicates that the majority of the study participants are currently married. 199 respondents representing 54.9% are married, 91 respondents representing 26.5% are separated while 18.6% are currently divorced. It can be taken for a fact that these statuses are critical in birth control and family planning discussions. The type of marriage of the respondents shows that 221 representing 64.2% are in monogamous marriage while 123 respondents representing 35.8% are in polygamous marriage. This is not surprising considering the fact that majority of study participants are Christians where the doctrine of 'one-man one-wife' is strictly taught. The marriage life distribution of the respondents reflects an increasing experienced population of married people in Ogbadibo. Out of the 344, majority (72.3%) of the

respondents have spent more than a decade at least in their marriages (11 and above years). The issues of family planning cannot be a strange subject matter among these cohorts. Also 61 respondents representing 17.1% have spent between 6—10 years in marriage while 34 respondent representing 9.9% have spent between 0—5 years in marriage.

From table 2 below, the family size information of the respondents shows that most married people in Ogbadibo are in large families with children 10 and above. Out of the 344, majority (52.9%) of the study participants are in families that have at 10 and above children. The desire for large families appears to be an age long tradition among the inhabitants of Ogbadibo LGA. Also 78 respondents representing 22.7% are from families that have 7—9 children, 59 respondent representing 17.2% are from families that have 4—6 children while 25 respondents representing 7.3% are from families that have 0—3 children. The age-group of youngest child data of the respondents shows that most married people in Ogbadibo have children that are two or less years. Out of the 344, majority (61.6%) of the respondents indicate that the age of the youngest child in their families is two or less years. Also 100 respondents representing 29.1% of the respondents indicate that the age of the youngest child in their families three and above years. Only 32 respondents representing 9.3% of the respondents say that the age of the youngest child in their families is between 2—3 years.

**Table 2 Percentage Distribution of Socio-Demographic Features of the Respondents**

<b>Socio-Demographic Variables</b>	<b>Frequency (N=344)</b>	<b>Percent</b>
<b>Sex</b>		
Male	141	41.0
Female	203	59.0
<b>Age-Group</b>		
18-25 yrs	30	8.7
26-30 yrs	115	33.4
31-35 yrs	104	30.2
36-40 yrs	45	13.1
41-45 yrs	30	8.7
46+ yrs	20	5.8
<b>Religious Affiliation</b>		
Christian	268	77.9
Muslim	12	3.5
Traditional	64	18.6
<b>Ethnic Group</b>		
Idoma	151	44.0
Igala	82	23.8
Igbo	62	18.0

Others	49	14.2
<b>Marital Status</b>		
Currently Married	189	54.9
Divorced	64	18.6
Separated	91	26.5
<b>Type of Marriage</b>		
Monogamy	221	64.2
Polygamy	123	35.8
<b>Marriage Life</b>		
0-5 years	34	9.9
6-10 years	61	17.7
11-15 years	160	46.5
16-20 years	62	18.0
21+ years	27	7.8

Source: Author's Field Survey, 2021

Results of this study indicate that most of the respondents are Idoma, Christian females in their late twenties and early thirties when reproduction is at its peak. Also, majority is currently in monogamous marriage that have lasted 11 and above years in large families with children 10 and above with the age-group of youngest child that is two or less years. The distribution of the respondents by their educational level in table 3 shows that while most married people are educated, the general educational level attained remain very low with majority completing only primary education. 142 respondents representing 41.3% stopped at primary education, 113 respondents representing 32.8% completed secondary education, whereas 79 respondents representing 23.0% have no formal education and 10 respondents representing 2.9% have attained tertiary level. Also, the data in the table 3 shows respondents' occupation. The general inference that can be drawn from the figures is that most married people in Ogbadibo LGA are engaged in very low income occupations. 106 respondents representing 30.8% are farmers. 72 (20.9%) of the study participants are engaged petty trading and 69 (20.1%) are artisans. 45 (13.1%) each are civil servants and other occupations respectively whereas 07 (2.0%) are not engaged in any occupation.

The data in the table further shows the estimated monthly income of respondents. The result reveals a very low income among married people in Ogbadibo LGA. It is clear from the information that majority (83.4%) of the respondents earn below N10, 000 per month. Only 32 (9.3%) of the respondents earn between 10, 001 to 50, 000 per month and 25 (7.3%) of the respondents said that the earn 30, 000 to 60, 000 monthly, while 16 (21.1%) of the respondents earn 50,001 and above monthly.

**Table 3 Percentage Distribution of Socio-Economic Features of the Respondents**

<b>Socio-Economic Variables</b>	<b>Frequency (N=344)</b>	<b>Percent</b>
<b>Educational Level</b>		
No Formal Education	79	23.0
Primary	142	41.3
Secondary	113	32.8
Tertiary	10	2.9
<b>Occupation</b>		
Farming	106	30.8
Civil Service	45	13.1
Artisan	72	20.9
Petty Trading	69	20.1
Others	45	13.1
None	07	2.0
<b>Estimated Monthly Income</b>		
Less than N 1,000.00	66	19.2
N 1,001-N 5,000.00	113	32.8
N 5,001-N 10,000.00	108	31.4
N10,001-N 50,000.00	32	9.3
N 50,001 +	25	7.3

Source: Author's Field Survey, 2021

The general level of education is found to be low, where majority are engaged in crude subsistent farming a very low income where majority (83.4%) earn below N10, 000 per month. Given these socio-demographic, marital and economic characteristics, TFPMs will appear the best alternatives to any MP seeking to plan the family in the face of the current social and economic realities of our world. Many studies (Santow 1993; Johnson-Hanks 2002, Basu 2005 & Bajos et al. 2014) have identified TFPMs to be cheaper, safer and easily accessed than other conventional methods. Hence, it is considered suitable to our communities with such characteristics.

#### **Knowledge of Married People (MPs) towards TFPMs in Ogbadibo LGA**

This section of the study highlights the various knowledge of MP of the respondents. It presents data on whether the study participants have ever heard about TFPMs; know these natural methods of family planning and to mention the ones they know. The section further provides information on the source(s) of knowledge of TFPMs for married people, the appropriateness TFPMs and a description of the knowledge level of married couples towards TFPMs Ogbadibo LGA. The data on these variables are presented below.

The respondents were asked whether they have ever heard about TFPMs. The responses gathered as shown in figure 1 reveal that the majority of respondents have not heard about TFPMs. 58.0% of the participants responded “No” while 42.0% responded “Yes”. This is not surprising considering the fact that issues of birth control in general is treated with secrecy with regard to traditional beliefs. However, the changes in beliefs are beginning to make for greater openness towards discussing these issues as seen in this open acceptance of the fact that they have heard about TFPMs (42.0%).

The participants were further asked whether they know any of TFPMs. The data gathered as shown in figure 2 reveal that the majority of them know particular TFPMs. 72.1% of the participants responded “Yes” while 27.9% responded “No”. This is surprising given the preceding findings that majority have never heard about TFPMs. This might not be unconnected to the secrecy with which birth control and family planning are shrouded due to traditional beliefs. It further revealed that most people are aware but are reluctant to accept that fact.

Some respondents also show their awareness of TFPMs by describing what they think constitute such methods. A female (35 years old graduate and LG employee) held that

In my view, natural family planning is the use of natural methods to space or limit the number of children in a home without the use of drugs or injections. Examples of natural family planning methods are; withdrawal, abstinence. For now, we do not need any of the method I would like to have as many children as possible because God say so and our people too love many children if not a woman has no much regard in her home.  
(35 years old graduate and LG employee, Ai-Oono I)

Another female respondent held that

I know of TFPMs like the safe periods, abstinence from conjugal meeting when pregnancy is likely to occur. Breastfeeding mothers hardly gets pregnant but these methods may work for other women but not for me because my husband will not like to hear of safe and unsafe period I am a Muslim and my religion forbids me to say no whenever my husband needs me for conjugal reasons. Although it is true that larger families may not go well with the present economic situation but the number of children to have should be left in God’s hand not for us to decide.

The mentioned types of TFPMs are further grouped into the rhythm, withdrawal and both for ease in description and are presented in table 2 below. From the above table, responses on the types of TFPMs mentioned by respondents show that most married people in Ogbadibo mentioned none of the various types of TFPMs. Out of the 344, majority (75.6%) of the study participants indicate none of the TFPMs. Also 46 respondents representing

13.4% mentioned both rhythm and withdrawal methods. Only 21 respondent representing 6.1% mentioned rhythm method while 17 respondents representing 4.9% mentioned withdrawal method.

**Table 4. Distribution of Types of TFPMs Mentioned by Respondents**

<b>Type of TFPMs</b>	<b>Frequency</b>	<b>Percent</b>
Rhythm method	21	6.1
Withdrawal method	17	4.9
Both rhythm a & withdrawal methods	46	13.4
None	260	75.6
<b>Total</b>	<b>344</b>	<b>100.0</b>

Source: Field Survey, 2021

The study participants were also asked to identify some possible sources of knowledge of TFPMs that are available to married people. From the table below the respondents indicate TV/Radio as well as health personnel are the most identified sources of information and knowledge on TFPMs for married people in the LGA. The information in the table further shows that there could be others (41.3%), family members (37.5%) and friends/relatives (35.5%) sources of knowledge of TFPMs available to married people in Ogbadibo.

**Table 5. Source(s) of knowledge of TFPMs by Respondents**

<b>Source(s) of knowledge</b>	<b>Frequency</b>	<b>Percent</b>
From Family Members	129	37.5
TV/Radio	277	80.5
Friends/Relatives	122	35.5
Health Personnel	274	79.7
Others	142	41.3

Source: Field Survey, 2021

Some of the respondents also identify sources such as word of mouth considered as the main and most reliable and immediate source of information across the LGA. A female (farmer) from Itabono II said, "We live in one village, so if anybody finds out any information about these things (TFPMs) they share it with each other." In addition, MPs with previous experience of TFPMs use are considered a reliable source of knowledge. Another female participant from Ai'Oono I said, "We have heard about different TFPMs from people around us who had used these methods."

Asked whether or not TFPMs are appropriate methods for family planning, the responses gathered as shown in table 5 reveal that the majority of the study participants do not know whether TFPMs are appropriate or not. 75.3% of the participants responded "I do not know". 68 of the respondents

representing 19.8% responded “No” while 17 of the respondents representing 4.9% responded “Yes”.

**Table 6. Responses on whether TFPMs are appropriate method for FP**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Yes	17	4.9
No	68	19.8
Do not Know	259	75.3
<b>Total</b>	<b>344</b>	<b>100.0</b>

Source: Field Survey, 2021

Table 7 below shows that 25.0% of study participants have ‘fair’ level of knowledge of TFPMs, while 17.7% and 11.4% of them have adequate and very high levels of knowledge of TFPMs respectively. Furthermore, 28.8% and 17.2% of the respondents have poor and very poor knowledge of TFPMs.

**Table 7. Knowledge of MP towards TFPMs by Respondents**

<b>Knowledge level</b>	<b>Frequency</b>	<b>Percentage</b>
Very High	39	11.4
Adequate	61	17.7
Fair	86	25.0
Poor	99	28.8
Very Poor	59	17.2
<b>Total</b>	<b>344</b>	<b>100.0</b>

Source: Field Survey, 2021

The level of knowledge reflected in the above presentation is further buttressed with extracts from the IDIs with participants across the study area.

A male participant from Orokam I said:

We have heard that one natural FP is breast feeding. They say that some women breast feed their children and don’t get pregnant whereas in some cases women breast feed their children and from the second month they start getting their menses.

Similarly a 26 year old married woman primary school teacher mother of one responded on being ask about TFPMs:

In my view, TFPMs (is) the use of natural methods to space or limit the number of children in a home without the use of drugs or injections. Examples of TFPMs are; withdrawal, abstinence. For now, we do not need any of the method I would like to have as many children as possible because God say so and our people too love many children if not a woman has no much regard in her home



The findings of knowledge of MPs towards TFPMs reveals some intriguing results that are not typical of most studies. It was discovered that most of the participants have never ‘heard’ of TFPMs and majority of do not know of at least one TFPMs. While these findings are in tandem with Knodel and a van de Walle (1979) study that shows traditional methods were largely unknown, they are in contrast with the findings of Pakistan DHS (2012-13) where individual MPs had knowledge of at least one method of contraception. This might be as a result of inappropriate descriptions by the research assistants or due to the fear of *alekwu* deity.

However, some of the respondents mentioned and described what they can do to have children as desired and this potential knowledge can be worked upon for desired results. The findings also indicate that TV/Radio as well as health personnel are the most identified sources of information and knowledge on TFPMs for married people in the LGA. But ‘word of mouth’ considered as the main and most reliable and immediate source of information across the LGA.

### **Suggestions to improve knowledge of married people towards TFPMs in Ogbadibo**

This section presents qualitative data gathered on suggestions towards improving knowledge of MPs towards TFPMs in the study setting. Respondents were asked to suggest what individuals MP, community and religious leaders, NGOs, CSOs or FBOs and Government can or should do to improve knowledge of MPs towards TFPMs. Since it is taken for granted that if knowledge is improved, attitudes and practices will also improve, the responses on the open-ended questions are summarized below. Responses towards improving knowledge of MPs towards TFPMs show that the study participants suggest that individual MPs in Ogbadibo can and should more concern about their reproductive health in general as an entry point to talk about getting knowledge. A respondent (25-30 years female graduate) held that:

You know around here, individuals especially MPs tend to take little part in family planning or reproductive health consultations. Individual MPs must seek more opportunities to speak out and ask questions, express concerns and get information about TFPMs. Nobody can do that for you and I am not sure there are any cultural restrictions to that.

Another male (31—35 years, artisan) suggested that improving knowledge of MPs towards TFPMs must begin from the community and religious leaders as they are the custodians of their culture and faith. In his words:

My sister, in issues like this we cannot disregard the importance of our culture and religion. I think the first point of call should be our community and religious leaders. If they start to teach messages MPs will take up from

there. They can encourage people to have fewer number of children and where possible, relevant portions of the sacred books like the Bible and Quran should be emphasized during religious preaching so as to enlighten to TFPMs and reproductive health in general. Our community leaders can organize for friends/relations where forums of free discussions on TFPMs can be held for a better understanding of these methods you are talking about.

Some of the participants also pointed out that NGOs, CSOs or FBOs and Government have a lot to do to improve knowledge of MPs towards TFPMs and birth control in general. A female (36+ years, graduate) suggested that:

These organizations can print materials (just pictures of local people) in and past in strategic locations to reinforce this message. They can set up FPs especially TFPMs educational forums for MPs where they will receive useful teachings and messages that will make them shift focus away from looking forward to having many children as a social security.

The study participants were asked about what they think MPs, community and religious leaders, NGOs, CSOs or FBOs and government should do to improve attitudes of MPs towards TFPMs. The responses in this regard imply that well targeted behavior change and communication campaigns can change the attitudes regarding TFPMs. Most respondents are of the opinion that improvement in attitudes is usually a response to a superior argument. Therefore, MPs that have used one TFPMs of the other with successful returns can champion the campaign in their community. According to a female (30 years, petty trader):

... word of mouth is not only the main and most reliable immediate source of information, it can be use by those MPs like me to encourage other younger or older couples to change their perception and negative attitudes towards TFPMs. Just tell them your experiences, relate and genuinely show them what they are missing... they will sure turn around.

### **Socio-economic factors influencing Knowledge of TFPMs among MPs in Ogbadibo**

The study hypothesized that given certain socio-demographic features, the level of knowledge of MPs towards TFPMs is poor in Ogbadibo LGA. In order to test this assumption, educational level of the respondents was cross-tabulated with level of knowledge using the Chi-Square. From the results table 7, there appears to be some relationship between level of education and the level of knowledge of MPs towards TFPMs. It shows that the higher the educational attainment of the MPs the higher their level of knowledge towards TFPMs. To test this observed relationship, the chi-square test was applied to the data in Table 15. The result reveals that the relationship observed here is significant at 0.032 levels with a chi-square

value of 13.763. This implies that MP's level of education is crucial in understanding their level of knowledge towards TFPMs.

**Table 8. Knowledge level of MP towards TFPMs by Level of Education**

Knowledge level	Level of Education				
	Total	NF Edu.	Primary	Secondary	Tertiary
	F (%)	F (%)	F (%)	F (%)	F (%)
Very High	01 (1.3)	09 (6.3)	23 (20.4)	06 (60.0)	39 (11.4)
Adequate	06 (7.6)	25 (17.6)	26 (23.0)	04 (40.0)	61 (17.7)
Fair	09 (11.4)	37 (26.1)	40 (35.4)	00 (0.0)	86 (25.0)
Poor	31 (39.2)	63 (44.4)	05 (4.4)	00 (0.0)	99 (28.8)
Very Poor	32 (40.5)	08 (5.6)	19 (16.8)	00 (0.0)	59 (17.2)
<b>Total</b>	<b>79 (100.0)</b>	<b>142 (100.0)</b>	<b>113 (100.0)</b>	<b>10 (100.0)</b>	<b>344 (100.0)</b>

**$\chi^2=13.763$ ;  $P<0.032$ ;  $df=7$**

Source: Field Survey, 2021

The study shows a significant relationship with MPs' level of education and their level of knowledge towards TFPMs. While these findings are not entirely new as they have been seen in several previous studies on this subject matter; they demonstrate the urgency of activating them into targeted interventions.

### Conclusion and Recommendations

The study concludes that knowledge of MPs towards TFPMs is very low in Ogbadibo LGA. The LGA and indeed Nigeria in general continues to face substantial challenges to improving the reproductive health of her general population and MPs in particular. The strong cultural beliefs of MPs in Ogbadibo which holds that "any deliberate attempt to delay or halt the processes of conception will attract severe consequences from the *alekwu* deity" is a major factor responsible for the low and incomprehensive knowledge of MPs towards all contraceptive technologies including TFPMs. In a population with a relatively low level of education and income, such as Ogbadibo access to comprehensive sources of knowledge on contraception is found to be limited. The following recommendations proffered to assist individual MPs, community and religious leaders, NGOs, CSOs, FBOs and governmental agencies including primary care providers towards improving MPs' knowledge towards TFPMs in the Ogbadibo and Nigeria at large. Arising from the findings of this study, the following recommendations are offered. Since it was found in this study that knowledge of MPs towards TFPMs is both low and poor, individual MPs as direct actors and reapers of benefits of improved family health should take deliberate steps towards

seeking and acquiring the requisite knowledge that will improve their understanding TFPMs and other contraceptive technologies. This is given the fact that knowledge liberates while ignorance kills. The steps to be taken in this direction are multifaceted. They could determine to listen to family life programmes aired weekly on the radio, enroll in adult education with attention on family health and reproductive issues or organize and invite reproductive healthcare professionals for comprehensive discussions on contraceptive interventions including TFPMs. Such programmes will not only foster the necessary information required to discard inimical traditional beliefs and myths but equip them with requisite knowledge to make responsible decisions on child spacing, number of children to have and consequent improvement in childhood and maternal health.

Community leaders and elders should abolish traditional beliefs that are inimical to birth control and promote knowledge of TFPMs among MPs. The current social intervention programmes of government can be expanded to include families in the remotest communities. Government should also begin to be serious and decisive in enacting laws and policies towards streamlining the number of children a family must have as in other emerging economies like China etc. NGOs, CSOs and FBOs must intensify their advocacy towards encouraging smaller family sizes in the face of the economic, social and security realities of our time. They should organize programmes in collaboration with community and religious leaders, vested interests and governmental agencies to promote knowledge of MPs and the entire populace towards TFPMs and other interventions in Ogbadibo LGA.

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