Acknowledge, Attitude and Practice towards Family Planning among Women of Reproductive age in Egbe-Liasu Ikotun LCDA, Lagos State

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Abstract
This study assessed the knowledge, attitudes, and practices regarding family planning among women of reproductive age in Egbe-Liasu, Ikotun LCDA, Lagos State.

Study Design and Methods
A descriptive cross-sectional survey was employed, with primary data collected via questionnaires administered to 100 women of reproductive age selected through random sampling. Data were compiled in Microsoft Excel and analyzed using SPSS version 27, employing descriptive statistics (frequencies and percentages) and chi-square tests for inferential analysis.

Key Findings
All participants (100%) demonstrated awareness of family planning, primarily acquired from health facilities (49%) and schools (21%), reflecting substantial knowledge levels. Modern methods such as condoms (69%), oral contraceptives (66%), injectables (58%), and intrauterine devices (56%) were most recognized, alongside predominantly favorable attitudes emphasizing maternal health and child spacing benefits, though misconceptions about side effects and infertility persisted. Practice levels showed 62% prior use (mainly condoms and pills), but only 35% current utilization, hindered by fears of adverse effects, spousal opposition, and pregnancy desires; no significant association existed between attitudes and practices (p=0.147).

Recommendations and Conclusion
Enhanced education, counseling, and male partner engagement were recommended to boost uptake. Despite strong knowledge and attitudes, family planning practice remained suboptimal among these women.
Keywords: family planning, methods, knowledge, attitude, practice, reproductive-age women

Chapter One
Introduction
Background to the Study
Family planning constitutes an essential element of reproductive health, enabling individuals and couples to regulate fertility, bolster maternal and child health outcomes, and foster economic well-being. The World Health Organization (WHO, 2020) posits that access to family planning services mitigates maternal mortality by averting unintended pregnancies, unsafe abortions, and high-risk gestations. Notwithstanding global initiatives, women aged 15–49 years encounter persistent barriers in knowledge, attitudes, and uptake of contraceptive methods, shaped by sociocultural, economic, and healthcare system dynamics.Globally, approximately 218 million women in low- and middle-income countries exhibit an unmet need for modern contraception, precipitating elevated incidences of unintended pregnancies, unsafe abortions, and maternal deaths (WHO, 2021). The worldwide contraceptive prevalence rate stands at roughly 49%, with pronounced disparities between developed and developing regions (UNFPA, 2022). In Africa, fertility averages 4.3 births per woman, while sub-Saharan Africa's contraceptive prevalence rate lags at 33%, with a 22% unmet need (World

Bank, 2022; UNFPA, 2021).Nigeria, surpassing 220 million inhabitants, records a fertility rate of 5.3 births per woman and a national contraceptive prevalence rate of 17%, marked by urban-rural divides (National Population Commission [NPC], 2022). Lagos State, Nigeria's most populous and urbanized region, exceeds the national average in contraceptive prevalence yet grapples with gaps influenced by cultural, economic, and spousal factors (Ezeanolue et al., 2020). Within Alimosho Local Government Area, particularly Ikotun LCDA—a blend of urban and semi-urban settings—high population density among reproductive-age women compounds challenges like limited awareness, cultural resistance, and inadequate counseling (Owolabi et al., 2021).Knowledge profoundly influences contraceptive adoption, with informed women more inclined toward evidence-based reproductive decisions (Sedgh et al., 2021). Attitudes are modulated by cultural norms, religious doctrines, personal histories, and social influences, often yielding spousal opposition and misconceptions about side effects like infertility (Ezeanolue et al., 2020; Bearak et al., 2022). Practice barriers include method discontinuation due to adverse effects, partner dissent, and economic hurdles, underscoring the necessity for targeted education and male involvement in locales like Egbe-Liasu, Ikotun LCDA.

Statement of the Problem
Family planning remains pivotal to reproductive health, yet its adoption falters among reproductive-age women in low- and middle-income settings due to entrenched sociocultural norms, misinformation, religious convictions, economic limitations, and service inaccessibility. An estimated 218 million women globally face unmet contraceptive needs, fueling unintended pregnancies and maternal mortality (WHO, 2021). Sub-Saharan Africa's 33% contraceptive prevalence rate and 22% unmet need exemplify these disparities, exacerbated by discontinuation linked to side effects (31%), partner opposition (26%), and health apprehensions (23%) (UNFPA, 2021; Bearak et al., 2022).

Disparities between awareness and utilization persist; for instance, Ethiopian women showed 82% familiarity with modern methods but limited comprehension of mechanisms (Ali et al., 2020). In Nigeria, 67% awareness translates to merely 38% usage, hindered by religious and familial pressures (Akinyemi et al., 2021; Ochako et al., 2021). Systemic issues, including stockouts (36%) and inadequate provider training (40%), further impede sustained practice (Bearak et al., 2022; WHO, 2020).This investigation addresses contextual voids in knowledge, attitudes, and practices among Egbe-Liasu women, informing interventions to enhance accessibility, acceptance, and reproductive health metrics.

Objectives of the Study
- To evaluate knowledge levels of family planning methods, encompassing modern and traditional options, among reproductive-age women.
- To investigate attitudes toward family planning.
- To identify prevalent practices and their utilization extent.
- To determine the influence of attitudes on family planning practices.

Research Questions and Hypotheses
- What is the knowledge level of family planning among reproductive-age women?
- What attitudes do reproductive-age women hold toward family planning?
- What are the common family planning practices and their prevalence among reproductive-age women?

Hypotheses
H$_0$: No significant association exists between attitudes toward family planning and contraceptive practices among reproductive-age women.
H$_1$: A significant association exists between attitudes toward family planning and contraceptive practices among reproductive-age women.

Significance of the Study

This research furnishes evidence for stakeholders in nursing, healthcare, communities, government, and families to advance family planning.

To Nursing Profession

Findings illuminate knowledge-practice gaps, enabling tailored education, culturally sensitive counseling, and curriculum integration for optimal maternal-child outcomes.

To Healthcare Providers

Insights guide enhanced counseling, interdisciplinary collaboration, and patient-centered strategies addressing sociocultural barriers.

To the Community

Results promote stigma reduction, open discourse, and lowered unintended pregnancy risks via awareness dissemination.

To Government

Data underpin policy refinement, resource allocation, and national program efficacy.

To Individuals and Families

Empowers informed choices, financial stability, male involvement, and risk mitigation from high-parity pregnancies.

Scope of the Study

The study targets knowledge, attitudes, and practices of family planning among women aged 15–49 years—married, partnered, or sexually active—in Egbe-Liasu, Ikotun LCDA, Lagos State.

Operational Definitions

- Attitude: Predisposition or evaluation shaping behavior toward an entity.
- Contraceptive Methods: Devices or techniques preventing conception.
- Family Planning (FP): Regulation of childbearing via contraceptives, fertility awareness, and services.
- Healthcare Providers: Professionals delivering medical care, including physicians, nurses, and midwives.
- Knowledge: Acquired awareness, comprehension, or familiarity.
- Practices: Actual implementation of methods or beliefs.
- Primary Healthcare Centers (PHCs): Facilities offering essential preventive, curative, and rehabilitative services.
- Women of Reproductive Age: Females aged 15–49 capable of reproduction.
- World Health Organization: UN agency addressing global health priorities.

Chapter Two
Literature Review

A systematic examination of extant literature on knowledge, attitudes, and practices toward family planning among reproductive-age women is vital for elucidating demographic-specific challenges within healthcare and societal frameworks. This review delineates corrective strategies and identifies lacunae addressed by the present study.

Conceptual Review
Overview of Family Planning

Family planning represents a cornerstone of reproductive health, empowering individuals and couples to achieve desired family size, birth spacing, and timing via contraceptive methods and infertility management (World Health Organization [WHO], 2021). It encompasses population regulation aligned with resource availability, including contraception, infertility treatment, genetic counseling, sex selection, and abortion evaluation (Duru et al., 2018). Historical practices in African cultures involved postpartum abstinence, while global milestones include Jeremy Bentham's 1797 advocacy, Francis Place's 1822 principles, and Dr. Aletta Jacobs' 1881 initiatives in Holland.International bodies like the UN and WHO affirm family planning's benefits in enhancing maternal-child health, reducing poverty, and promoting gender equity (Nandagiri, 2021). Uncontrolled population growth underlies socioeconomic issues in developing nations (United Nations Development Programme [UNDP], 2015), with the 1994 International Conference on Population and Development advocating universal reproductive health access (Bracke,

2022).Knowledge entails awareness of contraceptive efficacy and availability (WHO, 2021), yet misconceptions persist, such as fears of infertility in Nigeria (NCF, 2020). Sources include providers, media, and networks (Guttmacher Institute, 2022), yielding economic gains through productivity and reduced healthcare costs.Unintended pregnancies exacerbate maternal morbidity, with WHO estimating 40 women suffering long-term issues per death, including obstetric fistula (WHO, 2020). Effective contraception averts 90% of abortion-related and 20% of obstetric mortality (Bernstein, 2020), aligning with Sustainable Development Goals for reproductive health.Positive attitudes toward family planning acknowledge benefits like pregnancy prevention (Bongaarts, 2021),

shaped by beliefs influencing behavior (Ajzen et al., 2020). Barriers include religious views favoring natural methods and norms valuing large families (Ogunjuyigbe et al., 2021; Feyisetan, 2020).African challenges involve high fertility, rural inaccessibility, and gender inequities (Gatune et al., 2020; Mulugeta et al., 2020). Nigeria's 19% unmet need reflects cultural resistance and low uptake despite awareness (National Population Commission, 2021; Odu et al., 2020).

Types of Modern Contraception
Modern methods comprise oral pills, implants, injectables, intrauterine devices (IUDs), condoms, sterilization, and lactational amenorrhea.

Method	Description	Duration/Effectiveness
Oral Contraceptive Pills	Hormonal (estrogen-progestin or progestin-only) to inhibit ovulation.	Daily; highly effective if consistent.
Implants	Subdermal progestin-releasing rods.	3–5 years.
Injectables	Progestin injection (e.g., Depo-Provera) thickening mucus.	Every 3 months.
IUDs	T-shaped uterine devices (hormonal or copper).	3–10 years.
Condoms	Barriers preventing sperm entry; STI protection.	Per use.
Sterilization	Permanent: vasectomy (male) or tubal ligation (female).	Lifelong.
Lactational Amenorrhea	Breastfeeding-induced ovulation suppression.	Up to 6 months postpartum.

Effectiveness categories: very effective (0–0.9 pregnancies/100 women/year), effective (1–9), moderately (10–19), less (≥20) (UN, 2020).

Level of Knowledge of Women Regarding Family Planning Methods
Knowledge encompasses acquired information on methods and sources (Chingayipe, 2020),

often shallow in rural settings due to economic and informational deficits (Mcleod, 2020). Gaps affect modern and emergency contraceptives, sex education, and STIs, with rural areas facing service imbalances.Nwosu (2020) reported low condom/IUD knowledge among Indian women aged 21–40. Nigeria's rapid population growth and 12%

contraceptive use highlight awareness-practice disconnect (Kebe, 2022), with urban-rural and education-based disparities. Mobile health innovations aid access (Feroz et al., 2020; Ajaja et al., 2020).

Attitude of Women Towards Family Planning

Attitudes involve learned evaluations—positive, negative, or ambivalent—affecting behavior (Kendra, 2021). Rural women exhibit poor attitudes due to stigma and side-effect fears (Chingyayi, 2020), varying by urban-rural divides, culture, and religion (Fogodi, 2020). In Bauchi, Nigeria, 64.4% held negative views despite awareness (Wahed, 2020).

Practices of Family Planning Among Women of Reproductive Age

Globally, 851 million use modern methods, but 172 million have unmet needs (UN, 2020). Sub-Saharan Africa's 30% unmet need persists amid population growth (UNDESA, 2020). Nigeria's 20.4% prevalence lags, with 15% usage despite high awareness (NDHS, 2019; Essien et al., 2021). Integration with maternity services enhances uptake (USAID, 2021).

Challenges Associated with Family Planning

Challenges include 200+ million unmet global needs (UN, 2020), rural barriers, gender norms, and Nigeria's 19% unmet demand (National Population Commission, 2021).

- Cultural/Religious Beliefs: Conflict with norms viewing family planning as foreign (Adeoye, 2020).
- Socio-Cultural Norms: Limit autonomy (Jones et al., 2020).
- Access Limitations: Infrastructure deficits in rural areas (Lamontagne et al., 2021).
- Misinformation: Myths deter use (Zhang et al., 2020).
- Provider Bias: Stigma erodes trust (Smith et al., 2020).
- Economic Constraints: Affordability issues (Speidel et al., 2020).
- Ethical Factors: Doctrinal prohibitions (Rowe et al., 2020).

Theoretical Review
Health Belief Model (HBM)

Developed in the 1950s by Rosenstock, Beck, and Sarason, HBM predicts health behaviors via:

- Perceived Susceptibility: Risk assessment prompting preventive action (Edberg, 2022).
- Perceived Severity: Evaluation of consequences, forming perceived threat.
- Perceived Benefits: Efficacy of actions outweighing barriers.
- Perceived Barriers: Obstacles like cost or discomfort.
- Cues to Action: Triggers (internal/external) initiating behavior.
- Self-Efficacy: Confidence in performing actions (Rosenstock et al., 2021).
- Modifying Variables: Demographics, psychosocial, and structural factors influencing perceptions (Rosenstock & Irwin, 2021).
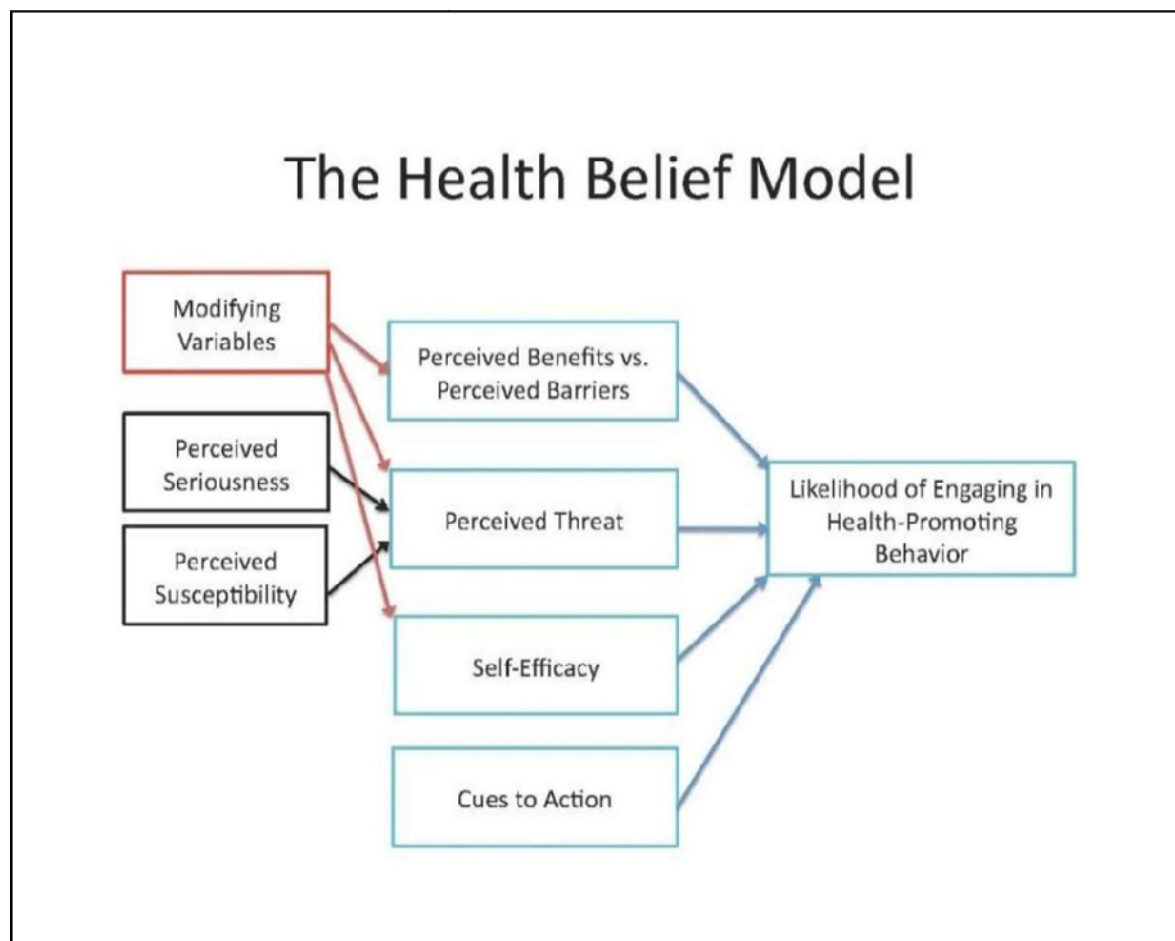
Figure 1: Interactive Health Belief Model (Jenna, 2022)

Theoretical Link to the Study

The Health Belief Model (HBM) provides a robust framework for elucidating knowledge, attitudes, and practices concerning family planning among reproductive-age women. It posits that behavioral adoption hinges on cognitive appraisals, rendering it apt for this investigation.

- Perceived Susceptibility: Women viewing themselves at risk of unintended pregnancy exhibit greater propensity to employ family planning methods.
- Perceived Severity: Recognition of grave ramifications from unintended pregnancies propels method utilization.
- Perceived Benefits: Belief in contraceptive efficacy against pregnancy fosters uptake.

- Perceived Barriers: Apprehensions over cost, accessibility, or societal censure deter engagement.
- Cues to Action: Encounters with educational campaigns, media, or peer endorsement catalyze adoption.
- Self-Efficacy: Confidence in proficient method application sustains long-term use.

HBM underscores that mere awareness insufficiently drives behavior, necessitating aligned perceptions to bridge knowledge-practice gaps in Egbe-Liasu.

Empirical Review

Nmadu et al. (2020) documented suboptimal knowledge (67.9% low) of reproductive health services among northwestern Nigerian women, contrasting Volita et al.'s (2020) 59% high knowledge in Makassar, Indonesia, and Gebreyesus et al.'s (2021) 95.5% in Ethiopia from diverse sources.In Edo State, Nigeria, 90.6% of tertiary respondents knew family

planning, favoring condoms (60.2%) and pills (51%), with mass media and providers as primary informants (25.1% each); Billings method lagged at 20%.Paschal and Matthew (2021) surveyed 280 Ghanaian women aged 15–49, revealing 89% awareness but 18% past use, linked to parity and education; spacing (94%) motivated uptake, while spousal opposition (90%) and myths (83%) impeded it, urging male-inclusive education.Shehu et al. (2023) found 90.6% antenatal clinic awareness in Port Harcourt, with injectables (71.8%), condoms (66.7%), and pills (61.5%) prominent; fears of side effects (56.4%), religion (46.2%), culture (35.9%), and partner dissent (30.8%) prevailed, echoing regional patterns.Muluwas et al. (2019) reported 64.6% contraceptive use among 536 Ethiopian women, influenced by education, knowledge, attitudes, and service availability, below national targets, recommending information-education-communication efforts.
Sonia et al. (2021) identified 22.6% prevalence in rural Burundi among 530 women, associating use with ages 25–29, secondary education, and parity ≤4, emphasizing attitudinal and access interventions for practice enhancement

Chapter Three
Methodology
This chapter delineates the research design, study setting, target population, sample size determination and sampling techniques, inclusion criteria, data collection instruments, instrument validity and reliability, data collection procedures, analysis methods, and ethical considerations.

Research Design
A descriptive cross-sectional survey design was employed, selected for its suitability in capturing data within a constrained timeframe from a population sample to evaluate knowledge, attitudes, and practices toward family planning among reproductive-age women in Egbe-Liasu, Ikotun LCDA, Lagos State.

Study Setting
The study was conducted in Egbe-Liasu community, Ikotun LCDA, situated centrally in Lagos, Nigeria. This densely populated area exhibits a robust cultural heritage, integrating traditional and contemporary practices, with women predominantly involved in income-generating pursuits such as petty trading, artisanal crafts, and domestic work.

Target Population
The target population comprised women of reproductive age (15–49 years) residing in Egbe-Liasu community, Ikotun LCDA.

Sample Size Determination
Sample size was calculated using the Cochran formula under simple random sampling to ensure representativeness for the research objectives.

$$n = \frac{Z^2 \times P \times (1-P)}{e\text{^}2}$$

$$n = \frac{Z^2 PQ}{e^2}$$

Where n= sample size

   Z= 1.96

   P= 0.

   E (margin of error) = 0.05

$$n = \frac{1.96^2 \times 0.063 \times (1-0.063)}{0.05\text{^}2}$$

$$n = \frac{3.8416 \times 0.059031}{0.0025}$$

$$n = \frac{0.226773489}{0.0025}$$

n=90.709

THEREFORE, 10% OF 90.709 = 9.070

N= 90.709 + 9.070= 99.779,

N= 100

Sampling Technique
Simple random sampling was employed to minimize selection bias. Accordingly, 100 women from Egbe-Liasu community, devoid of prior researcher affiliation, were randomly selected and each received a questionnaire.

Instrument for Data Collection
A researcher-developed, self-structured questionnaire was utilized, tailored to the study's specific objectives. It comprised the following sections:

- **Section A**: Socio-demographic characteristics of reproductive-age women.
- **Section B**: Knowledge of family planning among reproductive-age women.
- **Section C**: Attitudes toward family planning among reproductive-age women.
- **Section D**: Prevalent family planning practices among reproductive-age women.

Validity of the Instrument
Face and content validity were established through review by an health services research expert. The questionnaire, aligned with study objectives and research questions, underwent scrutiny, revisions, and approval for adequacy prior to administration.

Reliability of the Instrument
Reliability denotes the instrument's capacity to produce consistent results. A test-retest approach was applied to 10% of reproductive-age women in Egbe-Liasu, assessing question clarity and interpretive uniformity.

Method of Data Collection
The researcher personally administered the self-structured questionnaire, assisted by three supervised aides who guided respondents. Distribution and retrieval of 100 questionnaires occurred over two days, yielding full recovery for analysis.

Method of Data Analysis
Quantitative analysis utilized descriptive statistics—frequencies, percentages, and cross-tabulations—to summarize findings.

Inferential analysis employed chi-square tests for hypothesis testing, executed via Statistical Package for the Social Sciences (SPSS) version 26.

Ethical Considerations
Ethical protocols for human subjects' research were observed following approval from the, Lagos State College of Nursing, research committee, with permission extended to the community chairman. Participants received assurances of voluntary involvement, right to withdraw, anonymity, and confidentiality. All data sources were duly acknowledged.

Chapter Four
Data Analysis And Presentation
Results
This chapter delineates the analysis of collected data. A structured questionnaire was administered to 100 reproductive-age women in Egbe-Liasu, Ikotun LCDA, Lagos State, with all instruments retrieved and processed using Statistical Package for the Social Sciences (SPSS) version 27. Findings are conveyed descriptively through frequencies and percentages.

Presentation, Description, and Interpretation of Tables and Charts
Data visualization employed frequency tables and bar charts for their interpretive clarity and capacity to elucidate patterns. Tabulations highlight inter-variable relationships pertinent to the research inquiry.

Sociodemographic Data of Respondents

Table 1: Demographic Characteristics of Respondents

Variables	Options	Frequencies	Percentage
Age	15-21	17	17.0%
	22-29	24	24.0%
	30-36	8	8.0%
	37 and above	51	51.0%
Marital Status	Single	32	32.0%
	Married	64	64.0%
	Divorced	4	4.0%
Educational status	Secondary level	5	5.0%
	Tertiary level	94	94.0%
	No formal education	1	1.0%

Occupation	Unemployed	6	6.0
	Self employed	16	16.0%
	Civil servant	52	52.0%'
	Student	26	26.0%
Religion	Christianity	61	61.0%
	Islam	35	35.0%
	Traditional	4	4.0%

Table 1 above reveals that among 100 respondents, the predominant age group comprised 51 (51.0%) women aged 37 years and older, succeeded by 24 (24.0%) aged 22–29 years, 17 (17.0%) aged 15–21 years, and 8 (8.0%) aged 30–36 years.

Marital and Educational Profile
The majority, 64 (64.0%), were married, with 32 (32.0%) single and 4 (4.0%) divorced. Educationally, 94 (94.0%) held tertiary qualifications, 5 (5.0%) secondary, and 1 (1.0%) none.

Occupational and Religious Distribution
Occupationally, 52 (52.0%) were civil servants, 26 (26.0%) students, 16 (16.0%) self-employed, and 6 (6.0%) unemployed. Religiously, 61 (61.0%) identified as Christians, 35 (35.0%) Muslims, and 4 (4.0%) adherents of traditional beliefs.
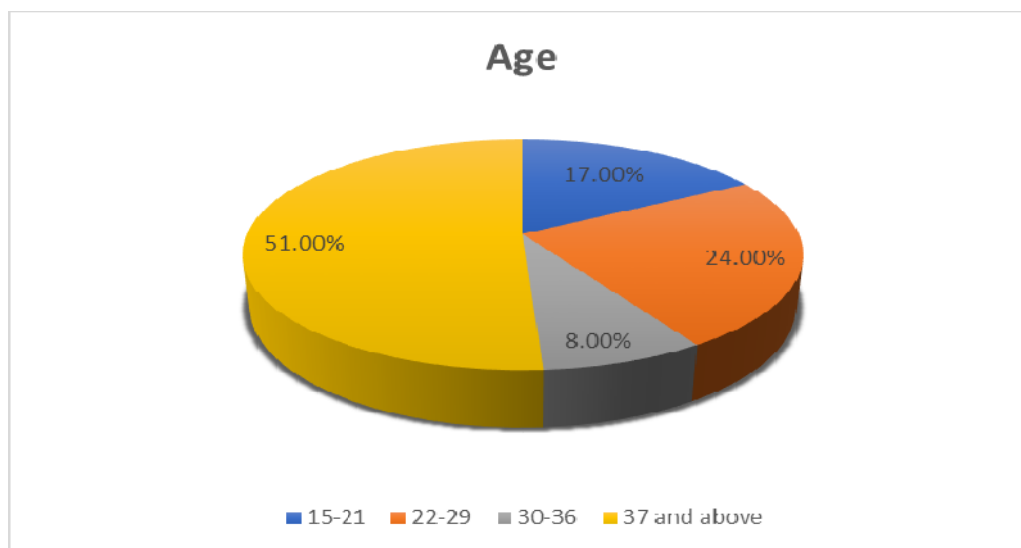

Fig. 1: Age Distribution of Respondents

Research Question 1: What is the level of knowledge of family planning among women of reproductive age?

Table 2a: Knowledge of Women of Reproductive Age on Family Planning

Variables	Options	Frequencies	Percentage
Have you heard of family planning?	Yes	100	100%
	No	0	0%
If yes, where did you hear about family planning?	Health facility	49	49.0%
	Friends/Relatives	11	11.0%
	Media (TV, Radio, Internet)	16	16.0%
	School	21	21.0%
	Community outreach programs	3	3.0%
Which of the following	Condoms	69	69.0%

family planning methods do you know?	Implants	51	51.0%
	Injectables	58	58.0%
	Intrauterine devices	56	56.0%
	Sterilization	37	37.0%
	Natural methods	54	54.0%
	Oral contraceptives	66	66.0%
	Emergency contraceptives	38	38.0%
Do you know the benefits of using family planning?	Yes	94	94.0%
	No	1	1.0%
	Not sure	5	5.0%
Do you think family planning can help reduce maternal and child mortality?	Yes	88	88.0%
	No	5	5.0%
	Not sure	7	7.0%

Table 2a above indicates universal awareness of family planning among all 100 respondents (100.0%), with primary sources comprising health facilities (49.0%), schools (21.0%), media (16.0%), friends/relatives (11.0%), and community outreach (3.0%).

Familiarity with Contraceptive Methods
Prominent methods recognized included condoms (69.0%), oral contraceptives (66.0%), injectables (58.0%), intrauterine devices (56.0%), natural methods (54.0%), implants (51.0%), emergency contraceptives (38.0%), and sterilization (37.0%).

Perceptions of Benefits
Overwhelmingly, 94.0% acknowledged family planning's benefits, 88.0% its role in mitigating maternal and child mortality, with minimal dissent (1.0% and 5.0%, respectively) and uncertainty (5.0% and 7.0%).

Table 2b: Knowledge of Women of Reproductive Age on Family Planning

Variables	Strongly agree	Agree	Strongly Disagree	Disagree
Family planning is 100% effective	26 (26.0%)	40 (40.0%)	6 (6.0%)	28 (28.0%)
Abstinence is considered a method of family planning	51 (51.0%)	29 (29.0%)	12 (12.0%)	8 (8.0%)
Family planning can be temporary or permanent	53 (53.0%)	46 (46.0%)	0 (0%)	1 (1.0%)
Condoms prevent pregnancy and STIs	43 (43.0%)	52 (52.0%)	2 (2.0%)	3 (3.0%)
Family planning helps to space children	59 (59.0%)	38 (38.0%)	2 (2.0%)	0 (0%)
Family planning causes infertility	9 (9.0%)	24 (24.0%)	22 (22.0%)	45 (45.0%)

Table 2b above demonstrates robust endorsement of contraceptive effectiveness, with 26 (26.0%) strongly agreeing and 40 (40.0%) agreeing that family planning achieves 100% efficacy, contrasted by 6 (6.0%) strong disagreement and 28 (28.0%) disagreement.

Understanding of Specific Methods and Benefits
A majority, 51 (51.0%) strongly agreeing and 29 (29.0%) agreeing, recognized abstinence as a family planning method, while 53 (53.0%) strongly agreeing and 46 (46.0%) agreeing affirmed its temporary or permanent nature. Condom utility in averting pregnancy and STIs garnered 43 (43.0%) strong agreement

and 52 (52.0%) agreement, alongside child spacing benefits endorsed by 59 (59.0%) strongly and 38 (38.0%) agreeing.

Addressing Misconceptions
Infertility concerns were largely refuted, with only 9 (9.0%) strongly agreeing and 24 (24.0%) agreeing, against 22 (22.0%) strong disagreement and 45 (45.0%) disagreement.

Summary of Knowledge Levels
Women of reproductive age in Egbe-Liasu exhibited elevated family planning knowledge,

with universal awareness (100.0%) primarily from health facilities (49.0%), schools (21.0%), and media (16.0%). Prominent methods identified included condoms (69.0%), oral contraceptives (66.0%), injectables (58.0%), and intrauterine devices (56.0%), complemented by 94.0% benefit recognition and 88.0% endorsement of maternal-child mortality reduction.

Research Question 2: What are the attitudes of women of reproductive age towards family planning?

Table 3: Attitudes of Women of Reproductive Age towards Family Planning

Variables	Strongly agree	Agree	Strongly disagree	Disagree
Family planning is beneficial for women's health	38 (38.0%)	48 (48.0%)	4 (4.0%)	10 (10.0%)
Family planning encourages promiscuity and immorality	12 (12.0%)	33 (33.0%)	31 (31.0%)	24 (24.0%)
My culture supports the use of family planning	32 (32.0%)	59 (59.0%)	2 (2.0%)	7 (7.0%)
I feel pressured by family members or community expectations not to use family planning	8 (8.0%)	21 (21.0%)	30 (30.0%)	41 (41.0%)
I believe my partner should be involved in family planning decisions	50 (50.0%)	43 (43.0%)	2 (2.0%)	5 (5.0%)
I believe some methods are unsafe and should be banned	16 (16.0%)	45 (45.0%)	13 (13.0%)	26 (26.0%)
I trust the advice of health workers about family planning	14 (14.0%)	52 (52.0%)	24 (24.0%)	10 (10.0%)
Family planning should be taught to young girls	24 (24.0%)	34 (34.0%)	22 (22.0%)	20 (20.0%)
Asking for family planning makes me feel uncomfortable	6 (6.0%)	25 (25.0%)	15 (15.0%)	54 (54.0%)

Table 3 above reveals strong endorsement of health advantages, with 38 (38.0%) strongly agreeing and 48 (48.0%) agreeing that family planning enhances women's health. Conversely, promiscuity associations drew limited support, as 12 (12.0%) strongly agreed and 33 (33.0%) agreed, against 31 (31.0%) strong disagreement and 24 (24.0%) disagreement.

Cultural and Social Influences
Cultural alignment garnered 59 (59.0%) agreement and 32 (32.0%) strong agreement, while pressure against use was minimal, with

8 (8.0%) strongly agreeing and 21 (21.0%) agreeing, outweighed by 30 (30.0%) strong disagreement and 41 (41.0%) disagreement. Partner involvement received robust backing from 50 (50.0%) strong agreement and 43 (43.0%) agreement.

Perceptions of Safety and Education
Safety concerns affected 45 (45.0%) agreement and 16 (16.0%) strong agreement regarding certain methods, while trust in health workers prevailed with 14 (14.0%) strong agreement and 52 (52.0%) agreement. Education for young girls drew 34 (34.0%)

agreement and 24 (24.0%) strong agreement; discomfort in inquiring was low at 6 (6.0%) strong agreement and 25 (25.0%) agreement, versus 54 (54.0%) disagreement.

Summary of Attitudinal Profile
Respondents displayed predominantly positive attitudes, with 86 (86.0%) affirming health benefits and 91 (91.0%) child spacing advantages. Strong support emerged for partner involvement (93.0%) and cultural compatibility (91.0%). Persistent reservations included method safety (45.0%) and promiscuity links (45.0%), alongside pressure perceptions (31.0%), yet overall favorability signals receptivity to guided adoption.

Research Question 3: What are the common family planning practices Among Women of Reproductive Age on Family Planning?

Table 4: Practices of Women of Reproductive Age towards Family Planning

Variables	Options	Frequencies	Percentage
Have you ever used any family planning method?	Yes	62	62.0%
	No	38	38.0%
Are you currently practicing any family planning method?	Yes	35	35.0%
	No	65	65.0%
If no, what is the reason for not practicing family planning?	Desire for pregnancy	13	21.7%
	Fear of side effects	18	30.0%
	Partner's disapproval	5	8.3%
	Financial constraints	2	3.3%
	Sexually inactive	15	25.0%
	Menopause	2	3.3%
	Religious/cultural beliefs	2	3.3%
	Lack of access to services	2	3.3%
	Lack of information	1	1.7%
How frequently do you visit a health facility for family planning services?	Regularly	9	9.0%
	Occasionally	23	23.0%
	Rarely	30	30.0%
	Never	28	38.0%
Where do you obtain your family planning services?	Government health facility	41	57.7%
	Private clinic/hospital	13	18.3%
	Pharmacy	14	19.7%
	Self-taught	3	4.2%
Are you satisfied with the family planning services you receive?	Yes	59	59.0%
	No	41	41.0%
If no, what is the reason for dissatisfaction?	Cost of services	2	2.0%
	Lack of Comfort	2	2.0%
	Inadequate counselling	10	10.0%
	Raises blood pressure	1	1.0%
	Affects period flow	5	5.0%
	Lack of availability	2	2.0%
	Lack of privacy	4	4.0%
	It fails at times	1	1.0%
Have you experienced any side effects from a family planning method?	Yes	42	42.0%
	No	58	58.0%

| Do you intend to continue using family planning in the future? | Yes | | 58 | 58.0% |
| | No | | 42 | 42.0% |

Table 4 above indicates that 62 (62.0%) respondents had previously utilized family planning methods, compared to 38 (38.0%) who had not. Current practice prevailed among 35 (35.0%), while 65 (65.0%) abstained.

Barriers to Practice

Non-utilization stemmed predominantly from side effect fears (30.0%), sexual inactivity (25.0%), and pregnancy desires (21.7%), alongside partner disapproval (8.3%), financial hurdles (3.3%), menopause (3.3%), religious/cultural factors (3.3%), access limitations (3.3%), and informational deficits (1.7%).

Service Access and Satisfaction

Facility visits were infrequent: 38.0% never, 30.0% rarely, 23.0% occasionally, and 9.0% regularly. Services were sourced chiefly from government facilities (57.7%), pharmacies (19.7%), private clinics (18.3%), or self-instruction (4.2%). Satisfaction reached 59.0%, with dissatisfaction (41.0%) attributed to counseling shortfalls (10.0%), menstrual disruptions (5.0%), privacy deficits (4.0%), cost (2.0%), discomfort (2.0%), unavailability (2.0%), hypertension (1.0%), and method failure (1.0%). Side effects affected 42.0%, while 58.0% encountered none; future intent favored continuation by 58.0%.
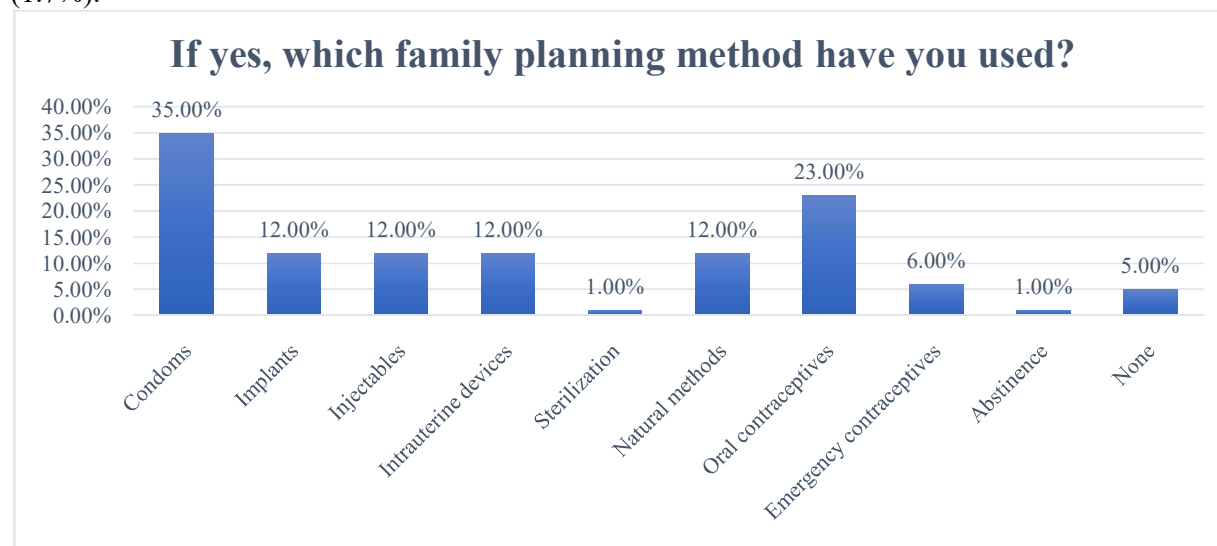

Fig. 2: Common Family planning methods used by respondents

Figure 2 above delineates method preferences among users, with condoms predominant at 35 (35.0%), succeeded by oral contraceptives at 23 (23.0%), and implants, injectables, and intrauterine devices each at 12 (12.0%), alongside natural methods (12.0%), emergency contraceptives (6.0%), sterilization (1.0%), and abstinence (1.0%).

Utilization and Barrier Analysis

Practice levels proved moderate, as 62 (62.0%) reported prior use and 35 (35.0%) current adherences. Non-use primarily arose from side effect apprehensions (30.0%), sexual inactivity (25.0%), and pregnancy aspirations (21.7%). Service satisfaction stood at 59.0%, tempered by infrequent visits (9.0% regular) and side effects impacting 42.0%, constraining sustained engagement despite elevated awareness.

Hypothesis Testing
Null Hypothesis (H₀): No significant association exists between attitudes toward family planning and contraceptive practices among reproductive-age women. Alternative Hypothesis (H₁): A significant association exists between attitudes toward family planning and contraceptive practices among reproductive-age women.
Significance Level: $p \leq 0.05$. Decision Rule: Retain H₀ if $p > 0.05$; reject H₀ and accept H₁ if $p \leq 0.05$.

Table 5: Chi-Square Analysis to Determine Significant Relationship between Attitude towards Family Planning and the Practices of Family Planning Methods among Women of Reproductive Age.

Attitude towards Family Planning	Practices of Family Planning Methods (Are you currently practicing any family planning method?)			Chi-Square (X^2) Value	df	p-value
	Yes	No	Total			
Positive Attitude	22 (22%)	31 (31%)	53 (53%)	2.100	1	0.147
Negative Attitude	13 (13%)	34 (34%)	47(%)			
Total	35 (35%)	65 (65%)	100 (100%)			

Table 5 above presents chi-square analysis examining the association between attitudes toward family planning and contraceptive practices. The test produced a chi-square value of 3.633 (df = 1) and p-value of 0.057, exceeding the 0.05 significance threshold.

Interpretation and Conclusion
This outcome signifies no statistically significant relationship between attitudes toward family planning and its practice among reproductive-age women in Egbe-Liasu, Ikotun LCDA, Lagos State. The null hypothesis is thus retained.

Chapter Five
Discussion, Conclusion and Recommendation
This chapter addresses the interpretation of findings, study implications, limitations, contributions to knowledge, summary, conclusions, recommendations, and suggestions for future research.

Discussion of Findings
Women of reproductive age in Egbe-Liasu, Ikotun LCDA, Lagos State, demonstrated elevated knowledge of family planning, with universal awareness (100.0%) derived chiefly from health facilities (49.0%), schools (21.0%), and media (16.0%). Familiarity encompassed condoms (69.0%), oral contraceptives (66.0%), injectables (58.0%), and intrauterine devices (56.0%), alongside 94.0% recognition of benefits and 88.0% acknowledgment of maternal-child mortality reduction.Attitudes leaned favorably, affirming health benefits (86.0%), child spacing (97.0%), and partner involvement (93.0%), with 91.0% cultural endorsement. Persistent misconceptions affected 45.0% regarding method safety and promiscuity, and 29.0% noted usage pressure.Practice remained moderate: 62.0% prior use versus 35.0% current, favoring condoms (35.0%) and oral contraceptives (23.0%). Non-use stemmed from side effect fears (30.0%), sexual inactivity (25.0%), and pregnancy desires (21.7%). Facility visits were sparse (9.0% regular), satisfaction at 59.0%, marred by counseling deficits.Chi-square analysis (χ^2 = 2.100, p = 0.147) confirmed no significant attitude-practice link, highlighting barriers like partner dissent and misinformation overriding positive perceptions.

Implications of the Study

High knowledge and attitudes juxtaposed with moderate practice signal sociocultural and psychological impediments, necessitating beyond-awareness interventions. Alignment with Gebreyesus et al. (2020) and Shehu et al. (2023) underscores regional awareness gains, contrasting Nmadu et al. (2020), while echoing Paschal and Matthew (2021) on favorable views tempered by myths (Oluwasanu et al., 2022). Non-significant attitude-practice correlation, per Sonia et al. (2021), advocates accessibility, male engagement, and sustained education.

Limitations of the Study

- Generalizability Constraints: Findings pertain solely to Egbe-Liasu women, limiting extrapolation to diverse contexts.
- Response Bias: Self-reported data risked socially desirable responses over authentic views.

Contributions to Knowledge

This research augments reproductive health literature with localized, urban Nigerian insights on knowledge-attitude-practice dynamics, bridging gaps in contraceptive uptake factors. It furnishes policymakers and practitioners empirical data for program refinement, extending Health Belief Model and Theory of Planned Behavior applications amid sociocultural influences. Methodologically, the KAP framework and validated instrument offer replicable tools, while enhancing researcher proficiency in methods, analysis, and reporting to advance national health objectives.

Summary of the Study

The investigation evaluated family planning knowledge, attitudes, and practices among Egbe-Liasu reproductive-age women, predominantly married, aged ≥37 years, and tertiary-educated. Universal awareness (100.0%) sourced from facilities (49.0%) highlighted methods like condoms (69.0%). Positive attitudes prevailed on health and spacing benefits, offset by safety misconceptions. Prior use reached 62.0% (condoms 35.0%), current at 35.0%, impeded by side effects (30.0%). No attitude-practice association (p = 0.147) underscored access needs.

Conclusion

Reproductive-age women in Egbe-Liasu possess robust knowledge and favorable attitudes toward family planning, yet practice lags due to side effect fears, partner opposition, and cultural factors. The insignificant attitude-practice correlation implicates accessibility and male involvement. Nurses must amplify education, counseling, and myth-busting; policymakers, service integration. Culturally attuned strategies will narrow awareness-utilization gaps, curbing maternal morbidity.

Recommendations

- Healthcare providers, notably nurses, should escalate education and counseling to dispel misconceptions.
- Government must prioritize affordable, culturally congruent contraceptive access.
- Promote male partner engagement in decisions.
- Mandate ongoing training for nurses on contemporary methods.
- Tailor community campaigns to local languages for broader reach.

Suggestions for Further Studies

Subsequent research should probe male influences on decisions and assess nurse-led interventions' efficacy in boosting uptake.

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