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Original Research Article

Knowledge and attitude towards child spacing practices among postnatal clinic attendees of a tertiary health facility in Lagos, Nigeria

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ABSTRACT

Background: Child spacing practices play a vital role in reproductive health and safe motherhood however; their implementation is saddled with challenges especially in the developing countries where socio-cultural and religious beliefs hamper the knowledge and attitude towards family planning modalities. The study aimed to determine the knowledge and attitude towards child spacing practices among postnatal clinic attendees of a Tertiary Health Facility in Lagos, Nigeria.
Methods: A cross-sectional study of women who satisfied the inclusion criteria and attended postnatal clinic in Nigerian Navy Reference Hospital (NNRH) Ojo. A total of 360 women of reproductive age (18-49 years) who attended postnatal clinic of NNRH Ojo and were eligible for the study were recruited by systematic sampling method. The information obtained were their socio-demographic factors, knowledge and attitude towards child spacing practices. The results were analysed using SPSS version 26 with appropriate tables generated.
Results: Majority of the participants where 26–30 years old (39.4%), married (82.8%), educated (81.1%), Christians (65%), monogamous family setting (87.2%) and with 1–3 children (76.7%). Most of the participants have heard about child spacing before (86.7%), (74.2%) understood what it was but knowledge of long-term methods was lower (37.2%). Attitude towards child spacing practices was mostly positive with (80.5%) affirming that child spacing is necessary though (55%) feared the side effects of family planning methods.
Conclusions: The knowledge and positive attitude towards child spacing practices were significantly high among the postnatal clinic attendees. In addition, the higher the educational level of a woman the more knowledgeable and right perception she has about family planning methods. Health facilities should adopt flexible service delivery models to make child spacing services more accessible.

Keywords: Knowledge, Attitude, Child spacing, Postnatal, Practices, Clinic, Attendees

INTRODUCTION

Child spacing is an essential aspect of reproductive health; however, its effective implementation faces significant challenges in low-income countries.[1] Inadequately spaced pregnancies can be associated with significant health risks resulting in fatal or adverse health consequences such as maternal and neonatal morbidity and mortality, preterm birth, as well as very low-birth-weight neonates with essential needs for intensive care admission.[2] These health

complications resulting from poorly spaced pregnancies especially in low-income countries strain their healthcare resources and also lead to a vicious cycle of poverty with health disparities across generations.[2]

A minimum of two years is recommended between births by the WHO to allow the mothers enough time for physiological recovery, nutritional restoration, and bodily resource replenishment from pregnancy, childbirth, and lactation.[3,4] Birth spacing has been proven in many research studies to reduce pregnancy complications, strengthen maternal health, improve child survival, and advocate for better developmental outcomes since families can sufficiently invest their time, attention, and resources in each child during their early critical stages of development.[3]

One of the most effective, widely endorsed strategies for achieving optimal child birth spacing involves the utilization of contraceptive methods, which constitute the foundational pillars of comprehensive family planning and child spacing programs implemented globally.[5] Contraceptives and child spacing provide couples with the ability to exercise reproductive autonomy, plan their families according to their desires and circumstances, and protect maternal and child health by preventing unintended pregnancies and enabling deliberate spacing of births.[5] Studies conducted across diverse populations have conclusively demonstrated that contraceptive access and utilization significantly improve survival rates and overall well-being for both mothers and children by reducing exposure to the heightened risks associated with closely spaced pregnancies and high parity.[2]

Despite the overwhelming evidence supporting the health benefits of contraceptive use, child spacing and the existence of safe, effective contraceptive options suitable for various preferences and medical circumstances, many women residing in Sub-Saharan African countries, including Nigeria, continue to experience substantial barriers to accessing and utilizing contraceptive services and child spacing methods.[1] These persistent gaps in contraceptive access, child spacing method, and uptake stem from multiple interconnected factors including inadequate healthcare infrastructure, insufficient supply chains for contraceptive commodities, unavailability of desired child spacing method, geographical barriers limiting physical access to health facilities, attitudes towards child spacing practices, financial constraints preventing women from affording services, cultural and religious beliefs that discourage contraceptive use, gender inequalities that limit women's reproductive decision-making, as well as inadequate health education leaving women uninformed about available contraceptive options and their benefits.[6] Cultural beliefs, lack of education, financial limitations and strict religious beliefs play significant roles in hindering women from using contraceptives and these barriers vary before and after they have given birth.[6]

There is every need to evaluate the contraceptive choices of women during different stages in their reproductive life and gaps still exist to be explored concerning the knowledge and attitude of women towards child spacing practices especially in Sub Saharan Africa where socio-cultural factors are issues of concern in decision making. This study aimed to determine the knowledge and attitude towards child spacing practices among postnatal clinic attendees of a Tertiary Health Facility in Lagos, Nigeria.

METHODS

Study area

The study was conducted in the postnatal clinic of the Nigerian Navy Reference Hospital (NNRH) Ojo, Lagos State. Lagos is the most populous state in Nigeria and is commonly referred to as the commercial nerve of the Nation. The Ojo area has both Civilian and Military population, making the hospital a center of delivery of healthcare services to a multi-generational population. The location of the hospital in Ojo places it in a position of access by different socio-economic population that need medical care. NNRH Ojo is a major Tertiary Healthcare Center in Nigeria. It provides highly specialized services in all branches of medicine such as Paediatrics, Surgery, Internal medicine and Reproductive Health. It serves as a referral centre for hospitals in Lagos State and other neighbouring States.

Study population

The study population were women of reproductive age (18-49 years) who attended postnatal clinic of NNRH Ojo and were eligible for the study.

Inclusion criteria

Women in postpartum period, in reproductive age (18–49 years), at least one live birth and those attending postnatal clinic in NNRH Ojo.

Study design

The study was a cross-sectional study of women who satisfied the inclusion criteria and attended postnatal clinic in NNRH Ojo.

Study tool

Semi-structured, interviewer-administered questionnaire adapted from WHO.

Sample size

The sample size was 360 comprising women of reproductive age (18-49 years) who attended postnatal clinic of NNRH Ojo and were eligible for the study. It was determined by a previously validated formula for cross-sectional studies.[7]

Sampling technique

The sampling method was systematic sampling. After obtaining consent, all the women who attended postnatal clinic in NNRH Ojo were screened to determine those who satisfied the inclusion criteria. The first eligible woman who was the starting point of selection was recruited randomly. The sampling fraction was used to recruit other participants until the sample size was complete.

Data collection

Semi-structured, interviewer-administered questionnaire adapted from WHO was used to obtain information after a signed consent was obtained from the participants. The data collected were the socio-demographic factors of these participants and questions on knowledge, attitude and practices pertaining to child spacing. The interview was conducted by the researcher and four research assistants. The research assistants were nurses in the postnatal clinic who were trained on the study protocol (such as the content of the questionnaire and the consent form) for a duration of one week.

Data analysis

Data were entered, cleaned and analysed using the Statistical Package for Social Sciences Software (SPSS) version 26.0. Data were summarized using proportions for categorical data and mean and standard deviation for continuous data. Comparison of proportion was determined using chi-square. Significant variables (p value< 0.05) at bivariate level were fed into a multivariate model to compute adjusted odd ratio with a 95% confidence interval. Results were presented using tables and figures.

Ethical consideration

The ethical approvals were obtained from both the Ethical Review Committees of the University of Port Harcourt and NNRH Ojo. Participation in the study was voluntary. Written informed consent was obtained from each participant after adequate counselling, and data obtained from the study were treated with confidentiality and solely for the study. The benefits of the study (such as education and enlightenment on child spacing practices) and the risks (such as encroachment on participant's time and privacy) were explained to each participant.

Limitations of the study

The study design which was a cross-sectional (snapshot) was a limitation. A prospective cohort study which will follow up to observe the long-term effect would have been more representative.

The findings may not be representative of the knowledge and attitude towards child spacing practices since only women who attended postnatal clinic in NNRH Ojo were recruited for the study.

RESULTS

A total of 360 women of reproductive age (18-49 years) who attended postnatal clinic of NNRH Ojo were recruited for the study.

Table 1 showed socio-demographic characteristics of respondents. It showed that most of the participants were young, majority being within the age range of 26–30 years (39.4%) followed by 31–35 years (26.4%), with very few being above 40 years. Most of the respondents were married (82.8%), with only a minority of them being single, divorced, or widowed. Most of them were from monogamous families (87.2%) with only 12.8% being from polygamous families. Educational levels varied, though a majority of the women had secondary (43.3%) or tertiary (37.8%) education, which meant that most of them were well-educated, with only 6.4% reporting no education at all. Religion also played an important role because most of the respondents were Christian (65.0%), followed by Muslim (32.8%), with very few observing traditional or other beliefs. For the husbands of the married respondents the majority of them had secondary (44.3%) or tertiary (38.3%) education, which also showed a similar pattern of moderate to high levels of education. For family size, about 29.4% had one child, 26.7% had two, and 20.6% had three children, with fewer having bigger family size of four or more children. Household income levels showed that most made between ₦50,000 – 100,000 (39.4%), followed by ₦101,000 – 200,000 (26.7%), while about a quarter made less than ₦50,000. Only a minority (9.7%) made above ₦200,000, showing that most families were in the low to middle-income groups

Table 1: Relative risk of abnormal Doppler indices with adverse perinatal outcome.

Variables	Categories	Frequency	Percentage (%)
Age group (years)	18–25	89	24.7
	26–30	142	39.4
	31–35	95	26.4
	36–40	28	7.8
	Above 40	6	1.7
Marital status	Married	298	82.8
	Single	52	14.4

Continued.

Variables	Categories	Frequency	Percentage (%)
	Divorced	8	2.2
	Widowed	2	0.6
Educational level	No formal education	23	6.4
	Primary	45	12.5
	Secondary	156	43.3
	Tertiary	136	37.8
Religious affiliation	Christianity	234	65.0
	Islam	118	32.8
	Traditional	6	1.7
	Others	2	0.5
Number of children	1	106	29.4
	2	96	26.7
	3	74	20.6
	4	52	14.4
	5 and above	32	8.9
Family type	Monogamous	314	87.2
	Polygamous	46	12.8
Spouse's education Level (n=298)*	No formal education	18	6.0
	Primary	34	11.4
	Secondary	132	44.3
	Tertiary	114	38.3
	Not applicable	62	-
Monthly household Income (₦)	Less than 50,000	87	24.2
	50,000 – 100,000	142	39.4
	101,000 – 200,000	96	26.7
	More than 200,000	35	9.7

*Note: Spouse's education only applies to married respondents (n=298).

Table 2 showed knowledge of child spacing practices of respondents. Three hundred and twelve (86.7%) participants were aware of the concept of child spacing, while 48 (13.3%) had never heard of the practice. In further analysis 267 (74.2%) respondents correctly defined child spacing, 45 respondents (12.5%) incorrectly understood the term child spacing while 48 (13.3%) respondents said they had no conceptual meaning of the terminology at all. The most widely known advantage of child spacing (improvement in maternal health) was correctly identified by 234 (65.0%) respondents. Economic reasons were the second most recognized benefit, with 198 participants acknowledging spacing births reduces the economic burden on families, while 176 (48.9%) regarded an improvement in childcare as another important benefit. On the other hand, 67 (18.6%) could not state any, indicating a significant knowledge gap among nearly one-fifth of the sample population. The oral pills were the most widely known contraceptive 289 (80.3%) respondents followed by the injection form 245 (68.1%) respondents and condoms 198 (55.0%). The long-acting reversible contraception methods known included intrauterine devices among 43.3% of the participants, implants among 37.2%, and natural family planning among 34.2%, indicating a predominance of traditional and short-term methods among the general knowledge while awareness of modern, long-acting, effective contraceptive methods was relatively limited among members of the community.

Encouragingly, 198 (55.0%) respondents identified that spacing births by more than two years represents the ideal recommended interval. However, 50(13.9%) participants could not provide any answer regarding appropriate spacing duration. In terms of exclusive breastfeeding as a temporary contraceptive method, 246 (68.3%) participants said that exclusive breastfeeding can help delay the return of fertility. As many as 298 (82.8%) respondents reported knowing where to seek family planning services in their communities. Similarly, 278 (77.2%) participants demonstrated awareness that contraceptive methods can produce side effects. Two hundred and sixty-four (73.3%) respondents received instruction about spacing children from healthcare providers while 96 (26.7%) had never benefited from professional health education on this subject. On self-assessment only 34 (9.4%) of them rated it as excellent, while 142 (39.4%) thought their knowledge was good, 134 (37.2%) rated it fair, and 50 (13.9%) acknowledged a poor understanding.

Table 2: Knowledge of child spacing practices of respondents.

Knowledge domain	Variable/category	Frequency (N)	Percentage (%)
General awareness	Aware of child spacing	312	86.7
	Not aware	48	13.3
Understanding of Concept	Delaying next pregnancy	267	74.2
	Stopping childbearing	45	12.5
	No idea	48	13.3
Benefits knowledge*	Improves maternal health	234	65.0
	Reduces financial burden	198	55.0
	Enhances child care	176	48.9
	Don't know	67	18.6
Methods knowledge*	Pills	289	80.3
	Injectables	245	68.1
	Condoms	198	55.0
	IUD	156	43.3
	Implants	134	37.2
	Natural methods	123	34.2
Optimal spacing interval	Less than 6 months	23	6.4
	6–12 months	89	24.7
	More than 2 years	198	55.0
	Don't know	50	13.9
Breastfeeding knowledge	Yes, it helps spacing	246	68.3
	No, it doesn't help	62	17.2
	Not sure	52	14.5
Side effects awareness	Aware of side effects	278	77.2
	Not aware	82	22.8
Service access knowledge	Know where to access services	298	82.8
	Don't know where	62	17.2
Health education received	Received education	264	73.3
	Not received education	96	26.7
Self-assessment	Excellent knowledge	34	9.4
	Good knowledge	142	39.4
	Fair knowledge	134	37.2
	Poor knowledge	50	13.9

Table 3 showed attitudes toward child spacing practices of respondents**.** The perceptions of the respondents regarding child spacing practices were generally positive. One hundred and fifty-six (43.3%) participants strongly agreed that spacing pregnancies is necessary, while 134 (37.2%) agreed to this tenet. In combination, these data indicate that around four out of every five participants (80.5%) endorse positive views on the necessity for child spacing. A minority of 25 participants (6.9%) disagreed with the concept of child spacing. Two hundred and seventy-eight (77.2%) participants would advise other women to use birth spacing while 82 (22.8%) would not recommend the practice further to others. Two hundred and thirty-four (65.0%) respondents were comfortable discussing issues of child spacing with their spouses while 126 (35.0%) reported discomfort in discussing these issues with their partners. Trust in the advice of health workers was expressed by 276 (76.7%) respondents however, 84 (23.3%) showed a lack of confidence in professional medical opinion. Of all the participants, 245 (68.1%) said that child spacing was not incompatible with their religious beliefs and 67 (18.6%) reported that child spacing was incompatible with their religious beliefs while 48 (13.3%) were uncertain about whether birth spacing was religiously permissible. Child spacing considered as a culturally supported behavior, 198 (55.0%) participants believed that their cultural environment was supportive of the practice, though 98 (27.2%) were of the opinion that their cultures were against child spacing while 64 (17.8%) of the respondents did not know their cultural context's stance. The fear of side effects from contraceptives presented a major deterrent 198 (55.0%) were of the opinion that they were afraid of adverse effects related to family planning methods whereas 162 (45.0%) were not afraid of the adverse effects of the family planning methods. One

hundred and thirty-four (37.2%) participants had the belief that the method of child spacing affects sexual enjoyment while 156 (43.3%) did not believe that child spacing methods affect sexual enjoyment however, 70 (19.5%) were indifferent. In spite of the foregoing, future intention appears to be somewhat upbeat, as 245 (68.1%) respondents showed willingness to consider modern contraceptive methods in the future though 115 (31.9%) would not entertain the idea of the adoption of modern family planning approaches in the future. About satisfaction with the information provided, 264 (73.3%) were satisfied with the information obtained on child spacing while 96 (26.7%) were felt inadequately informed

Table 3: Attitudes toward child spacing practices of respondents.

Attitude domain	Variable/Category	Frequency (N)	Percentage (%)
Necessity of child spacing	Strongly agree	156	43.3
	Agree	134	37.2
	Neutral	45	12.5
	Disagree	25	6.9
Spousal communication	Comfortable discussing	234	65.0
	Not comfortable	126	35.0
Religious compatibility	Against religious beliefs	67	18.6
	Compatible with beliefs	245	68.1
Willingness to advise others	Would advise others	278	77.2
	Would not advise	82	22.8
Sexual satisfaction concerns	Affects satisfaction	134	37.2
	Does not affect	156	43.3
	Not sure	70	19.5
Cultural support	Culture supports spacing	198	55.0
	Culture opposes spacing	98	27.2
	Not sure	64	17.8
Trust in health workers	Trust health workers	276	76.7
	Do not trust	84	23.3
Side effects fear	Fear side effects	198	55.0
	No fear	162	45.0
Future method adoption	Would consider modern methods	245	68.1
	Would not consider	115	31.9
Information satisfaction	Not satisfied	96	26.7

Table 4 showed cross-tabulation of socio-demographic characteristics and knowledge of child spacing practices: This demonstrated that 312 (86.7%) have heard about child spacing. However, when specific groups were examined, important differences were observed in how much people know based on their education, age, marital situation, and other factors. Among women who attended Tertiary education, 126 (92.6%) have heard about child spacing. One hundred and fourteen (83.8%) of those with Tertiary education showed better understanding of what child spacing actually means, 90 (66.2%) knew the right period of time to wait between babies and 84 (61.8%) of them felt they had good or excellent understanding of child spacing practices when compared with those women who never went to school that had less understanding of the child spacing practices and the adequate spacing interval. Women in their late twenty and early thirty years better understanding of child spacing practices and spacing interval when compared to those at the extremes of reproductive age. Among those aged 26-30 years, 125 (88.0%) knew about child spacing, 108 (76.1%) understood it correctly and 81 (57.0%) knew the right spacing interval. Younger women aged 18-25 had slightly lower knowledge, with 85.4% awareness and 71.9% correct understanding. The oldest women over 40 years had the weakest knowledge, with only 66.7% awareness and just 33.3% knowing the correct spacing interval. Married women, who comprised the vast majority of participants 298 (82.8%) showed strong knowledge, 88.6% awareness, 75.5% correct understanding, and 57.0% knowing proper intervals while single women showed somewhat lower knowledge 80.8% awareness and 67.3% correct understanding. The religious background displayed a modest difference between the two groups; Christians outperformed Muslims, but both performed reasonably well. Of the 234 (65%) Christian participants, 207 (88.5%) had knowledge of child spacing, 177 (75.6%) understood it correctly and 134 (57.3%) identified the proper spacing interval. Muslims numbered 118 (32.8%) of respondents, and their knowledge was somewhat lower

with 83.9% awareness, 72.0% understanding, and 50.8% knowing correct intervals. The 6 participants practicing traditional religion showed much weaker knowledge, but this group is far too small to represent traditional believers generally.

Table 4: Cross-tabulation of socio-demographic characteristics and knowledge of child spacing practices.

Socio-demo Graphic variable	Category	N	%	Aware of child spacing		Correct understanding (delaying pregnancy)		Knowledge of optimal interval (>2 years)		Self-rated knowledge (good/excellent)	
				Yes (N)	%	Yes (N)	%	Yes (N)	%	Yes (N)	%
Age group (years)	18–25	89	24.7	76	85.4	64	71.9	47	52.8	41	46.1
	26–30	142	39.4	125	88.0	108	76.1	81	57.0	71	50.0
	31–35	95	26.4	84	88.4	72	75.8	54	56.8	48	50.5
	36–40	28	7.8	23	82.1	19	67.9	14	50.0	13	46.4
	Above 40	6	1.7	4	66.7	4	66.7	2	33.3	3	50.0
Marital status	Married	298	82.8	264	88.6	225	75.5	170	57.0	149	50.0
	Single	52	14.4	42	80.8	35	67.3	24	46.2	23	44.2
	Divorced	8	2.2	5	62.5	6	75.0	3	37.5	3	37.5
	Widowed	2	0.6	1	50.0	1	50.0	1	50.0	1	50.0
Educational level	No formal education	23	6.4	14	60.9	10	43.5	6	26.1	4	17.4
	Primary	45	12.5	34	75.6	28	62.2	18	40.0	15	33.3
	Secondary	156	43.3	138	88.5	115	73.7	84	53.8	73	46.8
	Tertiary	136	37.8	126	92.6	114	83.8	90	66.2	84	61.8
Religious affiliation	Christianity	234	65.0	207	88.5	177	75.6	134	57.3	118	50.4
	Islam	118	32.8	99	83.9	85	72.0	60	50.8	55	46.6
	Traditional	6	1.7	4	66.7	3	50.0	2	33.3	2	33.3
	Others	2	0.5	2	100.0	2	100.0	2	100.0	1	50.0
Number of children	1	106	29.4	89	84.0	75	70.8	53	50.0	48	45.3
	2	96	26.7	85	88.5	73	76.0	56	58.3	50	52.1
	3	74	20.6	66	89.2	58	78.4	44	59.5	39	52.7
	4	52	14.4	46	88.5	39	75.0	30	57.7	25	48.1
	5 and above	32	8.9	26	81.3	22	68.8	15	46.9	14	43.8
Overall		360	100	312	86.7	267	74.2	198	55.0	176	48.9

Table 5: Cross-tabulation of socio-demographic characteristics and attitudes toward child spacing (n=360).

Socio-demographic variable	Category	N	%	Believe in necessity (agree/strongly agree)		Comfortable discussing with spouse		Would advise others		Trust health workers	
				N	%	N	%	N	%	N	%
Age group (years)	18–25	89	24.7	69	77.5	52	58.4	65	73.0	65	73.0
	26–30	142	39.4	118	83.1	95	66.9	112	78.9	112	78.9
	31–35	95	26.4	78	82.1	65	68.4	76	80.0	74	77.9
	36–40	28	7.8	21	75.0	19	67.9	21	75.0	21	75.0
	Above 40	6	1.7	4	66.7	3	50.0	4	66.7	4	66.7
Marital status	Married	298	82.8	245	82.2	212	71.1	236	79.2	234	78.5
	Single	52	14.4	38	73.1	18	34.6	36	69.2	36	69.2
	Divorced	8	2.2	6	75.0	3	37.5	5	62.5	5	62.5
	Widowed	2	0.6	1	50.0	1	50.0	1	50.0	1	50.0
Educational level	No formal education	23	6.4	15	65.2	10	43.5	14	60.9	14	60.9
	Primary	45	12.5	32	71.1	24	53.3	30	66.7	30	66.7
	Secondary	156	43.3	125	80.1	98	62.8	118	75.6	117	75.0
	Tertiary	136	37.8	118	86.8	102	75.0	116	85.3	115	84.6
Religious affiliation	Christianity	234	65.0	195	83.3	159	67.9	186	79.5	185	79.1
	Islam	118	32.8	90	76.3	71	60.2	88	74.6	87	73.7
	Traditional	6	1.7	3	50.0	2	33.3	2	33.3	2	33.3
	Others	2	0.5	2	100.0	2	100.0	2	100.0	2	100.0
Number of children	1	106	29.4	82	77.4	62	58.5	78	73.6	78	73.6
	2	96	26.7	80	83.3	66	68.8	77	80.2	76	79.2
	3	74	20.6	62	83.8	52	70.3	60	81.1	59	79.7
	4	52	14.4	43	82.7	36	69.2	41	78.8	41	78.8
	5 and above	32	8.9	23	71.9	18	56.3	22	68.8	22	68.8
Overall		360	100	290	80.5	234	65.0	278	77.2	276	76.7

Women with two or three children demonstrated the highest knowledge levels. Among those with three children, 89.2% of the respondents knew about child spacing, 78.4% of the respondents understood it correctly and 59.5% of the respondents identified proper spacing interval. First-time mothers with only one child showed lower knowledge as indicated by 84.0% awareness and 70.8% understanding respectively. Interestingly, women with very large families of five or more children had somewhat weaker knowledge, with awareness dropping to 81.3% and understanding to 68.8%.

Table 5 showed cross-tabulation of socio-demographic characteristics and attitudes toward child spacing: Out of 136 Tertiary educated women 118 (86.8%) believed child spacing was necessary compared to 15 (65.2%) of 23 uneducated women. More striking, however, was a difference in comfort discussing child spacing with spouses, 75.0% of highly educated women felt comfortable having these conversations with their spouses whereas only 43.5% of uneducated women did. Similarly, 84.6% of the Tertiary educated participants developed trust in health workers as opposed to 60.9% of uneducated women showing such trust. The pattern was similar in the willingness to advise other women 85.3% versus 60.9%. Age-specific attitude patterns showed that belief in the necessity of child spacing was fairly strong in most age groups and peaked in the late twenties and early thirties for women. Whereas about 83.1% of 26-30-year-old and 82.1% of 31-35-year-old people believed spacing is necessary, the corresponding percentage among the youngest age group aged 18-25 years was about 77.5%, declining further to 66.7% among the oldest group of women over 40 years. Comfort discussing child spacing with spouses increased steadily with age from 58.4% among 18-25-year-olds to 68.4% among 31-35-year-olds, suggesting that relationship maturity and shared parenting experiences make these conversations easier. Willingness to advise other women reached a peak of 80.0% among 31-35-year-olds, with this age group showing most confidence in sharing experiences and opinions regarding reproductive matters. Trust in health workers remained quite steady across age groups, ranging between 73 and 79%. Among the 298 married participants, 212 (71.1%) felt comfortable discussing child spacing with their husbands, but among the 52 single women, only 18 (34.6%) felt this comfort. Belief in spacing necessity showed moderate variation by marital status, with 82.2% of married women endorsing it versus 73.1% of single women. Trust in health workers varied, 78.5% of married respondents had such trust while 69.2% of the single respondents had trust in health workers.

Among Christians respondents 83.3% believed spacing is necessary compared to 76.3% of the respondents who were Muslims who had similar opinion. Comfort discussing child spacing with spouses showed 67.9% of the respondents among Christians versus 60.2% of the respondents among Muslims. Trust in health workers was 79.1% of the respondents among Christians and 73.7% of the respondents among Muslims. Willingness to advise other women was seen in 79.5% of the Christian respondents and in 74.6% of the Muslim respondents. Belief in spacing necessity rose from 77.4% among women with one child to 83.8% among those with three children before falling to 71.9% among women with five or more children. Similarly, comfort discussing child spacing with spouses increased from 58.5% among first-time mothers to 70.3% among three-child mothers. Willingness to advise other women increased from 73.6% among one-child families to 81.1% among three-child families before falling to 68.8% among those with five-plus children.

DISCUSSION

This study showed that most of the participants were young, married, relatively educated, low to middle income class women in monogamous relationships and small family size. Studies that validate these findings indicated that these demographics are characteristic of reproductive studies in Nigeria and thus influence family planning attitudes. For instance, a study of Nigerian women of reproductive age observed that increased income and educational levels translate to small family size and easy accessibility to health services.[8] Similarly, a study in North Central Nigeria reported that child spacing was more likely among married women from monogamous families[7]. Monogamous family actually brings stable household dynamics which in turn lessens the desire for large families. The younger age of most of the participants was in agreement with the findings of research that evaluated younger cohorts in rural areas, however the study faced serious barriers to child spacing practices.[9] The low to middle-income status of the majority of the participants aligned with National Population Commission (NPC) (2020) reports that said that low- to middle-income urban Nigerian families prioritize basic needs over large family size.[10]

According to this study the knowledge levels of child spacing practices in terms of being aware of it, its adequate definition and cognizance of ideal child spacing interval were high. The study also observed greater awareness of the benefits of child spacing such as maternal health improvement but child spacing method awareness varied; significant percentage of the participants were aware of oral contraceptive pills and exclusive breastfeeding but the revise was the case for intrauterine contraceptive devices (IUDs). In addition, a vast majority of the women obtained their information about child spacing practices through the health workers and self-related awareness was fair. A study conducted in the urban region of Nigeria reported similar awareness and also the participants' interest in short-term child spacing methods such as oral contraceptive pills attributing limited knowledge of IUDs and implants to constrained education which was also in agreement with the finding of the index study[11]. Research carried out in Bangladesh reported that majority of the study women who participated in the study were

knowledgeable of exclusive breastfeeding as a child spacing method and also a culturally acceptable family planning modality.[12]

A Nigerian study on the role of health workers in knowledge dissemination concluded that health workers information on child spacing practices plays a significant role in increasing self-rated knowledge and awareness of benefits of birth spacing such as maternal health improvement.[13]

The World Health Organization guidelines align with the ideal child spacing interval knowledge, noting that education improves knowledge yet myths dominate explaining the responses of 'not aware' derived from some of the participants during the study.[3] These sources validate that while knowledge is widespread, targeted education on long-acting methods can address current shortcomings.

The study demonstrated significant positive attitude of the participants towards child spacing practices because there were increased percentage of respondents who felt the need for child spacing, comfortable to discuss with spouses and also felt child spacing was not against religion. Cultural support and trust in health workers were remarkably high while concern regarding side effects was expressed by approximately half of the participants. They also showed significant intention to use and as well recommend child spacing methods to others. This positive attitude towards child spacing practices was supported by various studies carried out concerning attitudes of women towards birth spacing in comparable circumstances. A study reported that religious teachings influence attitudes but overall positivity prevails where health is emphasized.[14] This was in keeping with a study that encouraged religious leaders to endorse family planning within Muslim and Christian communities.[15] A similar study conducted in the rural region of Nigeria observed that comfort spouse discussion levels is credited to better decision-making.[11] A systematic review of birth spacing practices practices found out that side effects of these family planning methods discourage the practice of child spacing despite high confidence in health workers.[16] This was in accordance with the findings of the index study that recorded that half of the respondents showed concern about the side effects of the child spacing methods irrespective of the confidence that had for the health workers.

CONCLUSION

The knowledge and positive attitude towards child spacing practices were significantly high among the postnatal clinic attendees. In addition, the higher the educational level of a woman the more knowledgeable and right perception she has about family planning methods.

Recommendations

The Ministry of Health and other government agencies should implement and enforce policies that guarantee free or low-cost family planning services in all public hospitals.

Healthcare facilities should invest in continuous training for healthcare workers on child-spacing methods. Hospitals should adopt flexible service delivery models to make child spacing services more accessible.

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REFERENCES

1. Ayane GB, Desta KW, Demissie BW, Woldemariam EB. Suboptimal child spacing practice and its associated factors among women of child-bearing age in Serbo Town, Jimma Zone, Southwest Ethiopia. Contracept Reprod Med. 2019;4:4.
2. Ahmed T, Rahman AE, Amole TG, Galadanci H, Matjila M, Soma-Pillay P. The effect of COVID-19 on maternal, newborn and child health (MNCH) services in Bangladesh, Nigeria and South Africa: call for a contextualised pandemic response in LMICs. Int J Equity Health. 2021;20(1).
3. World Health Organization. Family planning/contraception. Geneva: World Health Organization; 2021. Available from: https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception. Accwssed on 21 June 2026.
4. Elegbua C, Raji H, Biliaminu S, Ezeoke G, Adeniran A. Effect of inter-pregnancy interval on serum ferritin, haematocrit and pregnancy outcome in Ilorin, Nigeria. Afr Health Sci. 2023;23(1):326-37.
5. Ajayi AI, Adeniyi OV, Akpan W. Use of traditional and modern contraceptives among childbearing women: findings from a mixed methods study in two southwestern Nigerian states. BMC Public Health. 2018;18.
6. He X, Chen X, Wang X, Jiang L. Optimization of activated carbon production from corn cob using response surface methodology. Front Environ Sci. 2023;11:1105408.
7. Onoja SO, Egwuatu VE. Socio-demographic determinants of child spacing practice among women of reproductive age in Dekina Local Government Area of Kogi State, North Central Nigeria. Int J Health Sci Res. 2020;10(2):200-8.
8. Adebowale AS, Salami BO. Socio-economic determinants of contraceptive use among women of reproductive age in Nigeria. J Afr Health Sci. 2022;22(1):78-85.
9. Olarinmoye AT, Eniade OD, Kayode OO, Abiola AA, Onifade MO, Odewale SO, et al. Influencing factors of unmet needs for child spacing among selected

countries experiencing high maternal mortality in sub-Saharan Africa. International Journal of Reproduction, Contraception, Obstetrics and Gynecology. 2021;10(12):4361-72.
10. National Population Commission (NPC). Nigeria demographic and health survey 2020. Abuja: National Population Commission, Federal Republic of Nigeria.
11. Adebayo MS, Ogunyemi AB. Healthcare provider knowledge and contraceptive choices among women in urban Nigeria: a cross-sectional study. Afr J Prim Health Care Fam Med. 2023;15(1):1-7.
12. Chakraborty B, Hazari SK, Chakraborty A, Choudhury TA, Hafsa NJ. Factors Associated with Reluctance to Use Long-Acting Reversible Contraceptives among Rural Women in Bangladesh. Journal of Comilla Medical College Teachers' Association. 2026;30(2):99-102.
13. Atata CT, Oguzor UC, Green PA, Dienye PO. Family planning service uptake in hospitals in Rivers State, Nigeria. West African Journal of Medicine. 2023;40(12 Suppl 1):S18-9.
14. Adedini SA, Babalola S, Ibeawuchi C, Omotoso O, Akiode A, Odeku M. Role of religious leaders in promoting contraceptive use in Nigeria: evidence from the Nigerian urban reproductive health initiative. Global Health: Science and Practice. 2018;6(3):500-14.
15. Ashriady A, Salim LA, Widodo S, Ruhardi A. Role of religious leaders in adolescents' reproductive health and family planning: A systematic review. African Journal of Reproductive Health. 2024;28(10):303-17.
16. Asekun-Olarinmoye EO, Adebimpe WO, Bamidele JO, Odu OO, Asekun-Olarinmoye IO, Ojofeitimi EO. Barriers to use of modern contraceptives among women in an inner city area of Osogbo metropolis, Osun state, Nigeria. International journal of women's health. 2013:647-55.

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