COMPARATIVE ANALYSIS OF KNOWLEDGE AND USE OF MODERN CONTRACEPTVES AMONG MALE AND FEMALE IN OKPOKWU LOCAL GOVERNMENT AREA, BENUE STATE, NIGERIA

BY

Benedict EJEH
B.Sc (ED) ABU, 2009
M.SC/SCI/4542/2011-2012

A DISSERTATION SUBMITTED TO THE SCHOOL OF POSTGRADUATE STUDIES, AHMADU BELLO UNIVERSITY, ZARIA. IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTER OF SCIENCE DEGREE IN GEOGRAPHY

DEPARTMENT OF GEOGRAPHY
FACULTY OF SCIENCE
AHMADU BELLO UNIVERSITY,
ZARIA.

JANUARY, 2016

DECLARATION

I hereby declare that this research work titled "**Comparative Analysis of Knowledge and Use of Modern Contraption among Male and Female in Okpokwu LGA Benue State, Nigeria"** was carried out by me under the supervision of Professor M. Mamman and Professor J.G. Laah. All information obtained from literature has been acknowledged in the text as well as the list of references. No part of this dissertation has been previously presented for any degree or diploma at any university.

Benedict, EJEH **Date**

CERTIFICATION

This dissertation titled "**Comparative analysis of knowledge and use of modern contraceptives among Male and Female in Okpokwu LGA, Benue state, Nigeria"**. By Benedict EJEH has been read and certified as meeting the requirements governing the award of degree of Masters in Science, in Ahmadu Bello University, Zaria and is approved for its contribution to knowledge and literary presentation.

Prof. M. Mamman Chairman, Supervisory committee	_____ Signature	_____ Date
Prof. J.G Laah Member, Supervisory committee	_____ Signature	_____ Date
Dr. I.J. Musa Head of Department, Geography,	_____ Signature	_____ Date
Prof. K. Bala Dean, Postgraduate Studies	_____ Signature	_____ Date

DEDICATION

This dissertation is dedicated to Almighty God and my entire family.

ACKNOWLEDGEMENT

My special thank go to the almighty God who gave me the wisdom, knowledge, understanding and His grace to complete this work. To God indeed be the Glory.

In writing this dissertation, I am greatly indebted to many people. However, numerous as they may be, the following stand out in bold relief: my supervisors; Professor M. Mamman and Professor J.G Laah for not only painstakingly read and constructively criticize various drafts of the work, but also for their patience, love, friendliness, fatherly advice and more importantly, for being a propelling force that hastened its early completion. All these shall remain indelible in my memory.

I am also grateful to the family of Dr and Mrs. Lawrence Udeh Ejeh who have been there always for me as my caring benefactor throughout my study. Dr Lawrence is more than a brother, but a father, a role model and a mentor and his virtuous wife Mrs. Maria Modupe Ejeh. I am indeed grateful to them.

My gratitude also goes to the Head of Department Dr. I.J. Musa and the entire members of the academic staff of the department of Geography, Ahmadu Bello University, Zaria for their encouragement that facilitated the successful completion of this dissertation. Mention must be made of Dr. R.O Yusuf, Dr. Y.Y Obadaki, Dr. B. Akpu, Professor mamman and the Librarian, Malam Lawal.

I am equally grateful to the entire member of the Ejeh's family for their understanding, patience, love and support. My acknowledgement goes to my internal supervisors: Dr. R.O Yusuf and Dr. B. Abdulkarim for their efforts towards the successful completion of dissertation.

My gratitude goes to late Mrs. Achetu Adikwu for her motherly advice and care. I am indeed grateful to her. May her soul Rest in Peace. My friends also deserve commendation especially Christopher Enyigbe, Abah Christopher Peter and Agbo Jonh and Adoyi Janet for their advice towards the successful completion of this dissertation.

ABSTRACT

It is reported that 75% of the world population, live in developing countries characterized by high fertility rates, high maternal and infant mortality and low life expectancy including Nigeria. Although reports showed that worldwide the fertility rates have fallen due to wide-contraception. Studies on contraceptives in Nigeria as in other parts of the developing world have long focused on women as the subject of interest. Very little work in this area has focused on men. Therefore, this study attempts a comparative analysis of knowledge and use of modern contraceptives among male and females in Okpokwu Local Government Area of Benue State, Nigeria. The specific objectives are to: assess the kinds of modern contraceptives available in the study area, examine the sources of information on modern contraceptives among male and female in the study area, assess the level of knowledge of modern contraceptives among male and female in the study area. assess the level of use of modern contraceptives among male and female in the study area, examine the decision-making process on the use modern contraceptive among male and females in the study area, examine the challenges of contraceptives use and strategies employed to solve the challenges in the study area. The study used both qualitative and quantitative data. The quantitative data were obtained from 384 copies of structured questionnaires where in systematic sampling techniques were employed to facilitate a reasonable representation of men and women from the twelve (12) wards of the LGAs under study. The qualitative data were obtained from Focus Group Discussion (FGDs), two in each of the ward. The findings revealed that, majority of the respondents (95.3%) are Idomas by ethnic group and the most common religion is Christianity (99.5%) with high proportion of Catholics (90.9%). The level of education is relatively low with about 56.5% primary holders. This is reflected in their activities which are mainly farming. Income level is relatively low below the national average of eighteen thousand. Marriage is universal among men and women with about (75.8%) married. Polygamous marriage (78.4%) is the most common type of union. The study revealed that, the level of knowledge of modern contraceptives is almost universal (89.8%) among male and females. This knowledge of modern contraceptives is slightly higher among women (45.6%) than men (44.3%). The level of use of modern contraceptives is low (12.2%) and men (7.0%) are the major users than women (5.2%). The major sources of knowledge of contraceptives are family (26.8%) and electronic media (39.9%) while spousal approval (56.5%) is the major determinant factor of contraceptive use. The decision on the use of contraceptives is made mainly by husband/partner (64.3%) and joint decision (husband/partner and wife) (26.8%). Chi-square analysis x^2 value 3.082, df =1, P-value 0.56. Based on the decision rule, alternative hypothesis is rejected while Null hypothesis is accepted. This shows that there no significance difference between male and female respondents in the knowledge and use of modern contraceptives in the study area. Therefore, there is need for a programme that will focus or encourage male on the practice of contraceptives. Also there is need for a persistent drive against those social customs, beliefs, and traditions which belittle the importance of family planning in the society.

TABLE OF CONTENT

Title Page - - - - - - - - - - - i

Declaration - - - - - - - - - - - ii

Certification - - - - - - - - - - - iii

Dedication - - - - - - - - - - - iv

Acknowledgment- - - - - - - - - - - v

Abstract- - - - - - - - - - - - vi

Table of Content - - - - - - - - - - vii

List of tables- - - - - - - - - - - - x

CHAPTER ONE: INTRODUCTION - - - - - - - 1

1.1 Background to the Study - - - - - - - - - - 1

1.2 Statement of the Problem- - - - - - - - - - 6

1.3 Research aim and Objectives - - - - - - - - - 13

1.4 Research Hypothesis -- - - - - - - - - - 14

1.5 Scope of the Study - - - - - - - - - - - 14

1.6 Justification of the Study - - - - - - - - - - 14

1.7 Significance of the study --- - - - - - - - - 15

CHAPTER TWO: THEORETICAL FRAMEWORK AND LITERATURE REVIEW -17

2.1 Introduction - - - - - - - - - - - - - 17

2.2 Theoretical Frame Work- - - - - - -- - 18

2.2.1 Structuration Theory- - - - - - - - - 18

2.2.2 Gender and Development- - - - - - - - - 21

2.2.3 Health belief Model - - - - - - - - - - 23

2.3 Literature Review - - - - - - - - - - 24

2.3.1 Historical background of contraceptives in Nigeria- - - - - - 24

2.3.1 Knowledge and use of Contraceptives- - - - - - - 26

2.4 Determinant Factors and Contraceptives - - - - - - - 37

2.4.1 Socio-Economic Factors and Contraceptives- - - - - - 37

2.4.2 Socio-Demographic Factors and Contraceptives - - - - - - 40

2.4.3 Socio-Cultural Factors and Contraceptives - - - - - - - 43

2.4.4 Supply and Demand Factors and Contraceptives- - - - - - 45

2.5 Spousal Communication and Contraceptives- - - - - - 46

2.6 Gender Perspective and Contraceptive use - - - - - - - 52

2.7 Attitude towards Contraceptives - - - - - - - - 58

2.8 Men's Involvement and Contraceptive use- - - - - - - 60

2.9 Contraceptives and Methods - - - - - - - - 62

CHAPTER THREE: STUDY AREA AND RESEARCH METHODOLOGY - - 69

3.1 The Study Area- - - - - - - - - 69

3.1.1 Location - - - - - - - - - - - 69

3.1.2 Economic Activities - - - - - - - - - - - 71

3.1.4 Religion and Culture -- - - - - - - - - 72

3.2 Research Methodology - - - - - - - - - - 73

3.2.1 Reconnaissance Survey- - - - - - - - - 73

3.2.2 Types of Data utilized - - - - - - - - - 73

3.2.3 Sources of Data - - - - - - - - - - 74

3.2.3.1Primary Sources- - - - - - - - - - 74

3.2.3.2 Secondary Sources - - - - - - - - - - 74

3.3 Sampling Design- - - - - - - - - - 74

3.4 Methods of Data Analysis - - - - - - - - - 77

CHAPTER FOUR: DATA ANALYSIS AND DISCUSSION - - - - - 78

4.1 Introduction- - - - - - - - - - - 78

4.2 Demographic and Socio-Economic Characteristics of Respondents- - - 78

4.2.1 Place of Residence- - - - - - - - - - 78

4.2.2 Age of Respondents - - - - - - - - - - 79

4.2.3 Gender of Respondents- - - - - - - - - 80

4.2.4 Ethnicity of Respondents- - - - - - - - - 81

4.2.5 Religion Affiliation of Respondents -- - - - - - - 82

4.2.6 Religion Denomination of Respondents- - - - - - - 83

4.2.7 Level of Education of Respondents - - - - - - - - 84

4.2.8 Occupation of Respondents - - - - - - - - - 85

4.2.9 Income Level of Respondents- - - - - - - - 86

4.2.10 Marital Status of Respondents - - - - - - - - 87

4.2.11 Types of marital union of Respondents - - - - - - - 88

4.2.12 Age at first marriage of Respondents - - - - - - - 89

4.2.13 Number of female children of Respondents -- - - - - - 90

4.2.14 Number of male children of Respondents - - - - - - - 91

4.2.15 Preferred number of children of Respondents - - - - - - 92

4.2.16 Decision on the number of children of Respondents - - - - - 93

4.2.17 Number of Surviving children of Respondents - - - - - - 94

4.2.18 Birth spacing of Respondents - - - - - - - - 95

4.2.19 Practicing of exclusive breastfeeding of Respondents- - - - - 96

4.3.2 Level of knowledge of contraceptives of Respondents - - - - - 98

4.3.3 Sources of Knowledge of Contraceptives of Respondents - - - - - 100

4.3.4 Availability of contraceptive services within the Locality of Respondents - - - 101

4.3.5 Level of use of contraceptives of Respondents - - - - - - 103

4.3.6 Reason for contraceptives use of Respondents- - - - - - 104

4.3.7 Reasons for Discontinuation of Respondents- - - - - - 105

4.3.8 Where contraceptive services is Obtained of Respondents- - - - - 106

4.3.9 Payment Responsibility of Respondents- - - - - - - 107

4.3.10 Determinants of contraceptive knowledge and use of Respondents- - - - 108

4.3.11 Decision Making process on contraceptive use of Respondents - - - - 109

4.3.12 Method known and used of Respondents-- - - - - - - 111

4.3.13 knowledge of contraceptives by place of Residence - - - - - 113

4.3.14 Current use of contraceptives by place of Residence - - - - - 114

4.3.15 knowledge of contraceptives by educational level - - - - - - 115

4.3.16 Use of contraceptives by educational level - - - - - - 116

4.3.17 knowledge of contraceptives by Age - - - - - - - 117

4.3.18 Use of contraceptives by Age - - - - - - - - 118

4.3.19 Contraceptive use by Religious Denomination - - - - - - 119

4.3.20 Contraceptive use by Income level Denomination - - - - - 120

CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS - - 128

5.1 Summary of findings - - - - - - - - - 128

5.2 Conclusion - - - - - - - - - - - 129

5.3 Recommendation - - - - - - - - - - 130

5.4 Suggestions for Further Research- - - - - - - - 132

References- - - - - - - - - - - - **133**

Appendices A- - - - - - - - - - - 150

Appendices B- - - - - - - - - - - 155

LIST OF TABLES

3.1 List of sampled wards in the study area- - - - - - - - - 75

3.2 List of selected wards in the study area- - - - - - - - - 76

4.1 Distribution of Respondents by place of residence- - - - - - 79

4.2 Distribution of Respondents by age- - - - - - - - 79

4.4 Distribution of Respondents by ethnicity- - - - - - - 82

4.5 Distribution of Respondents by religious affiliation- - - - - - 82

4.6 Distribution of Respondents by religious denomination- - - - -83

4.7 Distribution of Respondents by level of education-- - - - - - 84

4.8 Distribution of Respondents by occupation- - - - - - - 85

4.9 Distribution of Respondents by income level-- - - - - - - 86

4.10 Distribution of Respondents by marital status-- - - - - - 87

4.11 Distribution of Respondents by marital union-- - - - - - 88

4.12 Distribution of Respondents by age at first marriage- - - - - - 89

4.13 Distribution of Respondents by number of female children-- - - - - 91

4.14 Distribution of Respondents by number of male children- - - - - 92

4.15 Distribution of Respondents by preferred number of children- - - - 92

4.16 Distribution of Respondents by decision on the number of children- - - - 93

4.17 Distribution of Respondents by number of surviving children- - - - 95

4.18 Distribution of Respondents by birth spacing-- - - - - - 96

4.19 Distribution of Respondents by practice of exclusive breastfeeding- - - - 97

4.20 Distribution of Respondents by level of knowledge of contraceptives- - - 99

4.21 Distribution of Respondents by sources of knowledge of contraceptives-- - - 100

4.22 Distribution of Respondents by level of use of contraceptives- - - - 103

4.23 Distribution of Respondents by reasons for discontinuation- - - - - 104

4.24 Distribution of Respondents by reasons for not using contraceptives- - - - 106

4.25 Distribution of Respondents by where contraceptive services are obtained- - - 107

4.26 Distribution of Respondents by responsibility for payment- - - - - 108

4.27 Distribution of Respondents by determinants for contraceptive use- - - - 109

4.28 Distribution of Respondents by decision making process on contraceptive us- - 110

4.30 Distribution of Respondents by contraceptive method known and used- - - 111

4.32. knowledge of contraceptive by Place of Residence- - - - - - 113

4.33 Contraceptive by Place of Residence- - - - - - - - 114

4.34. Knowledge of contraceptive by Educational level- - - - - - 115

4.35. Use of contraceptive by Educational level- - - - - - - 116

4.36. Knowledge of contraceptive by Age- - - - - - - - 117

4.37. Use of contraceptive by Age- - - - - - - - - 118

4.38. Use of contraceptive by Religious Denomination - - - - - - 119

4.39. Use of contraceptive by Income level - - - - - - - 120

LIST OF FIGURES

2.1 Conceptual frame work showing the selected factors affecting contraceptive use- - 44

3.1 Map of Benue state showing Okpokwu Local Government Area- - - - 70

4.1 Distribution of Respondents by Gender-- - - - - - - 80

4.2 Distribution of Respondents on the availability of contraceptives within the locality- - 102

CHAPTER ONE: INTRODUCTION

1.1 Background to the study

A rapid population growth is a burden on the resources of many developing countries. Unregulated fertility, which contributes to such situations, compromises the economic development and political stability of these countries especially the developing countries (Yahya, 2007). The rate of growth of the population continues to act as a serious impediment to the country's march towards economic modernization, sustainable development and poverty eradication. Many international institutions and organizations such as the World Health Organization (WHO), World Bank (WB), United Nations Population Fund (UNPF) and United Nations Children's Fund (UNICEF) have strongly advocated contraceptives as a means to space children and limit family size. Contraception has also been a key component of the WHO-UNICEF Child Survival Strategy which goes under the acronym – GOBIFFF (growth monitoring, oral rehydrating salts, breastfeeding, immunization, female education, supplementary feeding and fertility control (Yayha, 2007).

Contraception is a process or technique for preventing pregnancy by means of a medication device or method that blocks or alters one or more processes of reproduction in such a way that sexual union can occur without impregnation (Mosby's Medical, Nursing and Allied Health Dictionary 2001). Ehiozuwa (2011) defined contraceptive as the prevention of unplanned or unwanted conception or unwanted pregnancy. Wada (2012) sees birth-control or contraceptive as "a fertility regulation process mutually agreed and embarked upon by a man and his partner for the purpose of building a healthy and happy home. It is estimated that in developing countries as many as 1.8 million child deaths could be averted if all pregnancies were spaced by at least three years (Rutstein 2008). In the past few decades investments in family planning programs have raised the level of contraceptive use from 19% to 62% in the developing world and contributed to an estimated 75% decline in fertility

(Greanga *et al*. 2011). However, despite the increase in supply of and demand for family planning services, gross inequities exist both between and within countries in the use of contraceptives, posing challenges to health policy and programming. Use of modern contraceptives in developing countries remains comparatively low, with West Africa having the lowest rates. In many countries the demand for contraceptives is still not being fulfilled. Worldwide, in 2010 12% of women currently married or in union who do not want any more children or want to postpone their next pregnancies for at least two years are not using any form of contraception that is; they have an unmet need for family planning (Alkema *et al.* 2013).

In developing countries an estimated 222 million women have an unmet need for modern contraception (Singh and Darroch 2012). The proportion of married women with unmet need for modern contraception is 18% in the developing world as a whole, but is much higher than average (30–37%) in Western Africa, Middle Africa, Eastern Africa and Western Asia, and is somewhat higher than average (22–24%) in South Asia and the Caribbean (Singh and Darroch 2012). Nigeria being the seventh most populous nation in the world has a current estimated population of 183 million, which is projected to reach 285 million by 2050 (United Nations 2013). There are an estimated 35 million women of reproductive age in the country, with an annual number of births of approximately 7 million and annual population growth of 3.2% per annum. The country's rapid population growth is attributable to a high total fertility rate (TFR) of 5.5 children per woman (National Population Commission and ICF International and 2014). Thus raising the question if the gospels of the consequences of population explosion are made known to Nigeria and the authorities concern. Family planning is the ability of individuals and couples to attain their desired number and spacing of their children through contraceptive use is one of the most cost-effective public health interventions and is pivotal to reducing the country's fertility (Graff, 2014). The fertility level of a

country is generally regarded as high when its level is above five children per woman (United Nations, 2009). Nigeria, a country with average fertility rate of 5.7 children per woman can therefore be regarded as having high fertility (Nigeria Demographic Health Survey (NDHS), 2008). Fertility rates have fallen largely worldwide due to the wide contraception but, the fact seem to a utopian in Nigeria. In Nigeria today, the birth rate is higher than the world averages (Nwachukwu and Obasi, 2008).

Nigeria according to Khurfeld (2006) is already facing a population explosion with the resultant effect that food production cannot match the growing population. These growths are as a result of improved control over deaths that have not been matched by controlled births. By implication, the high fertility rate and hence high population growth rate are among the major economic and social problems facing Nigeria. This assertion was based on the fact that high population growth rate is associated with increased level of poverty (Dabral and Malik, 2004); Adanu *et al*.,2009., Avidime *et al.,2010;Adiri et al., 2011)* which is observed in the country. In another line of thought, high population rate may also imply excessive burden on the country's women. In support of this fact, high fertility rates have been associated with poor child and maternal health, as well as increase risk of maternal mortality (UNFPA, 2008; Chipeta *et al* 2010; Woldemicael and Beaujot, 2011; Mathe *et al*). Fertility decline is a means of achieving a demographic dividend, with the consequent potential of reducing poverty, boosting economic growth and contributing to the overall well-being of families and societies (Cleland *et al*. 2006; Graff and Bremner 2012; Gribble and Bremner 2014). It has been estimated that in Nigeria a reduction in fertility by one child per woman would lead to a 13% increase in GDP per capita within 20 years (Ashraf, Weil, and Wilde 2013). While family planning impacts all the MDG goals, it is most directly associated with MDG 5, improving maternal health (UNFPA and PATH 2008; Ezeh, Bongaarts, and Mberu 2012). Contraceptive use reduces the pregnancy rate, the

number of unintended pregnancies and associated induced abortions and the proportion of high-risk pregnancies, therefore causing a reduction in maternal mortality and an improvement in maternal and child health.

Studies have estimated that 30% to 40% of maternal deaths (Gerressu, and Cleland 2004 Singh *et al*. 2009; Ndugwa, and Zulu 2011; Ahmed *et al*. 2012; Cleland; Collumbien) and 90% of induced abortion related maternal deaths (Cleland *et al*. 2006) could be averted if all women who desired to use contraceptives had access to them. In addition, contraception makes significant contributions to reducing levels of infant, neonatal and under-five mortality (Tsui and Creanga 2009). Nigeria is yet to derive significant benefits of family planning, as her use of contraceptives has remained persistently low, prevalence of modern contraceptive use stagnating at 10% among currently married women (National Population Commission and ICF International and 2014), much lower than the African average. The resultant high fertility is a significant contributor to high maternal mortality in Nigeria. Even though Nigeria has only 2% of the global population, it contributes a disproportionate 14% to the global burden of 289,000 annual maternal deaths (World Health Organization 2014). Contraceptive use has increased in many parts of the world even in perpetually highly populated regions like the Latin America and Asia, but the prevalence continues to stagnate in sub-Saharan Africa. Modern contraceptive prevalence in Africa increased from 23% to 24%, Latin America- 64% to 67% while Asia stagnates at 62% (WHO, 2012). Statistics have shown that knowledge of modern contraceptive is as high as 70% in Nigeria but this does not translate into uptake (Adebayo, 2012). Over a period of time, the very little improvement in contraceptive use rose from 3% in 1990 to 10% in 2008 (NPC and ICF Macro, 2009). Also, between 1990 and 2008, contraceptive prevalence rate for all methods increased from 6% to about 15%.

However, use of modern contraceptive methods increased from 4% to 10% between the same periods (FOS, 1992; NPC, 2000; FMOH; 2004, 2006; NPC and ICF Macro, 2009). The current prevalence rate of contraceptive use in Nigeria is approximately 11%-13% (Emmanuel, Andrea, John and James, 2010). According to National Demographic Health Survey (NDHS) 2008, only 10% of married women of reproductive age use contraceptives in Nigeria (UNFPA, 2010). This is lower than the current Sub-Saharan Africa average of 17%. There are different types of contraceptives which can be broadly categorized as modern (effective) and non-modern (ineffective) methods. Modern methods of contraception include sterilization for male and female, pills, Intra-Uterine Devices (IUDs), male and female condoms. Others are injectables, implants (including Norplant), and vaginal barrier methods. Non-modern techniques of contraception include periodic abstinence, withdrawal method, lactation amenorrhea method (LAM) and folkloric methods. This study focused on the modern contraceptives due to its efficiency and effectiveness.

1.2 STATEMENT OF THE RESEARCH PROBLEM

The population of Nigeria was reported be 151.87 in 2009 and in 2015; Nigeria's population is expected to be 178.72 million persons and above (IMF, 2010). If this growth rate is not checked, the population will double in about 24 years and this will have enormous implications on the economy and the overall development of the country. Today, family planning has been advocated as a control mechanism to regulate and control this rapid population growth. Regrettably, available researches on family planning programmes in Nigeria have traditionally focused on women over the years in order to raise contraceptive prevalence and reduce the level of fertility. Population growth or increase comes about because of the interplay of the three main demographic variables namely fertility, mortality and migration Henrietta, 2006.

This growth can be high, low, constant or stable and all these have implications for a country's socio-economic development and hence the standard of living of the people. When human reproduction is left unchecked, it results into high birth rates, bringing about large family size with the negative effects on the health of the respective mothers and children. Consequently this leads to negative impact on the family, the community and the nation at large as a result of economic overload in covering the additional demand. Indeed, uncontrolled births can destroy a nation's development aspirations and prevent its people from enjoying an improved standard of living. Nigeria generally has high maternal mortality rates and low contraceptive uptake rates (National Population Commission 2008). The 2008 Demographic and Health Survey (NDHS) showed that use of regular contraception was 15% in 2008, use of modern contraception was 10% but married women still had a 20% unmet need for family planning (National Population Commission, 2008). The 2013 Demographic and Health Survey (NDHS) also show similar trends in contraceptive use (National Population Commission, 2013). Nigeria like many other African countries is faced with the problem of high population growth rate. A decline in population can result when there is a substantial fall in both mortality and fertility rates. Demographers, health professionals and family planning experts are of the view that one major way by which the country can reduce its fertility is through the use of contraception. It is however disturbing and unfortunate that contraceptive use in Nigeria as in many other African countries is low.

Analysis of the total contraceptive prevalence rate in Nigeria (CPR) indicates wide zonal variations, ranging from 2.7 in North West, 4.0 in North East. 12.6 in North Central, 28.5 in South West, 17.7 South East and 27.7 South South and State variation ranging from 8.7 in Kaduna sate, 0.3 in Jigawa to 41.6 in Lagos state, Taraba state 5.9, Niger state, 4.4, Osun state, 31.1, Cross river, 24.5 among others (UNFPA, 2010). The situation in Benue state is not different. According to World Health

Organization (WHO), United Nation children Education Fund UNICEF (2000) United Nations Population Fund (UNFPA, 2010) showed that in Benue State, the contraceptive prevalence rate (CPR) is very low, estimated at 13.7%, the total fertility rate (TFR) is 5.5 children per woman and the risk of maternal death is 1.16; These facts compared unfavorably with developed countries where the contraceptive prevalence rate (CPR) is high, the TFR has declined to 1.6 and maternal death risk is 1.2800 (Ogwuche, 2007). Studies on contraceptives in Nigeria as in other parts of the developing world have long focused on women as the subject of interest. Very little work in this area has focused on men. It is now increasingly recognized that the actions required to achieve improvements in reproductive health outcomes in general and maternal health in particular should include men's participation (Roth and Mbizva, 2001). The biological and social independence between men and women in their plan for family and practice of contraceptive makes the importance of including men in reproductive decision. Similar studies on modern contraceptive have been carried out in Nigeria and other parts of the world.

Ebrahimi, (2005) studied the perceptions of secondary school girls on sexual debut, contraceptives and planning for their families in Uganda employed a qualitative method involving eight focus group discussions with girls aged 14-19 years in secondary schools. The study revealed that, peer pressure and to some extent the media were the strongest reasons for an early sexual debut. The girls' attitude towards contraceptives in general was negative partly due to their concerns over safety and related health risks .The study focuses on secondary girls only and did not look at other girls in other places like higher institutions.

Hermine, (2007) carried out a study on the beliefs and attitude of rural nurses in lori marz, Amenia towards modern contraceptive methods: A qualitative study. The study employed interview method and it was observed that nurses have many misconception about modern methods of birth control.

This leads to incorrect counseling of women and contribute to unintended pregnancies. The underlying reasons for this are lack of knowledge and a reluctance to trust modern information and some cases, adherence to folk beliefs despite this information. The study concentrated mainly on rural nurses but failed to consider the urban nurses.

Tsedeke,Wakgari, and Davey, (2004) carried out a study on the role of men in contraceptive use and fertility preference in Hossana town, Southern Ethopia. They employed random sampling and pre-tested structured questionnaires. The study revealed that majority of the study participants 60.3% reported wanting more children. About 91% of the respondents were familiar with at least one of the family planning methods. The most commonly known methods of family planning include the pill (79.4%), injection 78.5%, male condom 65.6%, Norplant 42%, and IUD 30.5%. Nearly half 48% reported current use of contraceptive by their wives. The study concentrated on men only but does not consider the women.

Vivin, (2012) carried out a research on urban rural differences in the use of modern contraceptive methods among people in the republic of Yemen. The study concluded that the odds of people living in urban area using modern contraceptives are more compared to people who live in the rural areas. The primary supposed reason for this being the influence of modernization being more acute in urban Yemen. Education was also found to have an influence on the use of modern contraceptive use with the odds of using modern contraceptive among people who have secondary and higher education is 2.0 times more the odds of using modern contraceptives among people who have primary or no education. The study concentrated on the use of modern contraceptives but does not consider the level of knowledge of modern of contraceptives.

In Nigeria similar studies has been carried out on contraceptives use and those accessible:

Mamman (1992) looked at fertility differentials in Kaduna Metropolis, observed a significant relationship between family planning as well as contraceptive use and marriage type, religion ,education, ethnicity while income had an insignificant association with contraceptives use due to affordability of it at government source, attitude of users towards involvement was based on various reasons: 1% on women health ground,21% limited childbearing, 48% delay next conception,2% for completion of education and 9% was base on economic reasons. The study focuses on Kaduna metropolis leaving other localities in the state.

Valentine,Frank,and Friday (2001) carried out a research on why Nigerian adolescent seek abortion rather than contraception, employed Focus Group Discussions (FGD). The study revealed that fear of future infertility was an overriding factor in adolescents decision to rely on induced abortion rather than contraception .The study concentrated on the entire adolescents and Nigeria as a whole.

Oyedokun (2007) carried out a study on the determinants of contraceptive usage in osun state, employed random sampling and focus group discussion. The study revealed that the knowledge of contraceptive methods was high and the level of current use of contraceptive was low. The study focused on the factors that determine the use of contraceptives and also cover the entire

Ogwuche (2007) looked at the development and validation of meeting unmet needs programme for family planning in Benue State of Nigeria: Implications for counseling. The result observed low contraceptive prevalence rate, high fertility and unmet need among married women in the study area. This study focuses on married women, failed to consider single men and women that are of reproductive aged.

Nwachukwu and Obasi (2008) in their study on the use of modern birth control methods among communities in Imo state employed random sampling and the use of questionnaires and Focus Group

Discussions (FGD). The study observed that only 30% of the respondents used MBCM while 57% used the traditional birth control methods. The most popular modern methods was the condom (24.2%), this was followed by the IUD, used by only 2.5% of the respondents. The study focused on the entire community in the state.

Envuladu, Agbo, Chia, Kigbu and Zoakah (2009) conducted a research on the utilization of modern contraceptives among female traders in jos, Plateau state. The study employed semi-structured questionnaires and interview, the result obtained indicated that the level of awareness of modern contraceptive was high (93.4%) and the most popular methods were male condom 95.5%, injectable 87.4% and oral contraceptive pills 85.9 while the unpopular methods were female condon 40.4%, cervical Diaphram 17.5% cervical cap 12.1% and spermide 12.6%. The study focused on the female traders leaving other women that are of reproductive age.

Abubakar (2012) carried out an assessment of men's role and attitude towards family planning in zaria LGA employed questionnaire and focus group discussion (FGD). The study revealed that the decision to family planning is made by husband, religion, ethnicity, marital status and income are the socio-economic factors that positively influence men's role in the decision to use family planning methods. The study failed to consider the role women could play in the use of family planning (F.P) methods.

Jimmy, Osonwa, Osuchukwu, Nelson and Dominic (2013) looked at the prevalence of contraceptive use among women of reproductive aged in Calabar Metropolis. They employed a cross sectional survey and a structured questionnaire. The study revealed that greater proportion of the respondents were not currently using any contraceptives 239(78.4%). However, a handful of the respondents who currently use contraceptive methods uses male condom 27 (29.3%) followed by pills 20 (21.7%) predominantly. Effectiveness and reliability of contraceptive methods were their main reason for

usage whereas, a larger proportion of the respondents had no reason for non-usage. Hence, the point prevalence of contraceptive use is 21.6%. The study focused on only women leaving out the men and also the study concentrated on calabar metropolis but failed to consider other localities.

Osifo, Akpama, Shehu (2015) looked at contraceptive practice of married women in Ekpoma, Edo State Nigeria using structured questionnaire. The result shows 96% of contraceptive knowledge and 23.9% usage. The study focused on married women only and failed to look at other women and men of reproductive aged.

There is therefore, the need for a comparative study on the knowledge and use of modern contraceptives among male and female since most of the previous studies focused on single sex analysis also, previous studies did not single out those modern contraceptives methods since the traditional methods have low efficiency and effectiveness. So this study seeks to address the identified research gap in the field of medical geography, by comparing the knowledge and use of modern contraceptives among male and female in Okpokwu Local Government Area of Benue State where, no such study has been done in the past. The study seeks to address the following questions:

a. What kinds of modern contraceptives are available in the study area?

b. What are the sources of information on modern contraceptives among male and female in the study area?

c. What is the level of knowledge of modern contraceptives among male and female in the study area?

d. What is the level of use of modern contraceptives among male and female in the study area?

e. Who makes the decision on the use of modern contraceptive among male and females in the study area?

f. What are the challenges of contraceptives use and strategies employed to solve the challenges in the study area?

1.3 AIM AND OBJECTIVES

The aim of this study is to examine the knowledge and use of modern contraceptives among male and female in Okpokwu Local Government Area, Benue State. This was achieved through the following specific objectives to:

i. assess the kinds of modern contraceptives available in the study area.

ii. examine the sources of information on modern contraceptives among male and female in the study area.

iii. assess the level of knowledge of modern contraceptives among male and female in the study area.

iv. assess the level of use of modern contraceptives among male and female in the study area.

v. examine the decision-making process on the use modern contraceptive among male and females in the study area.

vi. examine the challenges of contraceptives use and strategies employed to solve the challenges in the study area.

1.4 RESEARCH HYPOTHESES

To achieve the stated objectives, the following null hypotheses are formulated to direct the study.

H_o There is no significant difference between male and female respondents in the knowledge of modern contraceptives.

H_o There is no significant difference between male and female respondents in the use of modern contraceptives.

1.5 SCOPE OF THE STUDY

The study is on comparative analysis of knowledge and use of modern contraceptives among men and women in Okpokwu Local Government Area of Benue State. The study is limited to six (6) council wards out of twelve (12) wards. These wards are Amejo, Eke, Ichama ward II, Ojigo, Okpoga central, Ugbokolo. The study examines the level of knowledge and use of modern contraceptives among men and women of reproductive aged and the socio economic characteristics of the respondents. This study focused only on men and women of reproductive age (15-49 years).

1.6 JUSTIFICATION OF THE STUDY

Most of the studies on contraceptive use are centered on women and there is evidence of ambivalence in the fertility intention and subsequent contraceptive behavior of women Cho, 1978.Monnier, 1989; Cho and Withers *et al* (2011). A reason for the mismatch in women's fertility intention and contraceptive behaviour of women may be due to the influence of the fertility intention of their male partners. Studies have also shown that males are main decision makers on fertility issues and as such have great impact on the fertility intention and contraceptive use of their female partners (Isiugo-Abanihe 1994, Ezeh 1996, Dodoo 1998, Agadjanian, 2006). Furthermore, some studies have shown that men's preferences are better predictors of women's contraceptive use than women's (Dodoo 1998; Dodoo and van Landewijk 1996; Bankole and Singh 1998). Given that fertility intention of men often dominate in their female partner's contraceptive use and fertility intention in households (Dodoo *et al,* 1997; Govind*a,et al* 2008 and Ibisomi and Odimegwu, 2011.This work will contribute to the existing body of knowledge on reproductive health issues in Nigeria because if the fertility intention of males has an effect or corresponds to their modern contraceptive use, the implication is that since the males are dominant forces in decision making, programmes will be needed to educate men to embrace small family sizes.

1.7 SIGNIFICANCE OF THE STUDY

Nigeria has an ambitious target of more than doubling her contraceptive prevalence rate with four years (2014 – 2018), from 15% to 36%. This is against a backdrop of persistently low and stagnating contraceptive use. The findings of this study will be of benefit to the couples, government and the society as a whole. The results of the study will among others help the individual couple to: improve family well-being. Knowing the attitude and involvement of men and women towards contraceptives provide the level of knowledge and acceptance of the programme with preference of modern methods in various cultural settings. Women the most vulnerable Population group can have their reproductive health improved and evaluate their reproductive choices, alongside improve the health of their children. This reduces infant, child and maternal mortality rate as well as enhances family welfare, decreases fertility rate, and consequently slows population growth rate. In addition, progressive increase in greenhouse gas emission can be curbed with the adoption of contraceptives as an adaptation and mitigation measures to climate change since large family size requires more demands of wood fuel for combustion, this leads to more emission of greenhouse gas. In addition to reducing the fertility of women and slowing population growth, contraceptives has a direct positive impact of reducing child and maternal morbidity and mortality, and the prevention of mother to child transmission of HIV, generally producing a healthier and more productive society. Government, policy makers on population, researchers, non governmental organizations (NGOs), men, women and children will benefit immensely from this research.

CHAPTER TWO: THEORECAL FRAMEWORK AND LITERATURE REVIEW

2.1 INTRODUCTION

Contraceptives have been a subject that has attracted great concern in both developed and developing countries because of the worldwide effort at controlling population growth and improving standard of living. It is widely accepted that reduction in fertility can only be achieved through the use of contraception. According to united Nation, contraception was the principal intermediate variable that led to the shift from high to low fertility in the late 19^{th} and 20^{th} centuries.

Men have long been an underserved audience in family planning programmes in the developing countries. For decades a preponderance of family planning intervention programmes and activities as well as resources for fertility regulation have been targeted to women, while the active participation of men in family planning was not promoted. In the African context men are posited as decision-makers and are perceived to be "gatekeepers" and custodians of cultural and traditional practices.

Despite these perceived men's roles in families, family planning programs have made little effort to include men. This chapter presents a conceptual and theoretical framework which comprises: Structuration theory, Health Belief Model, Gender and Development (GAD) and Women Culture and Development and review of literature on the level of knowledge and use of modern contraceptives among men and women, determinants of knowledge and use of contraceptives, spousal communication and contraceptives, gender perspectives and contraceptives, Nigeria population policy and contraceptives, attitude towards contraceptives, contraceptives and methods.

2.2 THEORETICAL FRAMEWORK.

There are numbers of theories that have been put forward by medical geographers and demographers which have been applied and tested with regard to the use of contraceptives that can be used to explain contraceptives. In this study however, the following theories were used. They are structuration theory, health belief model, Gender and Development (GAD) and Women Culture and Development (WCD) approaches advanced by feminist scholars.

2.2.1 Structuration theory

Structuration theories have been explained by scholars as Bourdieu (1977), Bhaskar (1979) and Giddens (1979; 1984). Among these scholars it is the work of the British sociologist Anthony Giddens that has had the most profound influence on human geography. Giddens (1984) tried to develop an ontology (a basis for understanding the world) of human society (concentrating on how to theorize human agency) and to consider the implications of this theorizing for the analysis of social institutions. Human agency refers to people's capabilities and their related activities or behaviours, but not to the agents themselves. In simple terms, Giddens argue that individuals are born into societies that entrap them with social structures, which both constrain and also enable them. While we

live out our lives under the rules made by society, we are also reproducing these rules, but not necessarily in the same form. There are some basic concepts spelt out in Giddens structuration theory. They include the concepts of structure, action, social rules and duality of structure. Structures are sets of rules (constraints) and resources (capacities or possibilities) which exist only as memory traces, the organic basis of human knowledge ability and as instantiated in action (Giddens 1984).

Simply put structures can be understood as rules and resources for action. In talking about structures as resources, a woman living in an urban area is likely to have access to a long term contraceptive method like tubal ligation or even Norplant than her counterpart in the rural area. This is because these methods can only be administered in well established Family planning units which may not be available in the rural or remote areas. There is also the concept of action. Action according to Giddens represents the routine actions of daily life. Action is regarded as a continuous process rather than as a series of isolated single actions with specific intentions or aims. However skilled and competent agents may be, their knowledge is limited. As a result conditions of actions may remain unacknowledged and the consequences of action may be unintended. Agents are just as much influenced by the actions of others as they are by the rules and limitations of structures. Social rules are implemented through the interaction of people with each other.

Social rules also structure interaction, and the rules which structure interaction are themselves reproduced by the process of interaction. Individuals in the society follow such rules consciously or unconsciously, depending on the degree to which they are self-evident to them. For instance many men and women in both urban and rural areas in Nigeria will decide to use one form of contraception or another because of the massive sensitization programs in the country and the need for contraceptive usage to minimize fertility rates and hence population growth. A man or woman may

however choose to use a contraceptive method because of other reasons. Lastly, is the concept of duality of structure. Structures set the conditions of human actions, but they are also the results of human actions. Individuals are formed by society and its institutions, but they are skilled agents who direct their own lives through actions (agency). Giddens idea is about the fact that structures influence individual behavior, but behavior can reciprocally influence structures (Cloke *et al.* 1991; Holt-Jensen 2000). In summary, structuration theory tells that both structures and agency/people influence each other and this leads to some structural changes in the society. The main criticism of this theory is that it does not give direct guidance on how to proceed in scientific investigations and for the absence of formal links between structuration theory and empirical studies. This theory can however be applied to the study in the sense that contraceptive usage by men and women can be influenced by their personal reasons as well as by existing structures and institutions in the society.

Men and women in this sense become the agents (human agency) and the structures can include available family planning units in an area constructed by the government or a Non Governmental Organizations, pharmaceutical shops where contraceptives are sold and the social structures comprising of the spouses of women, other family members and the entire society at large. The existence of a family planning unit or a pharmacy (structure) in one geographical area can perhaps influence how a man or woman will get access to contraceptives. Reciprocally, the individual concerns expressed by women (agents) who visit a family planning unit about the different contraceptive types (i.e. individual women's behaviours, perceptions and experiences) can influence family planning experts to know which methods to advocate for or the best strategies to adopt to improve contraceptive usage. Finally the theory will help to explain one research question which seeks to know where and how information about the different contraceptive types are sourced by women and men.

2.2.2 Gender and development

Theories on gender and development can also provide good basis for this research. Gender is simply defined as the socially constructed roles of men and women in societies. There are five main theories that have been put forward to explain researches in gender and development as well as in other researches. The theories basically try to explain the inequalities that exist between men and women when one considers their productive and reproductive activities. In different societies in Africa, the assumption is that women should be actively involved in reproductive activities than productive activities.

Each of these theories as discussed briefly, more emphasis was placed on Gender and Development (GAD) and Women, Culture and Development (WCD) as they pose a greater influence on the study. This is because contraceptive use by women is highly dependent on the relationships that exist between men and women in society as explained by GAD. Secondly, the culture, values and norms of individual societies influences the productive and reproductive activities of men and women and this is embedded in the WCD approach. Women in Development (WID) is mostly labeled as the first approach or theory used in studies on gender and development. It came into being in the early 1970s. The approach points to the fact that women are invisible and excluded in the development process. The approach calls for men and women to be treated equally in the working environment or in production. The approach has been criticized among others as taking the existing gender relations between men and women for granted and also failed to theorize about how women were suppressed by men. In view of the criticisms of WID, Women and Development (WAD) came into being in the late 1970s as a development upon the ideas of WID. WAD argues that women have always been part of the development process and that women are suppressed only when development is related to

modernization. WAD has also been criticized for taking for granted the gendered division of labour that existed both at the household level and at the international level. In the early 1980s, the ideas of Gender and Development (GAD) came to the forefront. GAD explains how women are suppressed in society on the basis of the gender relations between women and men. It is strongly believed that women's use of contraception and hence control over their bodies can to some extent be influenced by the role the women themselves play in reproduction but also their husbands reproductive rights as determined by the society has a greater influence. The gender relation between the man and the woman in the home is therefore a critical determinant of contraceptive use in the marriage. Women, Culture and Development (WCD) approach is seen as the most recent approach compared to the others.

This approach was developed by Bhavnani et al (2000). WCD compared to WID, WAD and GAD argues for one to consider the distinct cultures of individual regions as one studies gender relations between men and women. The approach also makes a distinction between the productive and reproductive roles played by men and women in a society. The approach can explain some aspects of the study because, contraceptive use by women in different societies can be better explained if we consider the roles and power relations between men and women regarding their reproductive lives. There may also be some values, customs, norms and other institutional arrangements in individual societies that may influence contraceptive use. These theories (GAD and WCD) can best explain the decision making process in the use of modern contraceptives among men and women's choice of contraception. The theories used in the study will serve as useful tools to help analyze the results as part of the responses will be in descriptive form.

2.2.3 Health Belief Model

According to the Health Belief Model, individual perception such as, perceived seriousness of pregnancy, perceived benefits, perceived barriers are more likely to affect the prevention action such as sing contraception which can prevent a specific condition such as unplanned pregnancy. In addition, perceived barriers such as difficult access to sexual and reproductive health services (SRH) and providers‟ negative attitude can prevent the use of services. In contrast the perceived benefit of communicating with parents may result in more effective use of contraception.

This model promotes an ability to weigh benefits and make changes when confronting a health risk. An example of a scenario for this model will be; a woman (especially if she is unmarried and does not intend to have a child or married and does not intend having more children) must first perceived that engaging in unprotected sexual intercourse involves consequences such as unwanted pregnancy Perceived Susceptibility; then the consequences could be negative such as, having a child and dropping out of school to support her child--if she is unmarried or having more children than needed because of economic reasons--if she is married Perceived Severity; however, adherence to prescribed intervention such as use of contraception will help prevent unwanted pregnancies Perceived Benefit. Family planning health education at designated centers will enhance women outweigh potential negative side effect such as weigh gain from contraception use or potential loss of social status by delaying parenthood Perceived Barriers. Most research have reported high awareness of family planning methods as television and radio remain the highest sources of information which could be used as a medium to remind women on the need to use contraceptive methods Cues to action. Women who have previously used contraceptives should serve as corroborative evidence to encourage other women who fear side effects of using contraceptives Self efficacy.

2.3 LITERATURE REVIEW

2.3.1 HISTORICAL DEVELOPMENT OF FAMILY PLANNING IN NIGERIA

Nigeria's family planning program began in 1964 with the National Family Planning Council of Nigeria (Oyediran 1969). Before the 1980s, however, family planning programs were not a priority for the government of Nigeria and consequently were driven by development partners and nongovernmental organizations. Following analysis of the consequences of unregulated population growth on health and development in Nigeria, starting in the late 1980s the country began formulating various policies aimed at improving reproductive health outcomes and reducing fertility levels through family planning. These include Nigeria's national population policy, first enunciated in 1988 and revised in 2004.

These policies focused on increasing uptake of modern contraceptives for health and national demographic goals (Federal Republic of Nigeria 1988). Targets of the first national population policy included increasing contraceptive prevalence to 80% and limiting the TFR to an average of four children per woman by 2000. The revised population policy calls for a reduction of maternal mortality by 75% by 2015, reduction of the fertility rate by 0.6 children per woman every five years and a 2% annual increase in the proportion of women using contraceptives. More recently, following the 2012 London Summit on Family Planning, Nigeria developed a blueprint for accelerating uptake of family planning with a target of increasing the national contraceptive prevalence rate to 36% by 2018 (Federal Republic of Nigeria 2014). Currently, family planning services are provided by both the public and private sectors, with the commodities provided free in public sector facilities. In spite of the various investments in family planning programs in the country, contraceptive prevalence has not shown any sign of increasing. According to the 2013 NDHS, while knowledge of contraceptives is generally high, uptake is low; only 15% of married women of reproductive age are using any contraceptive method and only 10% are using a modern family planning method, while unmet need for contraception is 16% (National Population Commission and ICF 2014).

The national rates have shown little change since 1990. Motivation to use contraceptives is low in the country, as pronatalism is one of the reasons for high fertility and low contraceptive prevalence (Federal Ministry of Health 2008). These national aggregate indicators mask wide variations in the uptake of contraceptives across the country. The southern zones of the country have higher contraceptive prevalence compared with the northern zones. The northern part of Nigeria has one of the lowest rates of contraceptive use in the world. Across the states of the country, contraceptive prevalence ranges from 26% in Lagos State in South-western Nigeria to less than 1% in Jigawa and Kano States, North-western Nigeria. The 2013 NDHS data aggregated by zones showed wide variations in fertility intentions and contraceptive use. While the national total fertility rate is 5.5 children per woman, it ranges from 4.3 children per woman in the South Zone to 6.7 children per woman in the North West Zone. Use of modern contraceptives ranges from 3% in the North East Zone to 25% in the South West Zone. Also, the 2013 NDHS showed variation in the method mix. For example while contraceptive prevalence was comparatively high in some of the eastern states of the country, contraceptive use includes more natural and traditional contraceptive methods. There are also variations in contraceptive use by religion, education, place of residence and socioeconomic status (National Population Commission and ICF International and 2014). In addition to the many socio-cultural drivers of high fertility, poor investment in strategic behavior change communication has contributed to low demand for family planning. The main sources of information on family planning in the country are friends or siblings, media, formal education and health workers (Oye-Adeniran *et al.* 2006; Monjok *et al.* 2010; Ankomah, Anyanti, and Oladosu 2011). Additionally, a number of supply-related factors limit contraceptive use. These include erratic supply of modern contraceptives, gaps in logistics supply chain, donor dependence, poor-quality services and dearth of skilled health personnel to provide family planning services (Federal Government of Nigeria 2014).

2.3.2 KNOWLEDGE AND USE OF CONTRACEPTIVES.

The knowledge of contraceptive is inevitable for those who are in their reproductive ages whose intention is to postpone a birth or who do not want any more children, and those who are not ready for a birth at all. Knowledge of contraceptive and use are the key variables in any study on fertility regulation and in the evaluation of family planning programmes. Acquiring knowledge about fertility control is an important step towards gaining access to and then using a suitable contraceptive method in a timely and effective manner Odusina,Ugal and Olaposi, 2012. This should be the priority of the less developed countries, Nigeria inclusive. But despite high birth and maternal mortality rates in Nigeria, government seems not to be keenly interested in pursuing any aggressive family planning measures Ebigbola, (1988). Knowledge and use of contraceptive among men and women showed very wide variation among regions of Sub-Saharan Africa than other regions of the world. In conformation with this, study among adolescent aged 15-19 in Ghana revealed that 85% knows at least one modern method of contraception while only 11% of sexually active adolescent used modern contraceptive and the rate for any methods was 27% (24). Yahaya in Yemen (2007) revealed that 90% of men were aware of the common types of contraceptives except for female sterilization (51.0%). It was suggested that religious leaders must be involved in clarifying religious issues regarding family planning.

Similar study in Nigeria has revealed that over 60% of urban adolescent have heard of at least one method of contraceptives but only 4.7% of sexually active adolescents practice contraceptive of which 3.5% of them practice modern methods. Knowledge of contraceptive methods among adolescents in most countries of Latin American, the Caribbean, Asia, Near east and North Africa, exceed 90%. The contraceptive information and services offer to women in Nigeria is often compromised (Ozumba *et al* 2005). Oye-Adeniran *et al*, (2004) states that large number of Nigerian

women experience unwanted, unintended or ill timed pregnancies and births. According to a 1997 survey of women in Southwestern Nigeria, at least 27% of women had ever been pregnant when they did not want to be. Similarly, in a survey conducted in Southwestern and Northern Nigeria in the mid-1990, 20% of women reported ever experience an unwanted pregnancy (Okonofua, *et al,* 1999).The 2003 Demographic and Health Survey (DHS) found that of live births to women in the previous three years, 15% were reported to be unplanned. It has also been reported that about 12% of all pregnancies in Nigeria (not including those that result in spontaneous abortion) end in induced abortion and another 9% result in unplanned births .(Henshaw 1998). According to the 2003 NDHS, the level of knowledge of at least one contraceptive method among all women (currently married, sexually active and inactive unmarried women and for women who have never had any sexual experience) was 79% and 77% know at least a modern method. Despite this high knowledge of at least one contraceptive method, only 29% of all women reported in the same survey to have used at least one of the known methods. The data showed that there had been no significant change in level of contraceptive use since 1999 (15% reported in 1999 and 16% reported in 2003).

The Demographic and Health Survey of 2008 revealed that 72% of all women know at least one method of contraceptive. However, only 29% of all women reported ever using a method of contraception at some time, 24% used at least a modern method and 13% used at least a traditional method. The overall contraceptive use prevalence among all women in Nigeria was 15%. This is an indication that prevalence of use is low. Low contraceptive prevalence in Sub-Saharan Africa has been attributed to high cultural and religious influence which promotes resistance to family planning practice (Caldwell and Caldwell 1987). Although contraceptive usage increased in some African countries, the increase that is observed is very modest. Envuladu *et al* (2012) opined that, the level of awareness of contraceptives among female traders in Jos was quite high as 93 percent of them were

actually aware of one form of modern contraceptive or the other. Some contraceptive methods were more popular than others; among the most popular methods were the male condom, being the most known among the female traders followed by the injectable and the oral contracetive pills. Only about 40% of the female were aware of the female condom and other contraceptive methods among them. Study by Oyedokun (2007) on determinant of contraceptive usage: lesson from women in Osun State found that knowledge of contraceptive methods was high among women in the area, reported level of current use of contraceptive was low. This Suggests that knowledge about methods does not translate to practice in the study area. Apaisaria (2011) on contraceptive method choice among women attending at amtullabital family planning clinic in Dares salaam revealed that knowledge of contraception in the area was found to be 95.1%. This include those with sufficient (8.1%) and moderate knowledge (87%) with low level of use. Tsedeke,Wakgari, Davey, (2004) on the role of men in contraceptive use and fertility preference in Hosanna town, revealed that the knowledge of contraceptive was high (93.4%) among married men, but a relatively low utilization (6.6%). Also, study by Islam (2006) on family planning knowledge and current use of contraception among the Mru indigenous women in Bangladesh revealed that only 40% of respondents had ever heard of contraceptive message. The current use of contraception was much lower (25.1%) among the Mru people than at the national level (55.8%). Study by Ravendra (2009) on contraceptive use among tribal women of central India revealed that current contraceptive prevalence among tribal women was relatively lower-only 42.1 percent of currently married, non-pregnant tribal women were using some method of contraception. Majority of these tribal users were using female sterilization (32.7%).

Also Amos (2007) in Ogun State revealed that though knowledge of contraceptive methods was high among women, only 30.1% ever used any of the known methods and less than a tenth were currently using any modern method at the time of the survey. The data from a study covering three states of

south-west Nigeria revealed that about 63% of men compared to just 35% of women would approve of the use of contraceptive. About 36% of the respondents gave an indication that their spouses would not stop them from using contraceptives method (32.3% males versus 35.5% females). Access to source of information has been found to be positively related to contraceptive use and women who have adequate knowledge of contraceptive source are substantially more likely to be using contraceptive than women who do not know a source (Ebigbola and Ogunjuyigbe 1998). Mohammed *et al* (2006), in their study on reproductive knowledge among adolescents in Tehran, examined a population of 1,385 males using self administered questionnaires. The study concluded that the relatively high prevalence of sexual activity and the lack of knowledge regarding contraceptives pose a significant threat to sexual and reproductive health of adolescent males in Iran.

A study was carried out in the southeastern Nigeria, to ascertain the knowledge, attitude and practice of contraception among single women in rural and urban communities, using a cross sectional survey of 279 single women in Ngwo (rural) and Enugu (urban) community. Contraceptive awareness was more among the urban (90.2%) than the rural respondents (34%). The major sources of contraceptive knowledge were mass media (68%) and peer group (86.3%) for the rural and urban respondents respectively. The study concluded that poor contraceptive information, highly critical behavior of family planning providers towards unmarried women seeking contraception and attitude of male partners militate against contraceptive practice Amazigo *et al*, (1997).

A study carried out among tertiary students in Durben, South Africa in 2004 on contraceptive knowledge and use, through the use of self administered confidential questionnaire for 436 students. A total of 57% of the study groups had heard of contraceptives. Overall knowledge and use of contraceptives by tertiary students is limited. The study reported a need for carefully designed education programme and promotion of contraceptives on campuses (Maharaj and Cleland, 2006). A

study carried out by Araoye *et al*. (1998) involving 971 male and female students aged 18-24 years attending a tertiary institution in Nigeria showed that 97.7% males and 98.4% female knew at least one method of contraception. The relatively underdeveloped state of mass media in Africa, Nigeria specially has stimulated the development of the other, less hi-tech approaches for disseminating health and population messages as government tightly controls mass media out-lets and often restricts the broadcast of potentially controversial messages on population and family planning (Otoide *et al,* 2001). Knowledge and practice of contraceptive has been found to be directly related to age, level of education, sexual activity, previous history of use of contraceptive methods in Nigeria (NPC, 2008).

studies by (Abiodun *et al*., 2001; Josaphat *et al*., 2006; Byamugisha, 2006; Nworah *et al*., 2010), revealed that, the commonest source of information about contraception was friends and rarely health institution and family planning clinics despite the fact that these are dedicated specifically to such duties. Information obtained from friends about the use and practice of contraception are often misleading as they contain a lot of misinformation, distortion, falsehood and misconceptions, and often times self centered (Baker and Rioh, 1992;Abiodun *et al*., 2001).

Contraceptive use is part of a family planning package. A large and empirically verified demand for contraceptive methods to space or limit childbearing exists worldwide. The use of contraceptive is inevitable for those who are in their reproductive ages whose intention is to postpone a birth or who do not want any more children, and those who are not ready for a birth at all. Proximate determinants of fertility includes contraceptive use and these determinants of fertility are behavioural variables through which socio-economic and other biological variables work to influence fertility rate in a population (Bongaarts 1978,' 1987). In countries in which fertility reduction is prominent, evidences have shown that various fertility reducing variables are thought to be responsible for this population decline (Cohen, 1998), and among these fertility reducing variables, modern contraceptive use is the

main factor affecting inter country variation when these countries are compared (Kirk and Pillet, 1998).

Family planning acceptance in Africa region has for long been low and the low contraceptive prevalence can be said to have influenced the resulting high fertility rates in Sub Saharan Africa compared to other parts of the globe. World Bank in 2009, reports that the average number of births for woman in Sub-Saharan Africa was (5.1). This statistics shows that average number of births per woman in Africa is more than doubled as much in South Asia with (2.8) or Latin America and the Caribbean with (2.2). The contraceptive prevalence (22%) for Caribbean, is almost half that of South Asia with (53%) and less than one- third of what is observed in East Asia with 77% (World Bank, 2009); Due to these patterns, Africa's population is growing at a fast rate (2.3%) compared to other regions in the developing world, which includes both some part of Asia and Latin America (1.1% each) (UN DESA, 2008).

The Contraceptive Prevalence Rate (CPR) which is the proportion of women of reproductive ages who uses modern contraceptive methods differs across Sub-Saharan African countries (UNDP, 2009). Wide variations exist in the pattern of contraceptive use between regions and countries of the world, and also at sub-national levels (Dynes *et al*. 2012; Alkema *et al*. 2013). It ranges from the lowest of 1.2% in Somalia to the highest 0f 60.3% in South Africa. Southern African countries like South Africa and Zimbabwe have the highest uptake of modern contraceptive, followed by countries from East Africa with Kenya at 31.5% leading the sub-region. Western and Central African countries reported very low rates of family planning uptake. Low contraceptive prevalence rates in the world can be observed in this sub-region with Chad with 1.7%, Niger has 5%, Nigeria 9.1% and Central African Republic with 8.6% (UNDP, 2009).

Currently, about 200 million women have an unmet need for modern contraception, that is, they are sexually active, want to delay or stop childbearing, and are not using a modern contraceptives method. More than 80 million unintended (mistimed or unwanted) pregnancies occur each year worldwide, contributing to high rates of induced abortion, maternal morbidity and mortality, and infant mortality (Esabella, 2012). Furthermore, family planning has been found to be an essential means by which countries can achieve the Millennium Development Goals (MDGs), particularly goals four and five for improved child and maternal health outcomes. The cost of averting unwanted births is miniscule compared with the costs of unwanted births at both the family and country level. Moreover, the need for contraceptive use is generally high in societies where poverty, illiteracy, and gender inequality are high. In such societies, unintended and repeated pregnancies make it difficult for women to participate in economic development and self-development. In most of Sub-Saharan African countries (e.g. Zambia, Namibia, Malawi Kenya, South Africa) it is a tradition that women should not have sex before marriage and because of this most teenage women find it difficult to have access to contraceptives to protect themselves from pregnancy and infections (Population Reference Bureau, 1992). They often feel shy if they are seen getting condoms from the nearby clinics. The fear is that people will know that they are having sex outside marriage and will not be respected in their communities. On the other hand, most young girls do not want to deny their boyfriends sex because they are afraid that they might lose their boyfriends as well as lose their relationships. Thus most of them decide to have sexual intercourse without protection (Eggleston et al., 1999). Some girls believe that relationships without sex will not turn into true love and hence this has caused most girls to have sex very young (in their first relationships).

Furthermore, some girls tend to emphasize prevention of pregnancy in relationships by using the pill, injections or the IUD, but these do not protect them against HIV and other infectious diseases. There

is evidence and cases reported that a high percentage of married women have been infected with HIV/AIDS by their husband (Ntozi and Ahimbisibew, 2001). Simply being married is a major risk factor for women who have little control over abstinence or condom use at home or their husband's sexual activity outside. Contraceptive use has increased worldwide over the last decade yet, Africa like many other regions of the developing world continues to have a high unmet need for family planning approximately 25% of women and couples in sub-Saharan Africa who want to space or limit their births are not using any form of contraception.

Overall, rate of contraceptive use is associated with wealth, education, ethnicity, place of residence, and strength of national family planning programs within countries. The low level of contraceptive awareness and usage in Nigeria correlates with the low level of contraceptive information resulting from the poverty of sources of information on contraception (Adinma, Agbai, Okeke and Okaro 1999). However, many Nongovernmental Organization (NGOs) have been established to serve the general public in various ways. Some are involve in various activities to ensure that people have access to accurate information and services, amongst this are Action Aid International Nigeria (AAIN), Action Health Incorporated (AHI), Life Agenda Initiative (LAI) and Life Vanguard. In recent times, the Action Health Incorporated (AHI) has been in the frontline of NGOs complementing government's efforts in raising awareness about adolescent health issues and setting a new direction for adolescent sex education in Nigeria (Adepoju 2005 in Adeyoju, 2013). Otoide, Oronsaye and Okonofua (2001) also said that, Nigerians generally have low levels of contraceptive use and their reliance on unsafe abortion is high with subsequent abortion-related complications.

Adinma *et al* (1999) carried out a research on contraception in teenage Nigerian school girls. According to this study, only 3 methods (pill, withdrawal and rhythm methods) have ever been used by the secondary school teenagers and the pregnancy rate was higher among the sexually exposed

secondary school girls. Peer group has been observed to be the commonest source of information on contraception and it has been assessed to be a very unreliable source often coming from similarly uninformed friends. Moreover, in a study titled "why Nigerian adolescents seek abortion rather than contraception by Otoide *et al* (2001) identified the following factors that hinders the use of contraceptives; fear of future infertility, adverse effects of modern contraceptives on fertility, abortion. Furthermore, a study in Addis Ababa on barriers to use of contraceptive among adolescents and their contraceptives choices and preferences. The study shows that great majority (245 out of 248) faced various barriers to use contraceptives both at acquisition and use level, these include ashamed disapproval and fear of side effect (Gadisa 2004). He concluded that great majority of adolescents has positive views toward contraceptives and were interested to know more about it from appropriate sources before the age they are likely to start sexual activity.

Otoide *et al* (2001) emphasized that if contraceptive use is to be improved among Nigerian adolescents, there is need to educate adolescents about the mechanism of action of contraceptive agents about their side effects in relation to unsafe abortion. Contraceptive use is still low in many developing countries, including Nigeria, where 23.7% of currently married women had ever used one (NPC and ICF Macro, 2009). Over the past four decades, there have been numerous publications on contraceptives and other family planning methods. While culture, poverty and poor access have been widely understood as militating against their use (CDC, 2000; Leke, 2000; USAID, 2008; NPC and ICF Macro, 2009).

A study in Belgium shows that trust-based counseling of women by their gynaecologists made many women select a different contraceptive method, or when they were previously undecided, they usually opted for the method their gynaecologist recommended (Merckx *et al*., 2011). Whereas in Germany and Austria, even though female physicians used extended-cycle contraceptive pills (COCs), it did

not impair their prescribing habits (Wiegratz *et al*., 2010).Though multiple factors influence the acceptance, choice and utilization of contraceptives (Bukar *et al*.,2013), our experience in Nigeria shows that patients expect their doctor's opinion on the choice of contraception to use and hardly question it, though this is gradually changing as people get more educated and more aware. A study in Gombe, Nigeria demonstrated a low number of respondents having the opinion that women have an independent right to contraceptive acceptance, choice and practice and echoed the importance of male involvement in contraception decision-making (Bukar *et al.*, 2013). A study conducted among the Kanuris in Nigeria revealed that few Kanuris women used modern methods of family planning, the barriers being objection by their husbands, the fear of delayed return to fertility, damage to the reproductive apparatus and the belief that modern contraception was introduced to reduce muslim populations (Mairiga *et al*, 2010). In another example, the Suri people of Ethiopia prevent and delay pregnancies using natural family planning methods. The desired benefits is that women regain their strength following the injuries caused by pregnancy and delivery, and that attention can be given to the welfare of growing children. But these objectives are often countered by lack of access to modern family planning methods and the desire for many children within a socio demographic context of threats to their tribal survival (Eyayou *et al*, 2004).

2.4 DETERMINANT FACTORS AND CONTRACEPTIVES

2.4.1 Socio-economic factors and contraceptives

In Sub-Saharan Africa, men have a higher chance to be literate and have better access to education (USAID, 2008). This translates that men are in a better position than women to inform themselves about what is best for the family reproductive health. Understanding how education of males influences their behaviour and reproductive decisions in the household is important since education accounts for trends in various demographic dynamics. Some studies have shown a significant

relationship between education and contraceptive use (Ezeh ,1993; Cochrane, 1997). The result of a study by Ezeh (1993) which made use of data from 1,010 matched husband-wife pairs in the Ghana Demographic and Health Survey 1998 (GDHS), suggested that husbands on the average have more education than their wives, and that a man's contraceptive behaviour depends on his level of education. The finding explained that an educated male is more likely to use and approve family planning than an uneducated male (Ezeh, 1993).

In a different study carried out by Cochrane (1997) it was noted that education was positively associated with birth regulation, increased awareness and use of modern contraceptive methods. The study argues that educated men prefer to have small families because they are more likely to have views and lifestyles that are consistent with lower fertility and higher quality of children (Cochrane, 1997). Amin (1994) in Bangladesh found that education increases contraceptive use and reduced fertility and the pattern of these effects is much higher among educated respondents beyond the primary level as compared with those educated only at primary level and below. In Nigeria, education has been found to increase contraceptive use (Oye-Adeniran et al. 2006). Nigerian women with tertiary level education are one-and-a-half times more likely to have ever used contraception than women with secondary education (Asekun-Olarinmoye *et al*. 2013).

Partner's level of education is equally important, as it may operate through many of the same pathways (childbearing preferences) as the woman's own education, given that education levels of husbands and wives are positively correlated (Malwade 2002). A study from Nigeria showed that the likelihood that a woman and her partner were using contraception was higher if at least one partner had a primary or higher education than if both had no education (Ibisomi 2014). However, women who are more educated than their husbands tend to use contraceptives more than women who are not as educated as their husbands (Stephen and Enoch 2014). Level of education is a predictor of

socioeconomic status, which correlates with contraceptive use. Thus, women of lower socioeconomic status have lower uptake rates of contraceptives (Acharya 1998; (Ibisomi 2014; Shah, Shah, and Radovanovic 1998; Stephenson and Tsui 2003). Occupation is another likely predictor of contraceptive behaviour. A Nigerian study which reveals that desired fertility is lower for women married to husbands employed outside agriculture, when compared to those in the agricultural sector and this in turn affect contraceptive use by the male (Bankole *et al.,* 1995).

The suggested interplay of variables is that the higher the educational level of men, the higher their likelihood to be in high paying jobs which in turn influence their family size and choice of contraceptive method. In other words, occupation is associated with the economic status of men and thus the affordability to purchase contraceptives (Ghosh, 1999). For example, Caldwell (1987) reports that there are different quality of condoms, so the satisfaction that a user will derive from the use of condoms is determined by his or her ability to purchase a better quality of a condom brand. In Kenya, a study found that male's occupation is positively associated with contraceptive use in which the author concluded that males with higher status occupation have a high propensity to use modern contraceptives (Odhiambo, 1997).

The link between education and occupation as important predictors of a man's contraceptive behaviour can be extended to the living standard of a man. Men who have improved living standards are likely to be educated, literate and thus have better knowledge of modern contraceptive methods. Therefore they are more likely to use contraceptives since that they can also afford it. A cross sectional study of men's attitude and participation in family planning were explored statistically using 150 married male respondents currently working in the Islamia University of Bahawalpur in Pakistan. One significant factor that influenced male contraceptive use was income level. According to the authors, evidence of distribution of income in the setting shows that the average annual household

(6.1 average number of members that are dependent on respondent) was PKR 9893 (9893 Pakistani rupees) which approximates to US$ 10 (Ten US Dollars per month). The study found that the use of contraceptives among the male employees whose income is more than PKR 10,000 is 3.52 times more as compared to other low income employees (Abdul *et al*, 2010). To corroborate this finding, other studies have shown that contraceptive use is positively associated with wealth status (Jejeebhoy, 1995). Some studies on women have also found that rich women were more likely to use effective contraceptive methods when compared to poor women (Creanga *et al*, 2011) and in line with this, Kanazawa suggests that although higher status groups have a higher sexual frequency but more contraceptive use prevents this frequent coition from being translated into higher fertility.

2.4.2. Socio Demographic Factors and Contraceptives

Studies have found that an inverse relationship exists between the number of living children and use of modern contraceptives (Uchindi 2001; Stephenson *et al*. 2007; Yihunie *et al*. 2013). Number of living children a person has can have an influence on modern contraceptive use because there is a tendency that the desire for additional children may decrease as number of living children increases. This assumption is based on the fact that economically, world economy is not improving and the cost of raising children in recent times is higher than before although, it is a general belief that men in Sub-Saharan Africa are lovers of children based on different reasons which is mostly cultural.

It may be unsafe to say therefore, that because African males are supporters of high fertility that they are less likely to want to limit or stop fertility at some point especially as their parity increases. In reacting to this view, the need to attest to whatever kind of association that exist between the number of living children and contraceptive use, and on what population is imperative to studies around the subject as number of living children is a more direct influence on male contraceptive use (Ringheim, 1993. A study carried out on women in Orissa found that one –third of the women with one child

used a method of contraception. That suggests that the use of contraceptives at lower parities is low and therefore concludes that there is an association between the number of living children and contraceptive use. Furthermore, the modern contraceptive uptake increases with number of living children (Sahoo, 2007). A landmark study was done in 1977; American University in Cairo conducted interviews with 22,799 women aged 15 to 44 living in 38 rural villages who were married in Egypt. Contraceptives were made available through by distribution to households. These women were offered oral contraceptives free of charge and nine months later, they were again interviewed and a definite pattern emerged. Overall contraceptive use increased with number of living children.

However, sex composition of the number of children also has an influence on the uptake of contraceptives. Among women who were not using contraceptives before the program, those with more sons were more likely to start using contraceptive and were more likely to continue use for a period of nine months after the distribution (Gadalla *et al*, 1985. The result shows that the chances of using permanent or modern contraceptive methods was highest among men who had at least two living sons and lowest among the men who had daughters only. The result further showed that the likelihood of using no method was highest among those who had only daughters irrespective of the parity. Men who report a desire to have no more children are likely to choose permanent methods only after they have two living sons (Dahal *et al*, 2008).Place of residence is often used to explain variation in factors about demographic and population studies. The fact that infrastructures are not evenly distributed across a space may affect the accessibility to opportunities which in turn may influence the way of life of the people. Islam *et al* 1995 found that place of residence has a substantial effect on fertility and contraceptive use by women in Bangladesh. They explained that the differences may be partly attributed to educational attainment and possession of modern objects (e.g. Radio) by urban dwellers which provide exposure to modern ideas and enlightenment on family

planning (Islam *et al*, 1995). Regional variation also exists in regard to contraceptive use because of different socio-cultural pattern and practices (Knodel, *et al*, 1996). In Nigeria, regional variation in fertility is pronounced and these differences in fertility pattern across the regions may be due to the religiosity and cultural variation (Feyisetan and Ainsworth, 1996). A Nigerian study interviewed 1,540 respondents from the three main regions namely Northern, Western, and Eastern on their contraceptive use. The analysis shows that different factors significantly affect the choice of contraceptive use in the different regions.

Contraceptive use is less practiced in the North compared to other regions. According to the authors, the reason for this disparity is low level of education and awareness in the north and secondly is the regions religious background (Odimegwu *et al*, 1997). The examination of the association between male contraceptive use and age is important in the studies on contraceptive use. It is expected that younger and older men are likely to have different reproductive objectives. One of the reasons for people in different age bracket to have varying reproductive objectives is that older men probably are holding on to the traditional big family size which may discourage the use of contraceptives especially in developing countries. In contrast, younger males may just be getting into reproductive stage and as such their contraceptive use may be low because they are likely to still be at lower parities (Daha *et al* 2008). It is important to know that age also influences the method of contraceptive used. Younger men often opt for the spacing methods if at all they have to use modern contraceptives while the older men go for methods like sterilization as they are more likely to have attained their desired fertility (Ringheim, 1993). A study carried out on Yoruba men on the relationship between age and contraceptive use also found that men of lower age 15 – 24 have high uninterrupted use of contraceptive compared to men in age 34 and above. A reason for this is that men of younger ages are probably still in school and cannot afford the burden of childbearing and as

such stick to contraceptive use to prevent unwanted pregnancy (Adewuyi & Ogunjuyigbe, 2003). There have been mixed findings on the association between marital status and contraceptive use.

A cross sectional study among women in a community in Nigeria showed a positive association between marital status of women and contraceptive use (Oye-Adeniran *et al*, 2006). Marital status was also a significant predictor of contraceptive use in a study carried out by Ankomah *et al* in 2011 in Nigeria. Ringheim in 1993 also found that most men believe that men should share fertility regulation responsibilities with their partners, but only a small proportion do so.

2.4.3. Socio cultural factors and Contraceptives

A body of evidences exist which demonstrates that use of contraceptives is associated with religious and belief of individuals (Warwick, 1986; Coale, 1986; Lesthaeghe, 1980 in Esabella, 2012). Religious affiliations affect customs and practices of individuals regarding general norms which include modern contraceptive use. The belief system that is propagated by a specific religion influences even the contraceptive method to be used. For instance, sterilization is not an acceptable contraceptive method among Muslims and Catholics (Ringheim, 1993). A study by Jones and Dreweke found that some individuals view the use of contraceptives as unacceptable due to their religious belief. For example contraceptive use is strongly opposed to by the doctrines of the catholic church and some other socially conservative religious organizations including Islamic fundamentalist (Jones and Dreweke, 2011). There have been mixed reports on how religion affects contraceptive use in a population depending on the religious composition of that particular population. A study in Ghana by Tawiah in 1997, the study surprisingly found that socio cultural variables such as religion and ethnicity do not have any significant effect on current use of contraceptives.

A possible explanation is that, once a person attains a higher educational status, his ethnicity and religious affiliation does not significantly influence his current contraceptive use. Contrary to this evidence, a study done on Nigerian males from the Yoruba ethnic group found that men who are Catholics had a significant lesser odds of using modern contraceptives when compared to men that were Muslims (Adewuyi & Ogunjuyigbe, 2003).

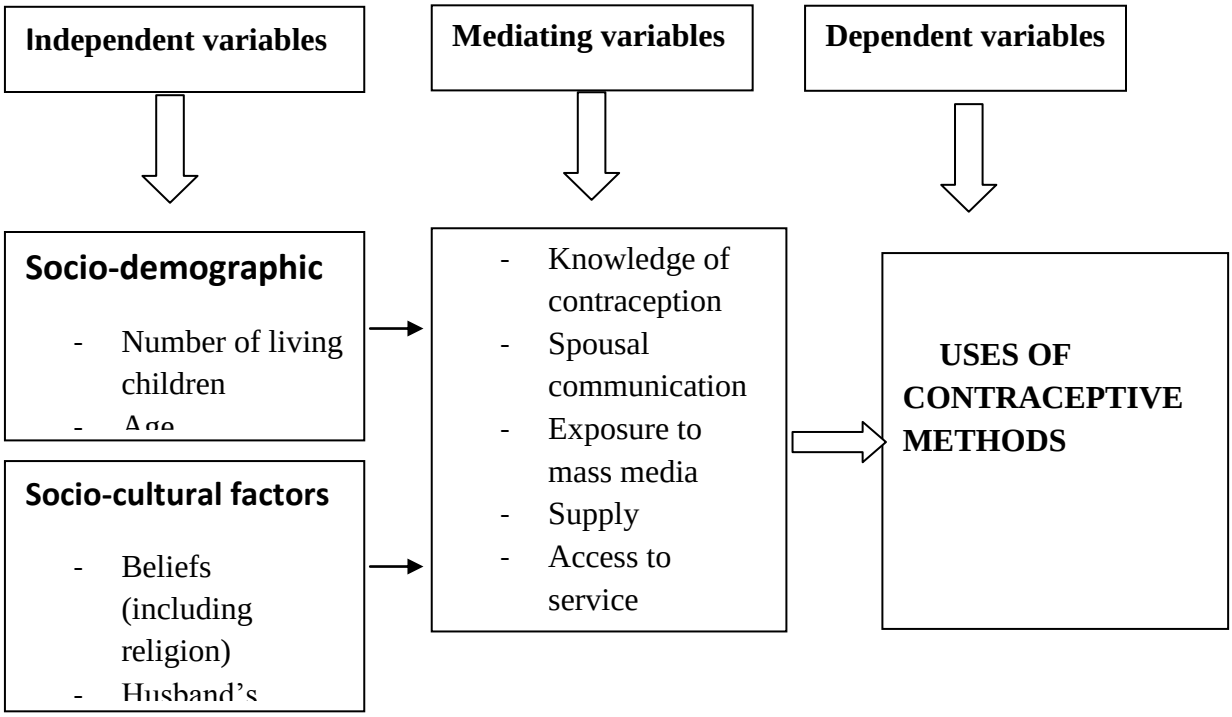


Fig 2.1 Conceptual framework showing the selected factors affecting contraceptive use.

Source: Adapted from Gizaw and Regassa (2011).

2.4.4 Supply and Demand Factors and contraceptives.

Studies have indicated that supply and demand factors have profound influence on utilization of family planning services which includes use of contraceptive methods. The overarching strategy of successful supply-side family planning programs is to ensure that contraceptive methods are as readily accessible to clients as possible. This includes ensuring that a wide range of affordable

contraceptive methods are offered, making services widely accessible through multiple service-delivery channels, ensuring that potential clients know about services, following evidence-based technical guidelines that promote access and quality, and providing client-centered services. These types of supply-side interventions ensure that women and couples are able to use contraceptive methods and family planning services effectively.

A different study in Lesotho, Africa found that the type of facilities to which women had access (e.g. hospital, clinic, community- based and employment – based) was a significant predictor of current use of contraception. Accessibility, reliability and responsiveness to women needs of contraceptives were also a predictor in the use of contraceptive methods by Iranian women. A study in Ethiopia showed that, problem of availability and accessibility influenced the use of contraceptive methods. The study in Bangladesh indicated that the main reasons for women not visiting MCH clinics were non availability of commodities, behavior of service providers and long waiting times. This was also evident in Iranian studies where women using contraceptive methods were dissatisfied with monthly provision of contraceptives and these led to seeking services from private outlets. Distance from the nearest health facility and availability of an all-weather road have a greater effect on contraceptive knowledge than they do on use. By contrast, health or family-welfare visits to the village in the previous month have a greater effect on use. From the UNPF report, it was observed that governments and service providers were aware of the importance of giving information as a part of family planning service delivery. Service providers are being trained to perform this function but such training did not seem to have the desired effect. Observation of consultations revealed that family planning clients often did not receive complete, accurate information about options available to them. When a method was selected, clients were only told how to use it and when to return for re-supply and/or check-up. Possible side-effects were rarely mentioned. The central goals of demand-side

family planning interventions include changing women's knowledge, men's knowledge, couples' knowledge, and attitudes about contraceptive methods and increasing their knowledge of contraceptive sources and use of family planning to meet their fertility desires. Communication through mass media (radio, television, or print) is an appealing strategy for the promotion of family planning because of its potential for expansive reach and its ability to address (in entertaining or informative way) issues that in many settings are culturally taboo. Other studies have shown that opposition from husbands, spousal communication had influence in the use of contraceptive methods. Thus, it is evident from different studies that use of contraceptive methods and uptake of contraception is a multifactor. Socio-economic status, cultural beliefs and value attached to children, educational level of a mother plays an important role.

2.5 SPOUSAL COMMUNICATION AND CONTRACEPTIVES

Khan and Patel (2005) reported that husband-wife communication on contraception and their reproductive goals suggests an egalitarian relationship between husbands and wife. Communication here encompasses both direct and indirect forms, ranging from verbal discussion to non verbal gestures (Lasee and Becker, 1997). Spousal communication is positively associated with contraceptive use. Demographic health survey data from seven African countries (Botswana, Burundi, Ghana, Kenya, Senegal, Sudan, and Togo) showed that the percentage of women using modern contraceptives is consistently higher in the group that had discussed contraceptive with their husbands in the year before the interview than in the group that had not (JHU/PIP, 1994). While discussion between couples or partners about contraceptive use is not a precondition for its adoption, its absence may be an impediment to use. Inter spousal communication is thus an important intermediate step along the path of eventual adoption, especially continuation of contraceptive use. Lack of discussion may reflect a lack of personal interest, hostility to the subject, or customary

reticence in talking about sex-related matters. Thus, promoting spousal discussion of contraceptive has frequently been advocated as a viable policy tool for narrowing the gender gap in partner's fertility intentions in developing countries. Discussion between spouses is expected to increase the use of contraceptive services, because sizeable minorities of women cite their husbands' non-approval as a reason for non use, despite having never discussed contraceptive with their husband. Understanding how spousal discussion affects the accuracy of reported participation or attitudes may help policy makers shape family planning programmes designed to lower unmet need (Laurie et al, 2004).

Tuloro, Deressa, Ali and Davey (2006) stated that discussion between couples on fertility issues is strongly associated with the use of contraceptives, indicating the importance of frequent discussions. Spousal communication in family planning has been found to be a crucial step towards increasing men's participation in safe motherhood (Biddle, Casterline and Perez, 1997). In addition, Ogunjuyigbe (2002) also opined that inter-spousal communication in Nigeria is a likely factor in the adoption and sustained use of contraceptive since it allows couples to discuss and exchange information that may change strongly – held beliefs as well as enable them question each other on what may appear unclear. Several studies have found a strong association between the literacy level of men and their attitude towards contraceptive use. Odumosu, Ajala, Nelson-Twakor and Alonge (2002) in a study on unmet need for contraception among married men in Urban Nigeria observed that men's education was negatively related to unmet need, but significantly for only secondary and tertiary education. In Africa, the decision on the number of children that a couple will have is typically made by men. In Nigeria, there is a high value placed on children and hence the use of contraceptive methods is significantly determined by the number of living children of a couple. According to Musalia (2003 in

Abubakar 2012), it is a taboo to be childless in many African cultures. The tragedy that befalls a childless couple is so great that any childless marriage will by and large fail. High fertility therefore enjoys community approval. Khan and Patel (1997) in a study of male involvement in family planning in India, discovered that spousal communication on family planning in most cases takes place only after the birth of two or three children and is mostly initiated by husbands. It was also posited that number of dead children was a factor related with contraceptive use. Contraceptive acceptance and continuation is negatively associated with the number of previous deaths of children. They discovered that senior women and women with five or more living children were more likely to have discussed family planning with their partners. The practice of family planning depends on knowledge of methods and the places where they can be obtained. The place of residence can positively or negatively affect the practice of family planning. Urban residents are much more likely than rural residents to have heard of contraceptive methods.

In traditional African societies, children are highly priced especially sons. Any marriage without a son is considered a disaster. This is a sufficient reason for divorce or taking of another wife. This is the case in all patrilineal societies since inheritance is through the male. Studies have shown that there exists a positive relationship between number of sons and adoption of family planning methods. Orji and Onwudiegwu (2002) reported in a study on contraceptive practice among married market men in Nigeria that out of four hundred and fifty respondents, 39.1 per cent of the respondents who reported that they were not using contraceptives, gave the following reasons: family size not yet complete, religious opposition, fear of contraceptive failure and continuous search for a male child. In many sub-saharan African cultures, spousal discussion of sexual matters are discouraged and other persons commonly in-laws, act as conduits, through which partners exchange ideas on these topics (Blanc *et al,* 1996).

According to a 1993 DHS, 45% of married women in Tanzania either did not know what their husband thought about family planning or thought their husbands disapproved of family planning, when in fact many of the husbands approved. Men's participation in or at least attention to conversation and exchanges of family planning matters, is not evenly spread throughout their reproductive lives. A man is more likely to engage in fertility-related communication in periods around reproductive events-childbirths or the perceived usually associated with weaning. Family planning specific conversations tend to occur when a man is psychologically ready for fertility control, that is, when he has come to terms with the practical and immediate utility of Family Planning. When such psychological readiness is absent, even if such conversations are heard, men are simply not interested. Men therefore, become interested in family planning when they decide to space the births of their children or when they are satisfied with the achieved number and sex composition of their children, even if they do not seek contraception explicitly for the purpose of preventing additional pregnancies. A study in Mozambique found that men who are in the middle of their reproductive years are somewhat more likely to participate in contraceptive-related discussion than others; however, even older men, with more offspring can be exposed to such discussions (Agadjanian, 2002). Researchers have however argued that women, who report frequent discussion, may in fact wrongly perceive that their partners disapprove of contraceptive, and may therefore feel inhibited from using a contraceptive method.

This line of reasoning is supported by an empirical research conducted in a wide range of context in Ghana, which shows that spouses who have discussed the topic are 2-10 times as likely as those who have not, to practice contraception (Lasee and Becker, 1997). A women can control her fertility without her husband's co-operation; yet when men and women are aware of and responsive to each other's health needs, they are more likely to obtain necessary contraceptive services. Moreover,

strengthening communication between partners about reproductive health and involving men in health promotion can lead to better health for the entire family (Drennan, 1998). Orji, Ojofeitimi and Olanrewaju (2007) in their study on assessing attainment level of spousal communication, employed Focus Group Discussion (FGDs) with couples consisting of 166 men and 234 women in central Ife: using Statistical Package of Social Science software (SPSS) version 13, observed that more than half of the respondents numbered 383, in the study have discussed with their spouse at least once. The male respondents hardly discuss contraceptive use with their wives: it was attributed to be a sign of promiscuity, and not necessary while the female respondents fear for not discussing with their husband is due to fear of rejection. In Kenyan study in 1996, about 83% of couples, one or both spouses reported having discussed contraceptive with their partners in the previous year. In 85% of couples, both partners approved of contraceptive, 6% each of either the couples approved and for 4%, neither of the couples approved. The 1993/94 second male motivation campaign in Zimbabwe encouraged couples to communicate more about family planning and to decide jointly on a contraceptive method. The proportion of women who reported discussing family planning often with their spouses or partners increased from 37% before the campaign to 57% afterwards. As men became more interested in family planning, many wanted to play an active role in the decision making process. Rather than leave family planning decisions to their wives or partners, men were more likely after the campaign to believe that they alone should be responsible for making such decisions or that the decisions should be made jointly.

The rise in interest in solely male decision-making recorded by the survey suggest that the campaign's reliance on traditional masculine images may have reinforced stereotypes about male decision-making and blurred campaign messages about the value of joint decision-making. Exit interviews, however, showed that, regardless of opinions expressed in the surveys, 61% of couples in

campaign areas actually decided jointly on a method (Kim *et al* 1999). According to the NDHS (2003) report, almost two-thirds of women said that they never discussed family planning with their husbands. Women aged 15-19 years were the least likely to have discussed FP with their husbands. However, it is notable that 12% of women discussed FP with their spouses, at least three times. In particular, women in their prime childbearing years were the most likely to have multiple discussions about FP with their husbands. The proportion of women who discussed FP with their spouses in the North West is 2%, the lowest in all the geopolitical zones.

2.6 GENDER PERSPECTIVES AND CONTRACEPTIVE USE

Gender is an array of societal beliefs, values, norms and attitudes that determine and shape what is acceptable as male and female behaviours and roles. According to Molokwu (2007) gender is used to describe those characteristics of men and women which are socially determined, in contrast to those which are biologically determined. Edewor (2001) defined gender as the differences between women and men within the same household and within and between cultures that are socially constructed and change over time. He further explained that these differences are reflected in roles, responsibilities, access to resources, constraints, opportunities, needs perceptions, views etc held by both women and men (Azikiwe, 2004). However, the gender dimension of women in Nigeria, including Benue State and okpokwu local government in particular is very discouraging and this may be due to the social responsibilities that come with the biological function of women which make them a peculiar force in the overall national development as noted by (Oke, 2001).

Furthermore Anagbogu (2005) listed some of the gender dimensions of women as child rearing, feeding the household , petty trading, farming, supporting the men marginalized in decision making in the family and society among others. Furthermore Nnadozie (2007) observed that because of the

social stigma attached to women's' roles, they are exposed to some problems which include rights of inheritance, widowhood, rape and sexual abuse, female Genital mutilation, wife battering, women trafficking, discrimination in appointment and women education, more so other areas in gender dimension include culture of patriarchy, equity, equality, access to resources. The differentiation between men's and women's roles and expectations involves a hierarchy in which men's activities and attributes are more highly valued so that men are given greater leverage over decision making and resources than women. Almost everywhere, but more fundamentally in Africa, the family remains the prime agent of socialization, the environment where sex-based roles and attitudes are learned and exhibited (UNAID,1999). Women have more of a stake in family planning, because it is they not men, who get pregnant, bear the physical and emotional strain of carrying pregnancy for nine months; if they live in the third world, they also face the substantial risk of dying in childbirth.

Men in contrast, share none of the burdens or health problems of pregnancy and childbirth. The narrow perspective of the role men can play in family planning and in the family in general is largely a product of male stereotype. In this traditional view, the typical man wants a large family to prove his masculinity. He is not in favour of family plannimg and he is unwilling to use FP methods. This stereotypical "macho" man has neither concern for the well-being of his partner nor interest in his own reproductive health and does not foresee any problems posed by rapid population growth. In all cultures, this profile fits some men but it does not fit all men Stokes, (1980). Within the context of socialization, every society prescribes appropriate roles for males and females, and these norms are inculcated and inhibited by individuals from childhood, and from generation to generation. The norms and folkways of the society, which children learn from their parents and kinsmen, are internalized and become part of their personalities and they feel guilty if they act against them. As such, sex roles and gender identities are formed through a process whereby an individual comes to

acquire values and adopt gender appropriate behavioral patterns. In all Nigerian societies, boys and girls learn early in life to distinguish between male and female roles by watching and helping their parents and elders around them, who also provide specific instructions on family and societal norms and appropriate behavior. Whereas boys stay close to their fathers and are trained in male roles and responsibilities, as fathers and heads of households, girls learn domestic chores from their mothers and significant female elders, and are taught maternal responsibilities, including how to be a good and submissive wife.

Ampofo (2001) observed that gender socialization, sexual attitudes and behaviors reveal that in almost all societies, the particular personality differences observed in males and females emerge from different ways in which the sexes are socialized. In Ghana, gender norms dictate that while girls should remain uniformed about sexual matters, boys are instructed on sexual matters by peers and family members; they are raised to see male aggression as a and are overtly or covertly encouraged to experiment with sex as a sign of maturity. Other social institutions that reinforce differential socialization include puberty rites for girls and various initiations rites for boys. All these help to buttress the ideology of male dominance over females, and males sexual attitudes which females are denied; it is with this orientation that a woman moves into a man's house and family at marriage, and is subjected to a new male dominant environment different from the one she was familiar with. As society modernizes, traditional gender ideologies come under growing pressure, and the differences between men's and women's views and preferences become increasingly hard. Studies that have focused on couples' productive and contraceptive decisions have often found considerable disagreement between spouses, even though their general reproductive goals and contraceptive attitudes may be similar (Biddlecom. *et al*, 1997 in Abubakar 2012). As fertility regulation and limitation is looked at through a gendered prism, men often see different kinds of problems and

barriers that women do not (Agadjanian, 2002). Given the overwhelming dominance of men in family life, there is the urgent need to change their orientation and behavior as a prelude to a positive change in family relationships and behavior, which have deep cultural roots. For family planning to succeed, it is important that men lend their utmost support. The transition from traditional societies to modern societies that is occurring throughout the world is generating a radically different culture for reproductive and sexual decision-making among men and women. When most of today's older generation were adolescents themselves, social roles and expectations were arguably better defined. In many developing countries, parents still have a tremendous influence over their children despite eroding traditional values, especially in urban areas.

Therefore, meeting the reproductive health needs of women mostly rests on the shoulders of parents. However, most parents do not discuss sexual matters with their daughters as a result of shyness, ignorance on sexual matters or societal norms that do not encourage open mother-with-daughter discussion on sexual matters. As was pointed out by Briggs (1998), most parents are either not knowledgeable on sexual matters or are embarrassed to discuss them with their daughters. Lack of information or misinformation about reproductive and sexual health may lead to teenage pregnancy. However, the lack of economic alternatives in the labour market and poverty are other factors that encourage girls to get pregnant and drop out of school prematurely (Al Azar, 1999). They may believe that the economic benefits of engaging in a sexual relationship with a sugar daddy is more rewarding than any economic opportunities that are available for better educated women. He further explained that young girls may also use pregnancy to hook a man of their liking or they may think it is important to prove their fertility in order to get a husband. More often than not, premarital pregnancy does not result in marriage. Instead the girl's family name and honour is soiled, their bride price is decreased; their education is ruined and their chances of getting marriage are lowered. They

become socially and economically dependent on their families. Political, social and economic changes and resulting social problem affect parent-child relationships, views of parental authority and the institutions that serve adolescents. There is great diversity in the circumstances of young people between and within countries.

In many setting, child parent relationship have traditionally been just one component of a web of extended family relations. However, according to Diloria et al., (1999) migration, new values and understandings, poverty, family dispersal and impact HIV/AIDs have reduced reliance on the extended family, particularly in cities. Many young people live without one or both of their parents and may not be able to rely on their families for support. Mufune et al (1999) report that, in Kenya, men who have some education on reproductive and sexual health are more likely than those who have not, to support their partners in family planning and contraception. They are also more likely to support their partners in pregnancy and in making better sexual and reproductive health care decisions. Therefore, the role of gender in family planning should not be downplayed. Both men and women together play an important role in fertility decisions, including decisions to use contraceptives and it is thus their responsibility. Ndunyu (1999) reports that family planning programes have been guilty in ignoring the role of men in family planning in their keenness to improves better contraceptive prevalence rates. In Africa, research has concentrated on finding out the nature of men's involvement in reproductive decision-making. Some studies (Babalola, 1999; Rono, 1999) reveal that men are instrumental in reproductive decision-making. This is because in most African cultures, upon marriage, a man and his family pay lobola (dowry price) to the family of the bride. An implicit outcome of this transaction is that it shifts reproductive decision-making power to the male side. Gender imbalances in sexual decision-making influence women's contraceptive use.

Waszak *et al.*, (2000) report that some women would rather risk pregnancies than ask a partner to use a condom. Gender roles and gender norms are culturally specific and they very around the world. Almost everywhere men and women differ from each other in power, status and freedom. However, in most societies men have more power than women. Gender roles begin at birth and span a lifetime. At very young ages boys and girls learn from their families and peers how they are expected to act around people of the same sex and of the opposite sex (Bender and Kosunen, 2005). Almost universally, young males experience more sexual freedom than young females. Gender has a powerful influence on reproductive decision-making and behaviour. In many developing countries, men are the primary decision makes about sexual activity, fertility and contraceptive use (Osayi Osemwenkha, 2004). Men are called "gatekeepers" because of the powerful roles they play in society as husbands, fathers, uncles, religious leaders, doctors, policy makers and local and national leaders. In their different roles men can control access to health information and services, finance, transportation and other resources. Gender is just one of the many factors that influence couples and affects their reproductive decision. Educational level, family pressures, social expectations, socio-economic status, exposure to mass media, personal experience, expectations for the future and religion also shape such decisions (Grady et al., 1993). In some developing countries, husbands dominate reproductive decision-making, whether regarding contraceptive use, family size, birth spacing or extramarital sexual partners. Traditional gender roles can jeopardize the reproductive health of both women and men. Inequalities in power often make women vulnerable to men's risky sexual behaviour and irresponsible decisions. Because of their gender roles, many women around the world have trouble talking about sex or mentioning reproductive health concerns. They may not be able to ask their partners to use condoms or to refuse sex even when they risk getting pregnant or being infected with STD, including HIV/AIDS. Women engage in dangerous sexual practices with

men because they are afraid of retaliation, such as being beaten or divorced because their gender roles place them in subordinate positions in society (Grady et al., 1993; Mufune *et al*, 1999; *et al.*, 2004). Kim *et al*. (2001) on the other hand report that gender roles with a host of economic factors contribute to risky sexual behaviours. Kim *et al.* (2001) further report that young women are socialized to be submissive and not to discuss sex with their partners, which leaves them unable refuse sex or insist on condom use. Women's economic dependence on men also leads young females to exchange sex for the opportunity of marriage of roe gifts, sometimes with older "sugar daddies". These are reports in the local newspapers that some of the "sugar daddies" engage in sexual intercourse with school-going young women in exchange for paying school fess and providing transport.

2.7 ATTITUDE TOWARDS CONTRACEPTIVE.

The attitudes of contraceptive held by men in many parts of the developing countries are often attributed to cultural or religious traditions different from those in the West. Few cultures assume that men will take primary responsibility for planning the family or that they will support women in their choice of contraceptive methods. In few societies are men expected to share equally the tasks of childrearing. Women do not have equal status with men, and males are often not held accountable for their acts. Yet no major culture or religious, tradition, be it Catholicism in Latin America, Islam in the Middle East, or tribal cultures in Africa encourages men to be irresponsible, to have more children than they, their wives, and their community can support Stokes, (1980).

The attitudes of elites, public servants, university teachers and students, and journalist have changed, at least in the Anglophone countries, faster than might have been anticipated. Part of the explanation for this change is globalization of society, but most of it springs from a lack of confidence induced by a decade and a half of grim economic news and the experience at the family level of meeting the costs of schooling and medical treatment. Most educated white collar workers now regard unrestricted

population growth as threatening to national and individual prosperity. The reversal has not been total. Most of the leaders even the family planning administrators in sub-Saharan Africa, do not have the dedication to lowering fertility levels that is widespread in Asia. Most would rather keep some distance between themselves and FP programmes and would not like to appear too devoted to the cause. Changing such attitude will be necessary if the region is to experience along-term replacement-level fertility within the next half century (Caldwell and Caldwell, 2002). The United Nations (1995) opined that husbands often report greater use of FP methods than their wives.

Adewuyi and Ogunjuyigbe (2003) confirmed this in their study in rural and urban Nigeria, where they observed the proportion of current use of contraceptive methods among married men to be higher than that of the females. About 50% of women and 38.1% of men indicated that they had talked about FP matters with their spouses on three or more occasion; more than 30% of the respondents had ever discussed FP matters with other persons other their spouses. When couples have a positive attitude towards FP, they are most likely to adopt a FP method. There is a significant regional variation which shows that, approval in the south tends to be higher than in the north. For example, 61% of women in the South-West said that both they and their husbands approved of FP, as do 51% of women in the South-East. However, more than half of women in the North-West said both they and their husbands disapproved of FP (NDHS, 2003).

Olawepo and Okedare (2003) showed in their findings that despite the influence of culture and religion in Ilorin, Nigeria; the positive attitude of men towards FP can improve family relations. About 25.5% of the respondents indicated that FP especially as related to their wives had enabled them to have more leisure time and spend much time with each child and their wives. According to Duze and Muhammad (2006), in their study of the attitudes of men towards FP in Northern Nigerian,

the attitudinal disposition of respondents towards FP methods was generally unfavourable. While 55%% of the respondents have unfavourable attitude, 35% have favourable attitude. On the other hand, 38.2% of the respondents were willing to use and allow their spouses to use FP for the purpose of child spacing and 61.8% were not willing to practice FP even for spacing births. Also 84% were not willing to or allow their spouses practice FP on economic grounds, only 15.2% expressed their willingness.

2.8. MEN'S INVOLVEMENT AND CONTRACEPTIVES USE

Toure (1996) observed that, given the elevated position of men in African society, involving them and obtaining their support and commitment to family planning is of crucial importance in the African region. It was stated that, most decisions that affect family life are made by men. The 1994 ICPD and the 1995 fourth world conference on women acknowledged the role of men in improving reproductive health. Reproductive health programs are likely to be more effective for women when men are involved. The role of men in the family, their relationships with their partners, gender patterns of society, male-oriented educational programs, and counseling activities on family planning all influence men's knowledge and behaviour regarding family planning. Willingness of husbands to adopt or allow their spouses to use family planning practices determines the pace of fertility reduction.

According to the International Planned Parenthood Federation (1984 in Toure,1996), the involvement of men in family planning would not only ease the responsibility borne by women in terms of decision-making for family planning matters, but would also accelerate the understanding and practice of family planning in general. Men can prevent women's contraceptive use and they themselves are an untapped group of potential users. Males are also primarily considered as a means of increasing contraceptive prevalence. The multiple decision making roles of men in reproductive

health, particularly family planning, have profound influences on women's health. Family planning is key for curbing the growth rate of a population and for the health of women of reproductive age. Reproductive health programs that attempt to reach women will have a higher probability of success if they also involve the husband or at least encourage such involvement (Becker 1996 in Ogunjuyigbe, Ebenezer and Liasu 2009). Therefore, an understanding of the males influence and the role they play in decision-making on contraceptive use can throw better light on mechanisms through which fertility reduction can be achieved. The reasons to involve men in contraceptive use are not hard to find. They have been enumerated in different articles and population reports. The growing HIV/AIDS pandemic, which has engulfed a large population in Africa and elsewhere, need men use of condoms. This calls for the exercise of responsible reproductive behaviour by both men and women in prevention of further spread of the infection (Ityai 2000, Drennan 1998, Khan 1997, UNFPA 1997, Roundi and Ashford, 1996). Moreover, men represent about half of the world's population, and use less than one-third of contraceptives, which are male methods or methods that require participation of both partners (FHI 1998, Ringheim, 1996).

The adaptation and correct use of female methods of contraception have been found to be positively affected by male involvement in contraceptive use. Moreover, men are more interested in reproductive health information than has generally been assumed (FHI 1998). A study in Gombe, Nigeria demonstrated a low number of respondents having the opinion that women have an independent right to contraceptive acceptance, choice and practice and echoed the importance of male involvement in contraception decision-making (Bukar *et al.*, 2013). Other compelling reasons for involving men in family planning are that millions of pregnancies are unwanted each year due to lack or failure of contraception and thousands of women die due to pregnancy complications where male involvement can make difference (UNFPA, 1997 and Drennan, 1998,).

2.9 CONTRACEPTIVES AND METHODS

About 85% of women will become pregnant within one year without contraception (Cleland *et al,* 2006). Thus, even the least effective form of contraception is considerably better than using nothing. There are a number of family planning methods available to both men and women. These methods can be divided based on several criteria such as natural/artificial, traditional/modern, temporary/permanent, male/female and oral/injectable/IUCDs. Natural family planning means abstinence from sexual intercourse during fertile period to prevent pregnancy. This includes the rhythm method (the calendar method), mucus method, basal body temperature method or a combination of these methods. This method has no systemic or long-term side-effects. However, these methods are based on the timing of the women's fertile period, which can be highly unpredictable, even if their menstrual cycles are regular. The timing is even less highly unpredictable with irregular menstrual cycles.

The fertile period occurred during a broad range of days in the menstrual cycles. On every day between 6 and 21, women have at minimum a 10% probability of being in their fertile period. Only about 30% of women had their fertile period entirely within the days of the menstrual cycle identified by the clinical guidelines, which is between day 10 and 17 and only 10 percent of women ovulate exactly 14 days before the next 11menses. Most women reach their fertile period earlier and others much later (Wilcox et al, 2000). In Malaysia, abstinence during the fertile period is the third most popular contraceptive methods used among all ethnic groups (Rohani, 1988 in Yahya, 2007). Some couples found that abstinence during the fertile period is difficult to practice consistently as it produce undesirable tension in their relationship. Other traditional methods include coitus interruptus or male withdrawal, which is one of the oldest method of contraception. The husband withdraws the penis just before the ejaculation to ensure that all sperms are deposited outside the vagina. It is a simple method,

moderately effective, widely acceptable by well-adjusted and motivated couples and does not require any professional supervision. Lactational amenorrhea method (LAM) is a contraceptive method that relies on, or uses, the state of infertility which results from exclusive breastfeeding. Other criteria necessary are that the woman is still having locational amenorrhea and up to six months post partum.

When these criteria are met, LAM can be more than 98% effective in preventing pregnancy (Hight-Laukaran V *et al*, 1996 in Yahya, 2007). As presently defined, the method is effective for maximum of six months, yet a large proportion of women remain protected from pregnancy beyond this time. Only about 5% (3-10%) of breastfeeding women have been known to conceive during amenorrhoea during the first year postpartum. Barrier methods of contraception prevent sperm in the ejaculate from entering either the vagina or the cervical or, by either mechanical or chemical means, or both. It includes male condoms, female condoms, diaphragms and cervical caps. It creates a barrier that prevents sperm from reaching the ovum. Male condoms are one of the most commonly used contraceptives. It is one of the oldest methods used to prevent pregnancy and sexual transmission of the diseases.

They were initially made from animal skins but most modern condoms are made from latex or polygurethrane. Use of condoms is advocated as an effective primary prevention for HIV/AIDS in the fight to control of the current epidemic. Spermicides can be used as a primary birth control method, or more commonly, as an adjunct to the barrier methods. They are chemical barriers that kill or inactivate sperm in the vagina before they can move into the upper genital tract. The spermicides are surfactants –surface-active-compounds that can destroy sperm- cell membranes. These barrier methods are safe and fairly effective if used consistently and correctly. It also can be used as a back up method in cases of failure by the barrier methods.

Hormonal methods are the most popular family planning method used worldwide. Ludwig Haber Landt, a physiologist in 1912 in Yahya, 2007 suggested that extracts of ovaries could be used as oral contraceptive. There are several types of hormonal contraception available. These include oral contraceptive pills, which include combined oral contraceptive pills, progestogen only pills and post coital contraceptive pills, injectable and implants. The first oral contraceptive, Enovid was marketed in the USA in 1960. Since then, many different steroidal contraceptive have been developed, progressively containing lower doses of estrogen and progestogen/progestin. More than 200 million women have used these preparations worldwide since 1960. By 1965, the pill had become the most popular birth control method used in the United states. Combined oral contraceptive pills contain two hormones, an estrogen and contains only active pills and requires 21 or 28 pills. The 21 pills pack contains 21 active pills and requires women to take a seven days break in between packs. The 28-pills contains 21 active pills and 7 inactive or hormones free pills. There are three types combined pills, which are biphasic pills and triphasic pills and triphasic pills, where the ratio of estrogen to progestin varies estrogen. They are especially suitable for women who are breastfeeding since this type of pills does not affect milk supply and quality.

Post-coital contraceptive pills are intended for emergency use and must be taken within 72 hours of a single episode of unprotected coitus and repeated exactly 12 hours later to prevent pregnancy. This method is indicated in a woman who is exposed to unexpected and/or unprotected sexual intercourse such as cases of rape. World-wide, this emergency post-coital contraception has been used extensively for over two decades. The options currently available include progestin alone (levonorgestrel, 750 mcg (prostinor), an esterogen-progestin combination, which comprises of combination of 100mcg ethinyl oestradiol and 500mcg levonorgestrel, which is called yuzpe regimen. The pregnancy rate in these treated women varies from 1% to 4%, depending on the stage in the cycle

when coitus occurred and also depends on the timing of the pill used. A recent analysis of the timing of pills use suggests an inverse linear relationship between efficacy and the time from intercourse to treatment. The earlier the pills were used, the more effective they were during the 72 hours period studied. Delaying the first dose by 12hours increased the odds of pregnancy by almost 50% (Piaggio *et al*,199). Injectable forms of hor monal contraceptive are considered safe, very effective, simple to use and easy to administer. Injectable contraceptives are among the most effect reversible contraceptive available, with a failure rate less than one percent after a year of use. It is particularly studied to the needs of young women, providing very high efficacy rate and less complication. The disadvantages include irregular bleeding, weight gain and delayed return to fertility. Injectable contraceptives work in several ways to prevent pregnancy.

The primary action is the inhibition of evaluation. Besides that, it also increases the viscosity or thickness of the cervical mucus, making it less permeable to sperm penetration to the uterine cavity. Another type of hormonal contraception is the contraceptive implant. It is an effective, long acting, reversible, low dose progestogen-only product, suitable for use in family planning programmes along with other currently available contraceptive preparations and devices. It offers long term contraception and is an alternative to the irreversible methods of contraception. Implants is inserted subdermally in the first seven days of menstrual cycle and once in place, it requires no further attention by the user. However, it must be inserted or removed by a specially trained health professional. The mode of actions includes inhibitions of ovulation, suppression of endometrial and increase the viscosity or thickness of the cervical mucus.

The effectiveness of this method is comparable to combined oral contraceptive pills and intrauterine device. Amenorrhea is common after insertion of implants, reported by 20% of users at any time in

the first two years (Kubba *et al*, (2000). Intrauterine contraceptive devices (IUCDs) are small plastic devices that come in different sizes and shapes and have a life span ranging from one to five years. It prevents pregnancy primarily by preventing fertilization. In the past, there were objections to IUCDs as it believed to function primarily as an abortifacient, preventing implantation of the fertilized egg. The IUCDs is inserted into the uterus through the cervix by a trained health professional at any time convenient to the user, normally within the first seven days after normal menses, or within the first seven days post abortion, or six to eight weeks post delivery, or within five days of unprotected sexual intercourse.

Grimse *et al* (2000) noted that the insertion of an IUCD immediately after abortion, either induced or spontaneous abortion was both safe and practical. Hanley and Huber (1992) also found that insertion of an IUCD in post menstrual and immediate post-partum period was convenient, efficient, safe and have a low incidence of infection. Sterilization is a permanent contraceptive option available to couples that have decided to end bearing child. Female sterilization involves occlusion or transaction of the fallopian tubes, commonly referred to as 'tubal ligation'. Male sterilization is performed by vasectomy. In many developed countries, this remains the most common birth control method at 30% worldwide for married couples, followed by intrauterine devices at 20% and contraceptive pills at 14% (Hamilton, 1997).

Despite calls for increased involvement of men in contraception, only the traditional methods of withdrawals and condoms are available (Kuba *et al*, 2000). The male condom is a essentially a sheath worn over the penis during intercourse. It is the most harmless form of modern contraceptives with a failure rate of about 12%. It prevents pregnancy by acting as a barrier preventing the sperm from reaching the ovum. The use of condom allows males have an active part in preventing pregnancy. It is suitable in couples who have infrequent sexual relationship and is only delaying pregnancy. Condoms

also protect males and females from contracting a sexually transmitted disease, including AIDS. They act as a barrier to organisms transmitting sexually transmitted disease. Some condom contain spermicidal to improve their effectiveness. Side effects are mainly allergy to latex rubber or to the lubricant. However, non rubber-based condoms are available for such situations. Studies on family planning programmes, policies and methods have increased drastically in the last decades as a result of the socio-economic problems influencing population growth, as well as public health problems, especially STD (sexually transmitted diseases) such as AIDS, using contraception as one of the means for family planning (United Nations, 1994).

CHAPTER THREE:

THE STUDY AREA AND RESAERCH METHODOLOGY

3.1 THE STUDY AREA

3.1.1 Location

Okpokwu Local Government Area is located between latitude 6^0 30'N to 8^{0}'30'N and longitude 7^{0}'30'E to 10 ^{0}'E. It has an area of 731 km² and a population of 176,647 according to the 2006 census. The local government is located about one hundred and seventy (170 km) kilometers Southwest of Makurdi, the State capital Benue State.. It shares land borders with Ohimini Local Government Area on the North, Ogbadibo Local Government area on its Western end, Ado and Otukpo Local Government Area on the East, Isiuzo Local Government of Enugu State on the South and Olamaboro local government area of Kogi State to the North West. Okpokwu Local Government Area was created out of the former Idoma Native Authority in 1976 as a result of the local government reforms throughout Nigeria by the then Obasanjo administration.

The Local Government which derives its name from the river Okpokwu, has since then given birth to two other Local Governments namely; Ado Local Government Area in 1989 and Ogbadibo Local Government Area in 1991. With it headquarters at Okpoga. It is transverse by three big rivers namely river okpokwu, river-oma, river Ideme and a stream flowing from ogbadibo L.G.A. The Local Government is made up of three main districts, namely: Edumoga, Okpoga and Ichama which together have twelve council wards. The wards include: Amejo, Eke, Ichama ward I, Ichama ward II, Ojigo, Okonobo,Okpale,Okpoga central,Okpoga North, Okpoga south, Okpoga west, and Ugbokolo. (Okokwu L.G.A 2013).

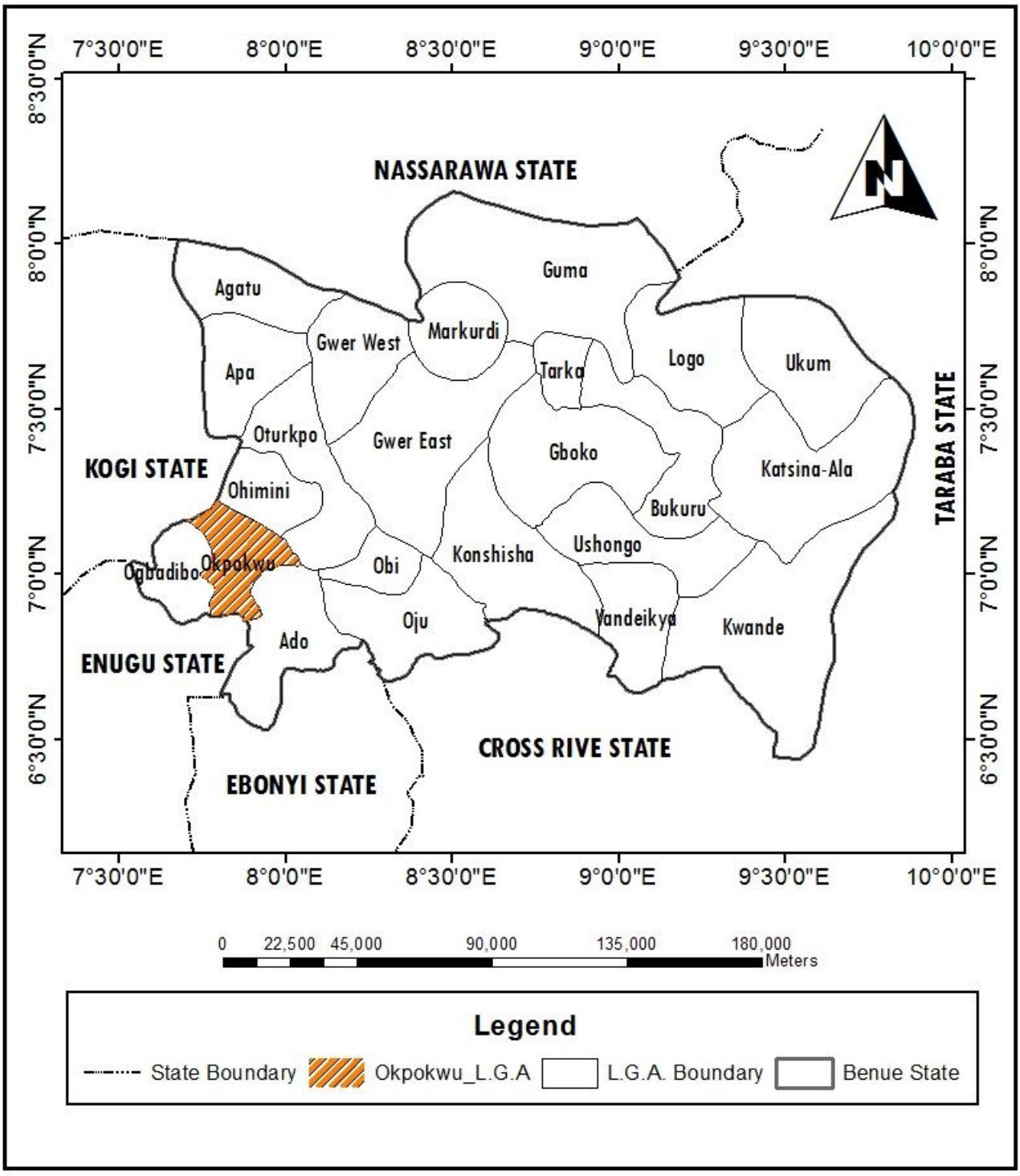


FIG. 3.1 Map of Benue State showing Okpokwu Local Government Area.
Source: Adopted from the Administrative Map of Benue State.

3.1.2 Economic Activities

Okpokwu local government Areas economy is based on agriculture as most of the indigenes are farmers. Their staple crops are yams and taro, known locally as cocoa yams. Harvesting is a time for great celebration. Yams are produced efficiently enough to export them to their neighbours. They also harvest the fruit of the oil palm which is processed into oil and exported to Europe in large quantities, making it a fairly profitable cash crop. Other crops of importance include maize, manioc, peppers, peanuts, tomatoes, squash, and sweet potatoes. Goats, sheep, chickens and dogs are kept by nearly everyone. Although hunting no longer provides a substantial contribution to the local economy, fishing has remained very important throughout the region. Sizeable number of the indigenes are also in other facets of life. Commercial activities such as banking transaction, wholesale, retail and petty trading, commercial transportation, hotel and communication services form the main economic activities. Other economic activities include civil service in government and institutions. Small industries such as barbing, catering, tailoring, craftworks provide the bulk population with employment.

The local government area has three banks; namely: Bank of the North,(Presently unity Bank),U.B.A both situated at Ugbokolo, and the Okpoga Community Bank, Okpoga.(presently micro finance Bank). These banks serve the business communities in the area. The local government is also blessed with some large markets, which serve the interest of the various market produce in the area. These markets include: Afor market, Ugbokolo; Ichama, Ede markets in Aliaba, Ede-Okpoga; Eke market in Olegbocho, Ai-dogodo and Ukwo markets at Okpoga and Adoga. These markets operate every five days and attract heavy business transactions. Okpokwu local government has an open door policy for investment. Prompt land acquisition and the provision of sites and services are readily available.

3.1.3 Religion And Culture

Christianity is the major religion and other traditional religion and culture forming the minority group. The traditional religion focuses on honoring lineage ancestors. The *Alekwuafia* festival celebrates the yam in what is referred to as *eja-alekwu*. Through the *Alekwuafia*, the Idoma worshipped ancestral spirits. At *Alekwu* communion, names of ancestors and the living dead are invoked so that through them the predator's supplication may be conveyed to the omnipotent God (*Owoicho*). The *Alekwuafia* is seen as a link between the living and the dead. Religiously, the *Alekwuafia* marks the height of communion and communication between the realms of the living. It ushers in blessings for adherents through their chants, songs and messages, thereby encouraging morality.

As a code of conduct, it is a symbol of peace, order and tranquility in the society. The ancestral spirits in form of the *Alekwuafia* is viewed as invisible watch dog of the family and communities. It is believed that if the living failed to observe the cultural norms and values of the Idoma, the ancestors will visit them with pestilence or, even death. It acts as strong instrument for social control against vices like adultery, theft and murder. A parallel cult that checks vices in Idoma land is the '*Onyonkpo*'. Morality among the Idoma are never compromised, hence the *Alekwu* cults exist to check them through warnings, followed by purification rites." Ochigbo S. Best (2008). Funeral ceremonies among the Idoma are often quite dramatic, with greater attention afforded to members of the community who have reached a combination of advanced age and prestige. Extensive funerals are held for both women and men in preparation for sending them on their final journey away from the village to the spirit world across the river. A memorial service, or second burial, is held for the deceased some time after the original burial in order to ensure that the dead pass on to the ancestor world in proper style.

3.2. RESEARCH METHODOLOGY

Methodology according to Kitchen and Tate (2000) can be defined as a coherent set of rule and procedures which can be used to investigate a phenomenon or situation. The method of data collection and the type of data used comprises the reconnaissance survey, primary and secondary types of data, sampling techniques and methods of data analysis.

3.2.1 Reconnaissance Survey

Reconnaissance survey of the study was carried out in order to be conversant with the area and this help to determine the sample, select the sampling frame or technique employed in selecting the sampling wards. It also guided the construction of the research instrument for data in terms of questions necessary to satisfy the objectives

3.2.2 Types of Data Obtained.

Data from men and women of reproductive age 15-49 were obtained. This include socio-demographic data such as: Age, religion, occupation, age at first marriage, level of education, income, marital status, level of knowledge and use of modern contraceptives, data on the factors that determine the knowledge of modern contraceptives, data on decision-making process in the use of modern contraceptive, data on the sources of information on modern contraceptives.

3.2.3 Sources of data

For the purpose of this research, data were collected from primary and secondary sources.

3.2.3.1 Primary Sources

The primary sources of data include responses obtained from the administration of questionnaires to the women and men of reproductive age (15-49). The questionnaires consist of structured questions specially designed to obtain information from the respondents on basic characteristics such as age, occupation, educational attainment, marital status, duration of marriage, ethnicity, types of marriage, religion, level of knowledge and use of modern contraceptives, differences in the knowledge and use of contraceptive, in rural and semi urban and the determinants of choice of modern contraception in the study Area. Also six Focus Group Discussion (FGDs) one in each of the selected wards with 6-10 members of the target population was carried out. Key informant interview (KII) was also carried out with the district or village heads

3.2.3.2 Secondary Sources

Secondary sources of data was obtained from textbooks, library research, journals, conference papers and other related works. The data obtained were collated and analyzed in relation to the level of knowledge and use of modern contraceptive among men and women in the study Area.

3.3 Sampling Design

Okpokwu local Government Area has a population of about 176,647(NPC, 2006). The study area is made up of twelve (12) wards both in rural and semi urban areas. The wards in the rural areas are Amejo, Ichama ward I, Ichama ward II, Okpale, Ojigo, Okpoga North Okpoga west. While the wards in semi urban area are Eke, Okonobo, Okpoga central ,Okpoga south and Ugbokolo (See Table 3.1). For this study, six (6) out of the twelve (12) wards were selected using the purposive sampling technique methods. Systematic sampling method was employed by drawing a list of the twelve (12) wards when arranged in alphabetical order, every Ist numbered ward in both rural and semi urban wards in that order was selected to make the sample frame.

Table 3.1 Sample wards in Okpokwu local Government Area.

Number of wards	Selected wards
Amejo	Amejo
Ichama ward 1	Ichama ward II
Ichama ward II	Ojigo
Inyle/okpale	Eke
Ojigo	Okpoga central
Okpoga North	Ugbokolo
Okpoga west Ugbokolo	
Eke	
Okonobo	
Okpoga central	
Okpoga south	
Ugbokolo	
Twelve	**Six**

Source: **Okpokwu L.G.A Office, 2013.**

To determine the sample size, Krejcie and Morgan (1970) method of determining sample size was adopted which state that for an area with a population between 75,000-999,000, the sample size could be 384. Since the population of the study falls between these ranges, the sample size used is 384. Purposive sampling method was adopted for the purpose of questionnaires administration at the ward level. In every ward, households with women and men of reproductive aged (15-49) were identified with the help of a local guide who is resident in the ward. The computation of the proportion of the questionnaire administered for each of the selected wards in table 3.2 below. The selection of these wards is purposive, due to the remoteness and accessibility of the area. The selected wards were

assigned a number of questionnaires proportionate to the population of each wards with the use of formula below.

$$\frac{n}{N} \times 384$$

n=ward population

N=Total population of selected wards.

Table 3.2 Selected wards and number of questionnaire administered

Selected wards	Total population	Number of questionnaire
Amejo	7,050	58
Ichama II	5,345	44
Ojigo	5,864	56
Eke	6,564	47
Okpoga central	8,688	71
Ugbokolo	13,104	108
Total	**46,615**	**384**

Source: Okpokwu L.G.A 2013

3.4 Method of Data Analysis

Both descriptive and inferential statistics were used in analyzing the data. The descriptive statistics was used to describe the characteristics of the respondents with the use of percentages. Summary of information in form of tables, chart, and figures were used. It was used also in analyzing objective (i),(ii), (v) (vi) and (v).Also inferential statistics was centered on Chi-square (X^2) which was used in analyzing objective (iii) and (iv) that is, whether there is significant difference between male and

female respondents in the knowledge and use of modern contraceptives. All tests were carried out at 0.05 level of significance.

CHAPTER FOUR:

PRESENTATION OF RESULT AND DISCUSSION OF FINDINGS

4.1 INTRODUCTION

The purpose of this chapter is to provide a demographic and socio-economic profile of individual male and female respondents which is essential for the interpretation of the findings. In comparing the level of knowledge and use of contraceptives of any population, it is very pertinent to assess the demographic as well as the socio-economic characteristics of the people under study. Some of the characteristics include age, sex, religion, ethnicity, income, occupation, educational attainment, number of children, type of union and place of residence among others. Their influence on contraceptive knowledge and use at each locality of the study is examined. Descriptive and inferential statistics through frequency table and pie chart were used.

4.2.DEMOGRAPHIC AND SOCIOECONOMIC CHARACTERISTICS OF RESPONDENTS

4.2.1 Place of residence

The analysis of place of residence of the respondents in Table 4.1 indicates that 51.6 percent of the respondents are residence in semi-urban areas while 48.4 percent are residence in rural areas.

This pattern could be traced in part to socio-cultural factors of less dominant roles performed by women especially in decision making. The place of residence can positively or negatively affect the practice of contraceptive.

Table 4.1 Distribution of Respondents by place of Residence

Place of Residence	Male		Female		Total	
	Freq.	%	Freq.	%	Freq.	%
Rural	78	20.3	108	28.1	186	48.4
Semi-Urban	117	30.5	81	21.1	198	51.6
Total	**195**	**50.8**	**189**	**49.2**	**384**	**100.0**

Source: Field survey, 2014

Semi- urban residents are much more likely than rural residents to have heard of contraceptive methods. According to NPC (2000), 83 per cent of married urban women have heard of a method compared with only 57 per cent of rural women. Varma and Rohini (2008) observed that women who approved of family planning and whose husbands also approved came mostly from the urban areas than the rural areas.

4.2.2 Age

Table 4.2 shows the percentage distribution of respondents by age. The age group 30 – 34 years constitutes 36.0 percent followed by age group 25-29 years with 22.4 percent.

Table 4.2 Distribution of Respondents by Age

Age Group	Male		Female		Total	
	Freq.	**%**	**Freq**	**%**	**Freq**	**%**
15-19	14	3.6	8	2.1	23	5.7
20-24	10	2.6	26	6.8	36	9.4
25-29	48	12.5	38	9.9	86	22.4
30-34	92	23.9	46	12.0	138	36.0
35-39	5	1.3	52	13.5	57	14.8
40-44	25	6.5	15	3.9	40	10.4
45-49	1	0.3	4	1.0	5	1.3
Total	**195**	**50.8**	**189**	**49.2**	**384**	**100.0**

Source: Field survey, 2014.

This is similar to the finding of Luka (2011) in Zaria where age 30-34 account 21.9% and 34.7% of the respondents followed by age 25-29 (19.8%) and 23.9% respectively. This is a clear indication that the study population is normal because the adult age groups are more experienced to give information about their reproductive issues. Also it constitutes the segment of the sexually active groups. At the ages of 40-above, reproductive ability by female parents ground to a stop (NPC, 2009) and only a few male parents may engage in further child bearing at 55-59 years of age. Age as a critical factor cut across issues involving decision-making on family size and reproductive health.

4.2.3 Gender

The distribution of the population according to gender in Figure 4.1 shows that 51.0% of the respondents are males and 49.0% are females. This is similar to the work of Abubakar (2012) and Luka in Zaria where the proportion of male are 69.5%, 82.9% and 30.5%,17.1% females respectively. The observed proportion of women compared to their male counterpart could be due to the nature of questionnaire administration. Secondly, it could be as a result of some cultural practices which tend to curtail women independence.

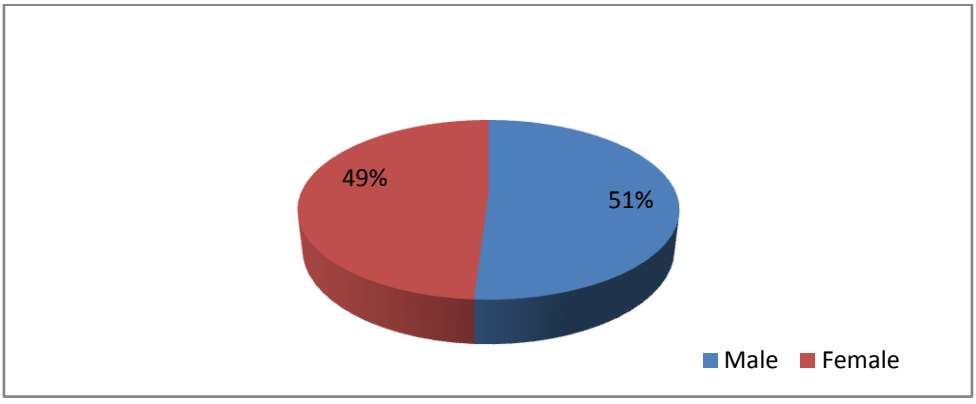


Figure 4.1 Distributions of Respondents by Gender

Source: Field survey, 2014

The sex and age distribution of any population has significant and important implications. The dynamics of a country's age and sex structure are central in any meaningful demographic analysis because its significant demographic economic and social implication (Laah, 2003).

4.2.4 Ethnicity

Ethnicity is one of the strong driving forces in cultural values which to an extent determine marital status and type of marital union engaged by women and men in any community. The ethnic composition of the respondents in Table 4.4 shows that Idomas constitute 95.3% of the respondents. This is not surprising because the study area is one of the local government areas among the six local government areas that constitute Benue south senatorial district which are mostly dominated by Idomas.

Table 4.4 Distribution of Respondents by Ethnicity

Ethnicity	**Male**		**Female**		**Total**	
	Freq.	**%**	**Freq**	**%**	**Freq**	**%**
Tiv	1	0.3	4	1.0	5	1.3
Idoma	187	48.7	179	46.6	366	95.3
Igbo	5	1.3	3	.8	8	2.1
Others	2	.5	3	.8	5	1.3
Total	**195**	**50.8**	**189**	**49.2**	**384**	**100.0**

Source: Field survey, 2014

The dominance of an ethnic group is related to its geographical location which is the Idomas. Numerous studies have analyzed the relationship between race/ethnicity and contraceptive use, nonuse and specific method choice. These studies reveal significant disparities in contraceptive nonuse among ethnic minorities

4.2.5 Religious affiliation

The distribution into the various beliefs adhered to by respondents is shown in Table 4.5. In all, 99.4% of the respondents are Christians. Comparatively, men account for 50.8% and women constitute 48.7% of Christians.

Table 4.5 Distribution of Respondents by Religious Affiliation

Religion	**Male**		**Female**		**Total**	
	Freq.	%	Freq.	%	Freq.	%
Islam	0	0	1	.3	1	.3
Christianity	195	50.8	187	48.7	382	99.4
Traditiona/Pagan	0	0	1	.3	1	.3
Total	**195**	**50.8**	**189**	**49.2**	**384**	**100.0**

Source: Field survey, 2014.

This is similar to the finding of Ogwuche in Benue (2007), Oyedokun (2007) in Osun, Envulado, et al (2009) in Jos where Christians constitute 89.1%, 83.3%,83.3% of the respondents respectively. This is to be expected due to the fact that, the study area is located in the middle belt closer to the eastern part of the country where Christians are the majority. This gives Christians higher percentage than other religion.

4.2.6 Religious denomination

Among those that adhered to Christian faith, 90.9 percent of respondents as shown in Table 4.6 are Catholics followed by protestants with 6.8.0%.

Table 4.6 Distribution of Respondents by Denomination

Denomination	Male		Female		Total	
	Freq.	%	Freq	%	Freq	%
Catholic	173	45.0	176	45.8	349	90.9
Protestants	18	4.7	8	2.1	26	6.8
Anglican	3	0.8	1	0.3	4	1.0
Pentecostal	1	0.3	4	1.0	5	1.3
Total	**195**	**50.8**	**189**	**49.2**	**384**	**100.0**

Source: Field survey, 2014

This is similar to the findings of Ogwuche (2007) in Benue where the proportion of Catholics constitute 68.3%. The relatively high proportion of catholic could be as a result of the influence of early missionaries from the west to the state who were mostly Catholics. The Catholics like the Muslims are generally against the use of contraceptives.

4.2.7 level of education

Education is seen as the acquisition of knowledge, values, skills and attitude which enables the individual to be useful to him/her self, to adapt to any changing environment and contribute to meaningful development of his/her community at large. The distribution of respondents by level of highest education attained is shown in Table 4.7 with 56.5% having attained primary education followed by (21.4%) secondary education and 12.5% attained post-secondary education.

Table 4.7 Distribution of Respondents by Education Levels

Education	Male		Female		Total	
	Freq.	%	Freq	%	Freq	%
Primary	108	28.1	109	28.4	217	56.5
Secondary	53	13.8	29	7.6	82	21.4
Quranic	4	1.0	7	1.8	11	2.9
Post-secondary	26	6.8	22	5.7	48	12.5
None	3	.8	22	5.7	25	6.5
Others	1	.3	0	.0	1	.3
Total	**195**	**50.8**	**189**	**49.2**	**384**	**100.0**

Source: Field survey, 2014.

This low level of education could be attributed to the individual value system. Some people see education especially female education as waste of time and resources because of the traditional belief that women's education ends in the kitchen. Other reasons may be lack of financial support, disability or sickness. Educational achievement may predict contraceptive use and nonuse, as well as specific method choice among men and women. Generally, the less education attained the higher the probability a contraceptive method is not used.

4.2.8 Occupation

Occupation is referred to as the activity which one regularly devotes oneself, especially ones regular work, or means of getting a living Wickleby (1992). The distribution of respondents by occupation according to background characteristics in Table 4.8 indicates that 43.5% of the respondents engaged in farming activities followed by 27.6% of civil servants.

Table 4.8 Distribution of Respondents by Occupation

Occupation	Male		Female		Total	
	Freq.	%	Freq	%	Freq	%
None	0	.0	1	.3	1	.3
Civil servant	87	22.7	19	4.9	106	27.6
Farming	66	17.2	101	26.3	167	43.5
Petty trader/Bus.	1	.3	11	2.9	12	3.1
Casual labourer	1	.3	3	.8	4	1.0
Students	15	3.9	30	7.8	45	11.7
Others	25	6.5	24	6.2	49	12.8
Total	**195**	**50.8**	**189**	**49.2**	**384**	**100.0**

Source: Field survey, 2014.

This is expected because most of the respondents are farmers. Even those who claimed to be civil servants and other activities are still involved in farming activities. This is similar to the finding of Yahaya (2011) in Zaria, Adugnaw e tal (2012) where 39.9% and 81.4% of the respondents are farmers respectively.

The above assertion is also supported by the result of FGD which says that:

> *Our major occupation here is farming and most of the civil servants also practice agriculture temporally because their salaries are not enough to cater for their needs.*
> *(A 31 year old Omoha Benjamin Eke ward)*

2.9 Income level

The distribution of respondents income shown in Table 4. 9 reveals that 59.9% of the respondents earned between N5,000 – N9,000 per month, another 28.1% earned less than N5,000. Only 3.4% earned 25,000 – 29,000, 0.3% earn 35,000 – 39,000 and 1.3% 40,000 above.

Table 4.9. Distribution of Respondents by Income Levels

Income Levels	Male		Female		Total	
	Freq.	%	Freq	%	Freq	%
Less than N5,000	44	11.5	64	16.7	108	28.1
N5,000-N9,000	118	30.7	112	29.2	230	59.9
N10,000-N14,000	21	5.5	5	1.3	26	6.8
N20,000-N24,000	0	.0	1	.3	1	.3
N25,000-N29,000	8	2.1	5	1.3	13	3.4
N35,000-N39,000	0	.0	1	.3	1	.3
N40,000 and above	4	1.0	1	.3	5	1.3
Total	**195**	**50.8**	**189**	**49.2**	**384**	**100.0**

Source: Field survey, 2014.

This occurrence is due to the fact that most work done by women in the study area are domestic in nature and unpaid for. This low level of income may be due to the nature of farming which is subsistence in the area which could be responsible for the rate of poverty. Relatively, it is obvious from the finding that most of the respondents are low income earners. This is so as more than half of the respondents earned below 93 US dollar that is eighteen thousand (18,000 naira) minimum wages as obtainable in Nigeria. This may also be attributed to the high number of respondents with primary education as highest qualification which may influence their opportunities to be gainfully employed in high income earning jobs. The level of income an individual earns could greatly influence his or her wellbeing. The work status of both men and women is linked to knowledge and use of contraceptives. Women who work outside the home have the higher rate of use than women who are house wives. Working women and men particularly those who earn cash incomes are assumed to have greater control over house hold decisions and increased awareness of the world outside home. Consequently, they have more control over reproductive issues/ child bearing.

4.2.10 Marital status

The presentation of marital status as shown in Table 4.10 indicates that 75.8% of the respondents are married and 12.5% are single. This is similar to the DHS (2008) report, with a little or more than 2/3 (69%) of women are currently married and an addition of 2% are in informal union (living together). The finding is also similar to the work Adegoke (1997) (60%) in Ile-Ife, Awusi 2012 (87.4%) in Delta, Abubakar, 2012 (91.8) in Zaria.

Table 4.10 Distribution of Respondents by Marital status

Marital status	**Male**		**Female**		**Total**	
	Freq.	**%**	**Freq**	**%**	**Freq**	**%**
Single	28	7.3	21	5.5	48	12.5
Married	154	40.1	135	35.2	291	75.8
Widow	8	2.1	23	5.9	31	8.0
Divorced	3	0.8	4	1.0	6	1.6
Separated	2	0.5	6	1.6	8	2.1
Total	**195**	**50.8**	**189**	**49.2**	**384**	**100**

Source: Field survey, 2014.

This could be attributable to the socio-cultural and religious background of the respondents hence; marriage between males and females is contracted quite early. Though the rate of remarriage is quite high because staying without a wife or husband at the age of 18years is regarded as an act of irresponsibility. This is partly the reason for the low proportion of respondents who are single and widow. This data also shows that marriage is hold high esteemed in both localities.

4.2.11 Type of marital union

The distribution of respondents by type of marital union shows that 78.4% of the respondents are in polygamous union while 21.0% are in monogamous. This is similar to the findings of Ekpo (2011) in markarfi L.G.A where the proportion of women in polygamous constitute 55.3%,while 22.5% of men and17.0% of women are in monogamous.

Table 4.11 Distribution of Respondents by Marital union

Marital union					**Total**	
	Male		**Female**			
	Freq.	**%**	**Freq**	**%**	**Freq**	**%**
Polygamous	155	40.4	146	38.0	301	78.4
Monogamous	40	10.4	43	11.2	83	21.6
Total	**195**	**50.8**	**189**	**49.2**	**384**	**100**
Number of wives If polygamous						
2	139	36.2	125	32.6	264	68.7
3	56	14.6	64	16.6	120	31.3
4	0	0	0	0	0	0
Total	**195**	**50.8**	**189**	**49.2**	**384**	**100.0**

Source: Field survey, 2014.

This could be attributed to the socio-cultural support of large family. Within the polygamous setting, 68.7% are married to two wives while 31.3.2% are married to three wives. Studies indicate that, women in a polygamous marriage are less likely to use contraceptives than women who live in monogamous marriages. A lower frequency of intercourse for women in polygamous marriages can discourage them from using contraception. Also, these women are likely to adhere to traditional values and customs that encourage large family (Martin, 2013)

4.2.12 Age at first marriage

The data in Table 4.12 show the age at first marriage, and it indicates that 50.5% of the respondents got married at the age of 20-24 years followed by age range 25-29 with 29.3%.

Table 4.12 Distribution of Respondents by Age at first marriage

Age at first marriage	Male		Female		Total	
	Freq.	%	Freq	%	Freq	%
15-19	34	9.9	31	8.1	69	18.0
20-24	84	21.9	110	28.6	194	50.5
25-29	71	18.5	42	10.9	113	29.4
30-34	2	0.5	6	1.6	8	2.0
Total	**195**	**50.8**	**189**	**49.2**	**384**	**100.0**

Source: Field survey, 2014

This could be as a result of socio-cultural support for early marriage. Marriage is generally associated with fertility which is related to life time exposure to maternal mortality. In some communities, especially in highly developed countries, couples in their late 30s and 40s are still attempting first pregnancy due to long delay in starting a family. However, in African countries (example Nigeria), women as young as 14 years have given birth or are in marriage unions and at the risk of pregnancy and childbirth (Ushie, 2009). Age at marriage is a proximate or intermediate determinant of fertility. In Nigeria for instance, the law states that a girl must at least complete her basic education and must be at least 18 years before entering into marriage union. However, enforcing such a law has been an uphill task given the cultural diversity in the country (Obong, 2003). This is because culture and religion plays significant positive influence on age of entry in marriage union and on fertility level (Lutz, 2003). Uniform policy of reducing fertility by increasing age at marriage to 18 years for all

Nigeria does not recognize the fact among the Igbo's and Yoruba's the age at first marriage is already higher than 18 years.In the rural area and the Northern Nigeria, the age at first marriage is usually between 14 and 17 years (Isiugo-Abanihe, 1996; Obong, 2003). The high incidence of early marriage in the study area signifies the partrilineal family system where in husbands or male partners determine familial fertility and family planning decision (Duze and Mohammed 2006)

4.2.13 Number of female children

Table 4.13 shows that 34.1% of the respondents have one female child, 19.0% 4 children and 17.2% 6 female children. This could be as result of high desired for either female or male child or desire for large families. The implication of this is that, there may be rapid population growth if not checked as those with few males or female may likely to give more birth for self reasons. This is further supported by Isiugo-Abanihe (2003) who noted that the seriousness of having a son is very strong in most parts of Nigeria where a male child is held in a very high esteem.

Table 4.13: Respondents Distribution of Female children

Female	Male		Female		Total	
	Freq.	%	Freq	%	Freq	%
1	101	26.3	30	7.8	131	34.1
2	22	5.7	34	8.9	56	14.6
3	10	2.6	16	4.2	26	6.8
4	26	2.8	47	12.2	73	19.0
5	2	0.5	8	2.1	10	2.6
6	23	6.0	43	11.2	66	17.2
7	1	0.3	3	0.8	4	1.0
8	2	0.5	2	0.5	4	1.0
9	7	1.8	4	1.0	11	2.9
	1	0.3	2	0.5	3	0.8
Total	**195**	**50.8**	**189**	**49.2**	**384**	**100.0**

Source: Field survey, 2014.

Hence, It is not surprising therefore that parents invest more in male children than female ones, to the point that in many households, male children attend school where the female are given out for marriage.

4.2.14 Number of Male children

Table 4.13 depicts that 27.9% has 2 male children followed by 18.0% with five male children.

Table 4.14: Respondents Distribution of Female children

Male	Male		Female		Total	
	Freq.	%	Freq	%	Freq	%
1	15	4.0	27	7.0	42	10.9
2	73	19.0	34	8.9	107	27.9
3	8	2.1	48	12.5	56	14.6
4	6	1.6	22	5.7	28	7.3
5	61	16.0	8	2.1	69	18.0
6	20	5.2	42	10.9	62	16.1
7	1	.3	1	.3	2	.5
8	3	.5	2	.5	5	1.3
9	7	1.8	4	1.0	11	2.9
	1	.3	1	.3	2	.5
Total	**195**	**50.8**	**189**	**49.2**	**384**	**100.0**

Source: Field survey, 2014.

4.2.15 Preferred number of children

The preferred number of children by respondents in Table 4.15 indicates that 51.0% of the respondents preferred to have 3-5 children and 31.3% preferred six children and above.

Table 4.15 Distribution of respondents by preferred number of children

	Male		Female		Total	
Preferred No	**Freq.**	**%**	**Freq.**	**%**	**Freq.**	**%**
1-2	6	1.6	12	3.1	18	4.7
3-5	93	24.2	103	26.8	196	51.0
6 and above	82	21.4	38	9.9	120	31.3
Others	14	3.6	36	9.4	50	13.0
Total	**195**	**50.8**	**189**	**49.2**	**384**	**100.0**

Source: Field Survey, 2014

The others could imply women and men that depend on God. This means that their desire for a particular family size is based on the number of children given to them by God. This is an indication that majority of the respondent's preferred 3-5 children. Consequently contraceptive practice remains low with high population growth. Ottong (1991) noted that the more dominant the position of male in the society, the higher the probability that the decision on the timing and number of children the wife/ partner will have remain the decision of the male.

4.2.16 Decision on the number of children.

The decision on the number of children in Table 4.16 indicates that husband makes the decision on the number of children as reported by 74.5% and joint decision constitute 17.7%. This is similar to the finding of Ekpo (2011) in Zaria. This further shows the dominant patriarchal nature of these communities wherein fertility is linked to paternal and not maternal irrespective of their religion.

Table 4.16: Distribution of respondents by Decision on the number of children

	Male		Female		Total	
Decision making	**Freq.**	**%**	**Freq.**	**%**	**Freq.**	**%**
Husband	125	32.6	161	42.0	286	74.5
Wife	21	5.5	7	1.8	28	7.3
Jointly	49	12.7	19	4.9	68	17.7
Others	0	.0	2	0.5	2	0.5
Total	**195**	**50.8**	**189**	**49.2**	**384**	**100.0**

Source: Field survey, 2014

The influence of culture, family organization and gender stereotype on family size makes the issues of decision on the number of children relevant to ethnographic studies. Men are proud of the number of their children particularly sons, because of the present and future benefits derived from them. In the absence of social welfare and security programmes, children constitute an important source of old age support for their parents. The abysmal low rate of contraceptive use in Nigeria of about 10% for modern method is a clarion call for development of communication interventions which can be implemented to encourage couples/partners to talk about the number of children to have, birth spacing and contraceptive use.

From FGD had with A 36 years old Mr Achigiri in Ugbokolo gave the reason why he decide on the numbers of children to have;

> *My wife is under me, so she cannot teach me how to control my family.*

Also a 32 years old Mrs Enuwa Linus in ugbokolo ward, I don't want my husband to divorce me, whatever number of children he want I am ready.

I will continue to give birth because I don't know the one that will succeed me or become the bread winner of the house tomorrow (Mathias ochigbo A 38 years old ward Okpoga central ward).

4.2.17 Number of Surviving Children

The distribution of respondents on the number of surviving children in Table: 4:17 shows that 36.5% between 1-2 children surviving followed by 4-6 18.8% and 9 and above children with 18.2%. This may arise from the desire to replace a dead child or to insure against childlessness. The survival status of children is likely to affect the practice of contraception.

Table 4.17 Distribution of Respondents by Number of surviving children

Surviving children	Male		Female		Total	
	Freq.	%	Freq	%	Freq	%
None	13	3.4	24	6.3	37	9.6
1-2	92	24.0	48	12.5	140	36.5
3-4	13	3.4	25	6.5	38	9.9
4-6	28	7.3	44	11.5	72	18.8
7-8	12	3.1	15	3.9	27	7.0
9 and above	37	9.6	33	8.5	70	18.2
Total	**195**	**50.8**	**189**	**49.2**	**384**	**100.0**

Source: Field survey, 2014

Parents who have experienced a death of a child may be less likely to use contraceptives than others of the same parity. The influence of polygamous union on women's decision-making on family planning is interlinked due to the tendency to compete amongst themselves, thereby making women not to be interested in family planning and contraceptive practice.

4.2.18 Birth Spacing

The distribution of respondents on the practice of child spacing in Table 4.17 reveals that 85.7% practice child spacing while14.3% do not.

Table 4.18: Distribution of Respondents according to interval

Birth interval					**Total**	
	Male		**Female**			
	Freq.	**%**	**Freq**	**%**	**Freq**	**%**
Yes	180	46.9	149	38.8	329	85.7
No	15	3.9	40	10.4	55	14.3
Total	**195**	**50.8**	**189**	**49.2**	**384**	**100**
Interval of Birth Spacing						
< 1	28	7.3	22	5.5	49	12.8
> 1	53	13.8	52	13.5	105	27.3
2years	109	28.4	108	28.1	217	56.6
Others	5	1.3	8	2.1	13	3.4
Total	**195**	**50.8**	**189**	**49.2**	**384**	**100.0**

Source: Field survey, 2014.

This distribution could be as a result of the fertility intention in the study area. Among those who practice child spacing, 56.6% does that within 2years which is similar to the findings of Ekpo (2011) in zaria where about 24.2% space their birth within 2 years, 27.3% more than a year.

4.2.19 Practicing of exclusive breastfeeding

Table 4.19 shows that, 49.2% of the respondents practiced exclusive breast feeding while 50.8% do not. Among those who practice excusive breast feeding, 32.0% does that within1-6months and 10.4% from 7-12 months. It is widely observed that exclusive breastfeeding is the period that the baby does not get water and food but breast milk from the mother.

Table 4.19 Distribution of Respondents Practice of exclusive Breastfeeding

Birth interval					**Total**	
	Male		**Female**			
Breastfeeding	Freq.	%	Freq.	%	Freq.	%
Yes	0	.0	189	49.2	189	49.2
No	195	50.8	0	.0	195	50.8
Total	**195**	**50.8**	**189**	**49.2**	**384**	**100**
Duration of Breastfeeding						
1-6month	0	.0	123	32.0	123	32.0
7-12month	0	.0	40	10.4	40	10.4
18months	0	.0	21	5.5	21	5.5
22month	0	.0	1	0.3	1	0.3
24month and above	0	.0	4	1.0	4	1.0
Total	**0**	**.0**	**189**	**49.2**	**189**	**49.2**

Source: Field Survey, 2014.

It is the most common family planning method used by African and when this is done within the period of six month: conception does not occur. The intensity of breastfeeding is believed to promote infants immunity against diseases.

FGD report

I cant practice breast feeding because i don't want my breast to fall.
(A 24 years comfort ukpoju Eke ward)

COMPARATIVE ANALYSIS OF KNOWLEDGE AND USE OF MODERN COMTRACEPTIVES

4.3.1 INTRODUCTION

The level of knowledge and use of contraceptive is inevitable for those who are in their reproductive age whose intention is to postpone a birth or who do not want any more children, and those who are not ready for a birth at all. This section presents results the type of contraceptive available in the study area, the sources of knowledge of modern contraceptives, the level of knowledge and use of modern contraceptive, factors that determine the knowledge of modern contraceptives, the decision making process on the use of modern contraceptives in the study area, the challenges of contraceptive use and the strategies employed to solve the challenges in the study. Both male and females were asked separately, using structured questionnaires about their knowledge and use of modern contraceptives.

4.3.2 Distribution on the level of knowledge of contraceptives

Table 4.20 indicates 89.9% of male and female reported to have heard of modern contraceptives while 10.1% have not heard. This high level of knowledge of modern contraceptive could be attributed to the vigorous campaign embarked upon by the government and Nongovernmental organization (NGOs) in providing information to its citizenry about their reproductive health issues thus, people are becoming more exposed to contraceptive knowledge (Agbese, 2011). The result is in agreement with Abubakar, (2012) in Zaira (97.7%). The sex analysis reveals that the knowledge of contraceptive among women is slightly higher (45.6%) than their men counterpart (44.3%).

Table 4.20 Distribution of Respondents on Knowledge of Contraceptives

Heard of	Yes		No		Total	
	No.	**%**	**No.**	**%**	**No.**	**%**
Male	170	44.3	25	6.5	195	50.8
Female	175	45.6	14	3.6	189	49.2
Total	**345**	**89.9**	**39**	**10.1**	**384**	**100.0**

Calculated chi-square= 3.082 df= 1 p- value = 0.56 Not significant

Source: Field Survey, 2014.

This is similar to the finding of mammam (1992) on fertility differentials in Kaduna metropolis where the knowledge of family planning among women constitute 84.3% and men accounts for 77.6% and Idonije, Oluba and Otamare, (2011) in Ekpoma with 42.3% of male and female 60.4% respectively and Nigeria demographic health survey DHS (2008) report where 72% of all women and 90% of all men know at least one contraceptive method. Chi-square analysis on the significant difference between male and female respondents in the knowledge of contraceptives reveals the following result x^2 = 3.082, df=1 p= 0.56 is not statistically significant. Knowledge of contraceptives is considered one of the essential factors associated with effective use of these methods. Biney (2011) observed that lack of knowledge about contraceptives among Ghanaian women led to failure of contraceptive use which in turn led to unintended pregnancies and induced abortions.

Table 4.3.3 Source of knowledge on contraceptives

The distribution of respondents on the sources of contraceptive information reveal that, about 39.9% of respondent sourced the information on contraceptive from electronic media followed by 26.8% from family members. This is because the most effective and fastest means of communicating to people about their reproductive health issues is through the media.

Table 4.21 Distribution of Respondents by source of knowledge of contraceptives

Sources of knowledge	Male		Female		Total	
	Freq.	%	Freq	%	Freq	%
Friends	12	3.1	10	2.6	22	5.9
Family	56	14.6	47	12.2	103	26.8
Electronic media	83	21.6	69	18.0	152	39.9
Hospital	37	9.6	49	12.8	86	22.4
Print media	1	0.3	9	2.3	10	2.6
Schools/Offices	6	1.6	5	1.3	11	2.9
Total	**195**	**50.8**	**189**	**49.2**	**384**	**100.0**

Calculated chi-square X^2 =24.551 D/f = 5 p value =.000

Source: Field Survey, 2014.

This is similar to NDHS (2008) finding which reported that radio is the most frequent source of contraceptive message for both men (59%) and women (40%) of reproductive age (25 -49). The third major source of information on contraceptive is hospital such as doctors, nurses others accounting for 27%. The justification for this is that some of the campaign on family planning is being carried out by medical personnel with the state ministry of health (Agbese, 2011). The high proportion of hospital among women could be as a result of the massage being targeted at them. Also, could be attributed to their regular attendance at the hospital for delivery and check-up during pregnancies especially those in the semi-urban areas. chi-square shows the following result X^2 =24.551 D/f = 5 p value =.000 is statistically significant. There is evidence that family planning messages through media may play

an important role in increasing the knowledge of FP methods and its acceptance and use, especially in those areas where the literacy level is low (Saluja *et al.*, 2011; Fikree *et al.*, 2001). Cheng (2011) established that in Taiwan mass media and social networks played important roles in disseminating contraceptive knowledge and that women transformed this knowledge into behaviour - that is, contraceptive knowledge reduced fertility.

4.3.4 Availability of contraceptive within the locality.

Figure 4.2 shows that 72.0% of respondents attests that contraceptive is easily available while not easily available constitute 28.0% within the locality. It implies that despite some of the respondents are in the rural area, contraceptive methods are made available and could be attributable to the establishment of comprehensive primary health care (PHC) centers around the state in order to extend services to the poor and rural dwellers Anonymous, 2009. Information on the availability of contraceptives facilities in any society is an indication that family planning programmes are making huge efforts to providing the population with family planning services and methods. The desire for a smaller family, size is becoming widespread as a result of the country's economic crises. This has led to conscious effort by men and women to decide on how many children to have and when to have them. This is made possible by availability, accessibly and affordability of modern contraceptives methods in a locality (Cunningham and Cunningham, 2008).

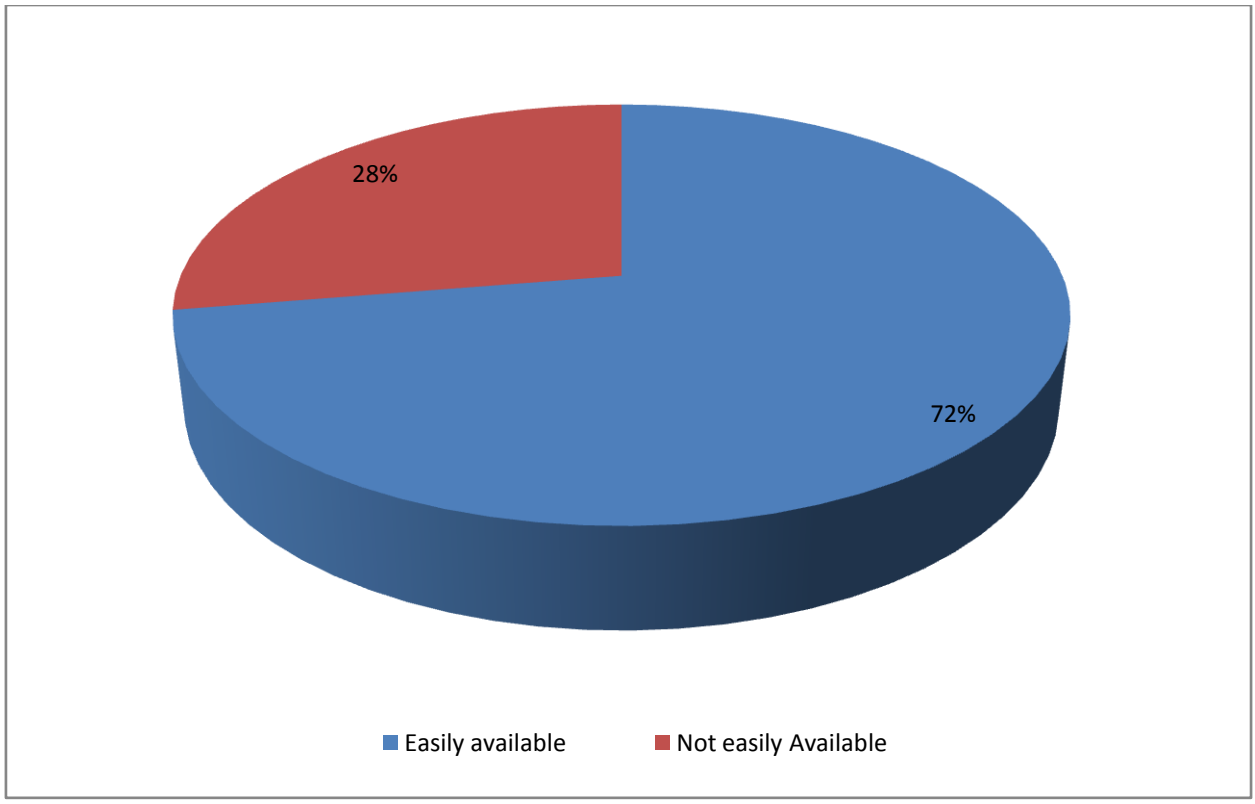


Figure 4.2 Percentage Distribution on the Availability of Contraceptive Service within the Locality

Source: Field Survey, 2014

In addition, studies have indicated the need for availability, accessibility and affordability of family planning methods in localities to help clients aid in diffusing family planning ideas and successful implementation of family planning programmes. Although, it said that 100 million women globally desire to adopt family planning methods , but most African women do not have access to it. (Cadwell et al, 2002; Cunningham and Cunningham, 2008).

From the FGD:
I can't go to any far place because of contraceptive and if I should go who will take care of my children. If my husband is not ready to buy any one he feel like using I will keep quiet.
(A 32 years old Enyanwu Apeh Ojigo ward)

4.3.5 Level of use of modern contraceptives.

The distribution of respondent's level of use of contraceptives presented in Table 4.22 shows that 12.2% respondents are currently using modern contraceptives while 87.8% are not. This low usage of contraceptive could be partly as a result of the level of education, culture and religious background of the respondents. This shows that the use of contraceptive in this part of the country is below the figure released by the National population commission where 23.7% of currently married women had ever used one method.(NPC and ICP macro, 2009). The sex analysis of the respondents reported that the proportion of male currently using contraceptives (7.0%) is slightly higher than women (5.2%).

Table 4.22 Distribution on Respondents level of use of contraceptives

Using	**Yes**		**No**		**Total**	
	No.	**%**	**No.**	**%**	**No.**	**%**
Male	27	7.0	165	43.8	195	50.8
Female	20	5.2	162	44.0	189	49.2
Total	**47**	**12.2**	**337**	**87.8**	**384**	**100.0**

Calculated chi-square = 1.451 df= 1 p- value = .0276 Not significant

Source: Field survey, 2014.

This shows that after many decades of contraceptive activity, there is still wide gap between knowledge and usage. This is worrisome in the face of increased sexual activity among men and women and the hazard of sexually transmitted diseases, unwanted pregnancy maternal mortality. Chi-square result reveals that $X^2 = 1.451$, d/f= 1 P- value= .276. This indicates that the use of contraceptives among male and females is not statistically significant. The low utilization of contraceptives can also be attributed to limited capacity of the health care system and structure within

which contraceptive services are offered. Secondly, unwanted fertility will continue to be experienced in this part of Nigeria because of the low modern contraceptive uptake by men and women. The low contraceptive usage suggests the need for sexual and reproductive health education program to promote the use of contraceptive services in the study settings.

Table 4.3.6 Reasons for Contraceptives use by Gender

In considering the reasons for the usage of contraceptive, 73.9% approved the use of contraceptive to delay pregnancy and 20.6% have achieved desired number of children.

Table 4.23 Reasons for Contraceptives use by Gender

Reasons For contraceptive use	**Male**		**Female**		**Total**	**%**
To delay pregnancy	154	40.1	130	33.8	284	73.9
Desired number of Children achieved	36	9.4	43	11.2	79	20.6
Lack of economic Resources	5	1.3	16	4.2	21	5.5
Total	**195**	**50.8**	**189**	**49.2**	**384**	**100**

Calculated chi-square X^2 3.132 df= 2 P- value= .209

Source: Field survey, 2014.

This is similar to the findings of mamman (1992) which shows 48.0% and 21.0% of the respondents approved of family planning because they want to delay the next pregnancy and to terminate child bearing accordingly and Ekpo (2011) with 21.1%. This means that the achievement of family planning programmes lies in its efficacy in delaying pregnancy which on the long run helps to space birth.

During the FGD, female respondents said:
Our culture is against the use of contraceptives and women are not allowed to use any form of contraceptives without the approval of their husband
(27 year old Iganya Ogbole Okpoga central).

4.3.7 Reasons for discontinuation

Among those who had ever use contraceptive and some had to discontinue for one reason or the other in Table 4.24 indicates that, 75.3% of respondents stop using contraceptive because their spouse disapprove of while 14.6% of respondents want more children. This is not unexpected as decision related to reproductive issues is mostly taken by men. Also, this could be as a result of restriction imposed by tradition and religion of the respondents on contraceptive practice.

Table 4.24 Distribution of Respondents by Reasons for Discontinuation of contraceptive use

	Male		**Female**		**Total**	
Reasons for Discontinuation	**Freq.**	**%**	**Freq.**	**%**	**Freq.**	**%**
My body reacted to it	2	0.5	5	1.3	7	1.8
Want more children	31	8.1	25	6.5	56	14.6
My spouse disapprove of it	148	38.5	141	36.7	289	75.3
No regular supply	12	3.1	7	1.8	19	4.9
Expensive	1	0.3	0	.0	1	0.3
Others	1	0.3	11	2.9	12	3.1
Total	**195**	**50.8**	**189**	**49.2**	**384**	**100.0**

Source: Field survey, 2014.

The predominance of spousal disapproval shows the strong influence of men's role and responsibility on women reproductive health issues. The implication is that, there will less demand for contraceptive except husband and cultural opposition is removed.

If I try to use any form of contraceptive method without my husband consent, either me or my husband may face the consequences by pleasing the gods and if my husband use any method on me since he have the final say, he will be punished by the gods.
(A 26year old Ondoma Ochigbo Christiana Ojigo ward).

4.3.8 Where contraceptive service was obtained

Information on where respondents obtain contraceptive methods is useful for family planning programme managers and implementers for logistic planning (NDHS, 2008).Table 4.25 indicates that 60.9% of the respondents obtained contraceptive from public hospital followed by 21.3% from private hospital. This is similar to the finding of Abubakar in zaria where private and public medical sectors are the main centres of family planning services. This is an indication that there are available healthcare centers due to government effort where contraceptive service could be obtained but, religious belief and spousal disapproval serve as a barrier to it usage.

Table 4.25 Distribution of respondents by where contraceptive service are obtained

Service centre	Male		Female		Total	
	Freq.	%	Freq	%	Freq	%
Public hospital	120	31.3	114	29.7	234	60.9
Private hospital	55	14.3	27	7.0	82	21.3
Herbal medicine	3	0.8	25	6.5	28	7.3
Medicine vendors	12	3.1	17	4.4	29	7.6
Pharmacy	4	1.0	6	1.6	10	2.6
Others	1	0.3	0	.0	1	0.3
Total	**195**	**50.8**	**189**	**49.2**	**384**	**100.0**

Source: Field survey, 2014.

The high patronage of public hospitals is attributable to the low cost of contraceptive service offered by the government. These findings differs from the findings of NDHS (2008) which found that

private hospitals provided 60% of family planning supply while those who reported public hospitals were only 23.0%.

4.3.9 Payment responsibility

Table 4.26 shows that husband account 68.2% followed by joint payment 19.0. This payment pattern is keeping with the religious and cultural nature of a typical Idoma community where in it is expected of the husband to pay for contraceptive service or jointly which is not expected of the women to do without the consent of their husbands.

Table 4.26 Distribution of Respondents on responsible for payment

Payment	Male		Female		Total	
	Freq.	**%**	**Freq.**	**%**	**Freq.**	**%**
Husband	135	35.2	127	33.0	262	68.2
Wife	26	6.7	23	6.0	49	12.8
Jointly	34	8.9	39	10.2	73	19.0
Total	**195**	**50.8**	**189**	**49.2**	**384**	**100.0**

Source: Field Survey, 2014.

This is not unexpected as women are not expected to use any form of contraceptive without the consent of her husband. This reaffirmes the findings of Ekpo (2011) in markarfi and Tyoden, 2010 which reveals 45.0% and 40.1% payment by husbands.

4.3.10 Determinants of contraceptive adopted

The main factors determining a particular method of contraceptives by individual contraceptors presented in Table 4.27 shows that both male and females reported spousal approval as the main

determinant of the method adopted with 56.5% of the respondents followed by 12.5% convenience of the practice. This is in keeping with the finding of Ekpo (2011) where 27.0% reported spousal approval as the determinant of contraceptive use. Men as the main decision maker influences women attitude to the practice of contraceptives since men's role on women family planning cannot be ignored because they are actively involved in reproductive issues as clients.

Table 4.27 Distribution of respondents by Determinants for contraceptive adopted.

Determinants of contraceptive use	Male		Female		Total	
	Freq.	%	Freq	%	Freq	%
Cost	15	3.9	21	5.5	36	9.4
Convenience	35	9.1	13	3.4	48	12.5
Spousal approval	105	26.6	115	29.9	217	56.5
Availability	22	5.7	14	3.6	36	9.4
Effectiveness	11	2.9	23	6.0	34	8.8
Others	10	2.6	3	0.8	13	3.4
Total	**195**	**50.8**	**189**	**49.2**	**384**	**100.0**

Calculated chi-square X^2 =8.741 df= 6 p-value =.257

Source: Field Survey, 2014.

This reaffirmed the result of Canda, DeGuzman, Hisanan and Baking (2000) who posited that Filipino men greatly influence their wives decision to practice family planning and that, the husbands consent is crucial to their wife's use of a method. Female spouses are believed or expected to submit to their husbands decision regarding family planning matters to maintain marital harmony. Chi-square result also reveals that x^2= 7.752, df = 6 value = .257 is statistically significant. The use of contraceptives by women is strongly determines by male spouse while such influence is less on men.

4.3.11 Decision making process on contraceptive use

The distribution of respondents on decision making on contraceptive use in Table 4.29 shows that 64.3% of respondents reported husband as the main decision maker on the use of contraceptives followed by 26.8% joint decision (husband and wife). Rarely did the wife make such decision on her own.

Table 4.29 Distribution of respondents by Decision makers on contraceptive use.

Decision maker	Male		Female		Total	
	Freq.	**%**	**Freq**	**%**	**Freq**	**%**
Husband	150	39.8	97	3.4	247	64.3
Wife	8	2.1	13	25.3	21	5.5
Jointly	36	9.4	67	17.8	103	26.8
Medical professionals	0	.0	2	.5	2	0.5
Others	1	.3	10	2.6	11	2.9
Total	**195**	**50.8**	**189**	**49.2**	**384**	**100.**

Calculated chi-square= X^2 31.171 df= 4 p- value = .000

Source: Field survey, 2014.

This is expected due to the societal support of men absolute control of the household's including the use of contraceptives or child spacing and women are expected to respect their husband's decision. Chi-square result also reveals that x^2= 31.171 df = 4 value = .000 is statistically significant. The decision to use contraceptive method is predominantly husband decision. Messages directed at husband would be a better information strategy to improve the level of contraceptive use in Nigeria. Since the husband is very important in family decision-making, it is essential that the male should be

adequately informed on population issues. This is necessary in order to increase his understanding and enhance his encouragement and support for his wife who is the main target of contraceptive innovation. Reproductive health programs that attempt to reach women will have a higher probability of success if they also involve the husband or at least encourage such involvement. Therefore, an understanding of the males influence and the role they play in decision-making on contraceptive use can throw better light on mechanisms through which fertility reduction can be achieved.

4.3. 12 Method known and used

Table 4.30 shows that breast feeding/LAM 96.9%, condom, male/female 91.9, and pill 74.0% as the major known method of contraceptive by the respondents followed injectable 39.0%, Douche 25.6% and others 25.6%.

Table 4.30 Distribution of Respondents on contraceptive methods known

	Male		Female		Total	
Methods known	**Freq.**	**%**	**Freq.**	**%**	**Freq.**	**%**
Pills	100	26.0	184	47.9	284	74.0
Injectable	60	15.6	90	23.4	150	39.0
Intra-Uterine Device	8	2.1	4	1.0	12	3.0
Diaghram	0	.0	0	.0	0	0.0
Sterilization(female)	0	.0	0	.0	0	0.0
Male sterilization	8	2.1	2	0.5	10	2.6
Douche	16	4.2	44	11.5	60	25.6
Condom(Male/female)	196	51.0	160	41.2	352	91.9
Breastfeeding	102	26.6	270	70.3	372	96.9
Others	65	16.9	30	7.8	95	24.7

The percentage of men and women who reported the knowledge and use of specific contraceptive method as shown in Table 5.11 also shows that, the condom (51.0%) pills (26.0) and LAM (26.6) is the most popular methods among men and while in the case of women, the most popular method are

Breastfeeding (70.3%) pills (47.9) inject able (23.4) and female condom (41.2%) Among men, the least methods used are diaghram sterilization, loop and breastfeeding. Among women the least methods used are breast feeding, pills and female condom. There appear to be a wide gap between knowledge and use. The proportion of the respondents that have ever heard of contraceptive devices seem to be higher than the proportion that has ever used. This could be as a result of a sense of guilt that normally surrounds the practice of contraception.

Table 4.31 Distribution of Respondents on contraceptive method used

	Men		**Women**		**Total**	
Methods used	Freq.	%	Freq.	%	Freq.	%
Pills	40	10.4	80	20.8	120	31.2
Injectable	23	6.0	20	5.2	43	11.2
Intra-Uterine Device	1	0.3	2	0.5	3	0.8
Diaghram	0	.0	0	.0	0	0.0
Sterilization(female)	0	.0	0	.0	0	0.0
Male sterilization	37	9.6	0	.0	7	1.8
Douche	18	4.7	22	5.7	40	10.4
Condom(Male/female)	160	41.7	192	50.0	356	92.9
Breastfeeding	0	.0	361	94.0	361	94.0
Others	75	19.5	20	5.2	95	24.7

while 74.0% are the major known method of contraceptive by the respondents followed by injectable 39.0%, others 24.7%, douche 25.6, IUD 3.0% while male sterilization have the least 2.6%. This in agreement with the finding of Idonije, Oluba, Otamare (2011) in Ekpoma where condom constitute 73%, Osonwa *et al* (2013) in cross river 50% This finding is also in keeping with the findings of Orji and Onwudiegwu and the 2008 Nigeria NDHS, which both showed that the male condom was also the most common modern method ever used by married men. Only few of the respondents had been sterilized. This might be partly due to the fact that none of the facilities in the study area where the study was conducted provided sterilization services to their clients and partly because the cultural

norm of the society is not in favour of male sterilization. In agreement with our findings, Orji and Onwudiegwu reported that religion was found to influence the attitude of married Nigerian men toward family planning. When men have a positive attitude towards family planning, use of effective contraceptive methods will be facilitated. Inter spousal communication is an important intermediate step along the path to eventual adoption and sustained use of family planning.

4.3.13 Knowledge by Place of residence

Analysis of respondents in Table 4.31 reported that the knowledge of contraceptive is slightly higher (45.6) in semi-urban areas than their rural counterpart (44.3%).

Table 4.32 Knowledge of Contraceptive by Place of Residence

Place of Residence	Have heard of	Have Not heard of	Total
Rural	170(44.3)	25(6.5%)	195(50.8%)
Semi-urban	175(45.6)	14(3.6%)	189(49.2%)
Total	**345(89.9%)**	**39(10.1%)**	**384(100.0)**

Calculated chi-square= X^2 34.145 df= 1 p- value = .000

Source: Field survey, 2014.

The observed variation in contraceptive knowledge in the semi-urban areas may be attributed to the level of education, information about contraceptive especially through the media, accessibility and health care services which may be more in semi-urban than the rural areas. This is similar to the finding of Martin (2003) in Malawi where the proportion of the knowledge of contraceptive constitute 37.5%, 30.4% in the urban and rural areas respectively. Chi-square result reveals that $X^{2 =}$ 34.145, d/f= 1 P- value= .000. This shows that the knowledge of contraceptives by place of resident

is statistically significant. In other words, place of residence have a positive influence on the knowledge of contraceptives.

4.3.14 Distribution of respondent's current use of contraceptive by Place of residence.

Table 4.32 reveals that the use of contraceptive in semi urban area is 8.3% higher than rural area with 3.9%. This variation in contraceptive use in semi urban could be as a result of accessibility and availability of contraceptive services.

Table 4.33 Contraceptives use by Place of Residence

Place of Residence	Using	Not using	Total
Rural	15(3.9%)	180(46.9%)	195(50.8%)
Semi-urban	32(8.3%)	157(40.9%)	189(49.2%)
Total	**47(12.2%)**	**337(87.8)**	**384(100.0)**

Calculated chi-square= X^2 .651 df= 1 p- value = .420

Source: Field survey, 2014.

Chi-square result reveals that $X^{2\,=}$ .651, d/f= 1 P- value= .420. This shows that the contraceptive use by place of residence is not statistically significant. Both male and female living in the rural areas tends to use fewer contraceptives and have more children than their semi-urban and urban counterparts (Rutstein, 2005; Conde-Agudelo & Balizan, 2006). In the 1990s, urban fertility in Sub-Saharan Africa was on average almost 30% lower than rural fertility (Dudley & Pillet, 1998 and Shapiro Tambashe, 2000). More recently, African countries like Ethiopia still show very high fertility rates in rural areas, whereas fertility in the cities has decreased considerably (Tadesse & Headey, 2012). A major reason might be that the costs of children are higher in more developed and urban

areas than in rural areas (Smith & Gozjolko, 2010). According to Bertrand *et a*l (1993) modern contraceptive is higher in urban areas than their rural counterparts. Urban men and women may be more likely to use modern methods than rural women because of greater access to modern methods and desire for smaller families.

4.3.15 Knowledge of contraceptive by educational level

There is a positive correlation between contraceptive use and level of education. Other things being equal the higher the level of education the higher the knowledge and use of contraceptive is expected to be. Table 4.33 indicates that, the knowledge of contraceptive among male and female with primary education constitute 55.5% followed by secondary education

Table 4.34 Knowledge of respondents on contraceptives by level of education

Education	Male		Female		Total	
	Freq.	%	Freq	%	Freq	%
Primary	104	27.1	109	28.4	213	55.5
Secondary	50	13.0	27	7.0	77	20.0
Quranic	4	1.0	7	1.8	11	2.9
Post-secondary	8	2.1	11	2.9	19	4.9
None	3	.8	21	5.5	24	6.3
Others	1	.3	0	.0	1	.3
Total	**170**	**44.3**	**175**	**45.6**	**345**	**89.9**

Source: Field survey, 2014.

This shows that the knowledge of contraceptive can improve with enhancement on educational qualification. Also, educational attainment can influence men and women knowledge of contraceptive. Education exposes people to innovation and new ideas, thereby helping to spread information very fast. Education provides people with the knowledge and skills they need to live better lives. One extra year of schooling may increase an individual's earnings by up to 10% (UNESCO, 2011). Education of both male and female is one of the key factors driving fertility

reduction. Women with higher levels of education are more likely to delay and space their pregnancies and to seek health care and support. Education influences women's reproduction by increasing their knowledge of fertility, increasing their socioeconomic status, and changing their attitudes towards fertility control (Castro & Juarez, 1994). A major pathway by which education influences women's contraceptive use is through increasing their level of knowledge (Hemmings *et a*l.,2008).

Table 4.3.16 Respondents use of contraceptive by level of education

Analysis of respondents on the use of contraceptive by level of education reveals that, the major users of contraceptive among male ad females are the primary education holders 7.8% and secondary education 3.1% respectively. From the analysis, it is observed that the level of education does not have positive influence on respondent's use of contraceptives.

Table 4.35 Respondents contraceptives use by level of education

Education	**Male**		**Female**		**Total**	
	Freq.	**%**	**Freq**	**%**	**Freq**	**%**
Primary	16	4.1	14	3.6	30	7.8
Secondary	10	2.6	2	.5	12	3.1
Quranic	-	-	3	.8	3	.8
Post-secondary	1	.3	1	.3	2	.5
None	-	-	-	-	-	-
Others	-	-	-	-	-	-
Total	**27**	**7.0**	**20**	**5.2**	**47**	**12.2**

Source: Field survey, 2014.

This reaffirmed the general agreement that level of educational opportunity influences modern contraceptive use though some studies have shown that this relationship is by no means unive rsal

4.3.17 Knowledge of respondents on contraceptives by Age

Analysis of respondents' knowledge by age in Table 4.35 reveals that age 30-34 35-39 among male and female are more knowledgeable than other age groups. This could be attributed to their exposure to various health systems and also their regular visit to the hospital for check-up and delivery especially the females. This shows that knowledge decreases as age increases.

Table 4.36 Knowledge of Respondents on contraceptives by Age

	Male		Female		Total	
Age	**Heard of**	**%**	**Heard of**	**%**	**Yes**	**%**
15-19	12	3.1	11	2.8	23	6.3
20-24	7	1.8	29	7.6	36	9.4
25-29	42	11.0	13	3.4	55	14.3
30-34	85	22.1	38	9.9	123	32.0
35-39	2	.5	58	15.1	60	15.6
40-44	21	5.5	25	6.5	46	12.0
45-49	1	.3	1	.3	2	.5
Total	**170**	**44.3**	**175**	**45.6**	**345**	**89.9**

Source: Field survey, 2014.

This is in keeping with the findings of Abubakar (2012) in zaria where the knowledge of family planning is 100% among respondents age 15-19, 30-34 and 35-39years respectively. This high level of knowledge could be as of government effort in creating awareness to the general public on family planning programs especially through the media. Also, this age bracket are sexually active and more expose to modern information especially on reproductive issues than the age above 45 years.

4.3.18 Contraceptive Service Usage by Age

Table 4.36 reveals that, age 30-34 constitute 5.5% followed by age 20-24 with 2.0%.35-39 (19.1%). This shows that, among men and women, contraceptive use increase with age. Age of women influences the usage of contraceptive while age does not have impact on contraceptive use among men.

Table 4.37 Respondents on contraceptives use by Age

	Male		Female		Total	
Age	**Using**	**%**	**Using**	**%**	**Yes**	**%**
15-19	1	.3	0	.0	1	.3
20-24	1	.3	7	1.8	8	2.0
25-29	2	.5	3	.8	5	1.3
30-34	19	4.9	2	.5	21	5.5
35-39	0	0	7	1.8	7	1.8
40-44	4	1.0	1	.3	5	1.3
45-49	0	0	0	.0	0	.0
Total	**27**	**7.0**	**20**	**5.2**	**47**	**12.2**

Source: Field survey, 2014.

The use of contraceptive method is more prevalent among the middle age group, with older group declining to practice of contraceptives. This could be due to the fact that other women who have reached menopause have no need for contraceptives or declining sexual activity among other men. This is similar to the finding of NDHS 2008 where the use of family planning methods increases with age from 7percent among women age 15-19 to 20 percent and among women age 35-39, and then declines to 10 percent for women age 45-49. The lower proportion noted among the older age group is perhaps because innovation was less acceptable by the time they were young Mammam (1992).

4.3.19 Contraceptive use by Religious Denominations

The distribution of respondents on contraceptive use by religion denomination in Table 4.37 shows that 9.6% and 1.0% reported using contraceptives among catholic and protestant. The less percentage of other denominations could be as result of their population.

Table 4.38 Distribution of Contraceptive Use by Religious Denominations

	Male		Female			
Denomination	**Using**	**%**	**Using**	**%**	**Total**	**%**
Catholic	22	5.7	15	3.9	37	9.6
Protestant	4	1.0	-	-	4	1.0
Anglican	-	-	3	0.8	3	.8
Pentecostal	1	.3	2	0.5	3	.8
Total	**27**	**7.0**	**20**	**5.2**	**47**	**12.2**

Source: Field survey, 2014

This low usage of contraceptives could be attributed to the individual religion doctrines especially among the catholic who strongly imposed restriction in the use of modern contraceptives.

> This corroborate with the result of FGD with a catechist who said that:
> *Our church teaches that the use of contraception in all its forms is immoral, is intrinsically evil, is contrary to the law of nature that any Catholics who practice contraceptives may not be allowed to receive holy communion except confession is made.*
> *(Ugbokolo ward)*

In general term the slow pace of contraception acceptance could be as a result of several factors which are hidden under some institutional norms and values which are responsible for the increase in fertility rate. This could be one of the reasons of unwanted pregnancy, high rate of maternal mortality

and abortion in the area. This suggests that, type of religious denomination could determine the use of contraceptives.

4.3.20 Contraceptive use by income level

The influence of male and females income status entails the ability to purchase the desired item needed for individual consumption and the reverse of it when there is no income.

Table 4.39 Respondents on contraceptives use by Income level

Education	Male		Female		Total	
	Freq.	%	Freq	%	Freq	%
Less thanN5000	1	.3	4	1.0	5	1.3
N5000-N9000	18	4.7	12	3.1	30	7.8
N10000-N14000	-	-	-	-	-	-
N15000-N19000	4	1.0	3	.8	7	1.8
N20,000-24000	-	-	-	-	-	-
N25000-N29000	1	.3	1	.3	2	.5
N30000-N34000	3	.7	-	-	3	.8
N35000-N39000	-	-	-	-	-	-
N40000 and	-	-	-	-	-	-
Total	**27**	**7.0**	**20**	**5.2**	**47**	**12.2**

Source: Field survey, 2014.

Table 5.20 shows that the number of respondents using contraceptives earned N5000-N9,000 with 7.8% followed by N15000-N19000. Income is a critical factor in determining whether a respondent uses contraceptives or not. This might due to the fact that contraceptives are relatively cheap and readily available at subsidized rates especially at government family planning units but cultural and religious opposition serve as a strong factor for its usage and patronage in this part of Nigeria. This shows that, the level of income does not have much influence on respondents' use of contraceptive.

4.4 Discussion

The study is on comparative analysis of knowledge and use of modern contraceptive among male and females in Okpokwu local government area of Benue State Nigeria. Data were collected using structured questionnaires from a sample of 384 comprising male and female aged 15-59. The specific objectives of the study were to assess the type of modern contraceptives available in the study area, examine the sources of knowledge of modern contraceptives, assess the level of knowledge and use of modern contraceptives, assess the factors that determine knowledge of modern contraceptives, examine the decision-making process in the use of modern contraceptives among male and female, challenges of modern contraceptive use and the strategies employed to solve the challenges in study area. Majority of male and female are Idoma ethnic group and the most common religion is Christianity with a relative high proportion of catholic population. The level of education is relatively low with about 56.5% of the respondents are primary school holders among male and females. These levels of respondents education is reflected in their daily activities which is mainly farming.

The level of income is relatively low below the national average of eighteen thousand naira. Marriage is universal among males and females in the study area with about 65.5% marrying within the age group 15-24. Polygamous marriage (79.0%) is the most common type of union in the study area. The study also reveals that, the desire for a particular number of children by the respondents is not reflected in the actual number of children they have, thereby showing the influence of decision-making on a particular family size The decision on the number of children in made by husband/partner. The analysis reveals that, the level of knowledge of modern contraceptive is almost universal (89.9%) unfortunately, these high level of knowledge is accompanied by a low level of usage with about 12.2% and 87.8% not using any form of modern contraceptive as of the time the

research was conducted. The level of knowledge is slightly higher among females than males while males are the major users. The Chi-square result shows a non significance difference between male and female respondents in the knowledge and use of modern contraceptives in the study area. This leads to the rejection of alternative hypothesis and the retention of Null hypothesis. Also there is no significance between male and female respondents in use of modern contraceptive which lead to rejection of alternative hypothesis and the retention of Null hypothesis.

Urban residents are more knowledgeable of modern contraceptives than their rural counterpart thereby, reflecting their exposure to media and identification with social media. The major sources of contraceptive knowledge are electronic media, family members and hospitals. From the analysis, it was discovered that, spousal approval is the major determinant of contraceptives and majority are using contraceptive to delay the next pregnancy while others stopped using contraceptives because of their spousal disapproval. The well known and used methods are condom, pills, and breastfeeding. The widespread usage of condom is as a result of its availability at commercial retail outlet. Men's role and responsibility as care givers is demonstrated in the study wherein 44.8% affirm payment of contraceptives by the husband. The result also reaffirms the position of men as major decision maker on contraceptives use. With men having absolute power over most of the family issues, the perceived wishes and decision of the husband/ partners may influence the behaviour of the wife/partners. Men are the major decision makers in the use of modern contraceptives due the desire for large family which is deeply rooted in the fundamental belief that children are gift from God, thus is not within human capacity to determine the number of children couples should have. Thus, unequal decision making power between partners in a patrilineal system established in this research could be the cause of high fertility in this area. Women who mainly bear the burden of child bearing are often ill-equipped to personally make fertility decisions that will be to their advantage. Nigerian men remain

predominantly pronatalist with majority of their wives not sufficiently empowered to make fertility decisions. Fertility levels will remain constant even rise beyond the present levels. Men opposition on contraceptives use in this part of Nigeria is bound to have significant effects on the success or failure of family planning program. Male involvement in present and future family planning program will give these programs a better chance of success.

4.4.1 Relevance of theories to the finding of the study

In the second chapter of this study, some theories were selected and explained in detail to aid in the discussion of the study. The selected theories are:

i.Stucturation theory

ii approaches of gender and development (GAD)

iii women culture and development (WCD), put forward by ferminist scholars. The theories were selected based on the fact that they can help in explaining the findings. Giddens (1984) explains the structuration theory simply as how individuals born into societies are entrapped with social structures, which both constrain and enable them. Individuals (human agency) in one way of the other also influence the structures of the society to their benefit. The structures in the society as used in this study can be physical or social. The physical structures that can influence women's choice of and use of contraception, include available family planning or reproductive health centers and pharmaceutical outlets. The social structures on the other hand, include influences from spouses and other family members especially those from the extended families. Socially, friends can also influence the decision by men and women to use contraceptives. The study revealed that there was less influence from the physical structures available for family planning on men and women's choice of and use of contraception. In other words the availability of these structures does not contribute much to the

lower usage rate of contraceptives by men and women. This was because there were health care centers in the study areas where men and women can access the different modern methods of contraception at least the common types which are most patronized.

There was also a family planning unit at the government hospitals and other private hospitals which provided services for both the inhabitants and other neighboring villages. In the theory it is argued that structures influence individual behaviour, but behaviour can reciprocally influence structures (Cloke *et al* 1991, cited in Holt Jensen, 2000). This assertion was realized in this study, as the senior nursing officer at the family planning unit and the chemist attendants reported of how the individual concerns of the men and women they serve have influenced the manner in which they provide their services. An example is that these service providers make sure that they always have the contraceptive types that are highly patronized available to them at all times. The social structures on the other hand may have much influence on the low usage rate of contraceptives in this study. The influence of husband and friends was seen as critical in the choices that women make on contraception. The study revealed that majority of the men interviewed were not encouraging their wives to use different contraceptive types also were mostly not willing to co-operate when they are to use some contraceptives themselves. Again some of the women especially the older women had pre-conceived ideas about the different contraceptive types because of the experiences of their friends. They were therefore not willing to encourage other women to use contraceptives. These women mostly rely on the information they get from their friends. The friends of these women may not give them the right information since these friends may also be ignorant about how the different methods work. Secondly, the approaches of gender and development (GAD) and women culture and development (WCD) by feminist theorists were adopted in this study as earlier mentioned. These

theoretical approaches simply try to explain the inequalities that exist between men and women when one considers their productive and reproductive roles.

The approaches of gender and development and women culture and development, best fit the explanation of the findings of this study because gender roles of men and women as explained by GAD cut across decisions regarding their reproductive lives. The societal norms, values, and cultures within the WCD approach also has much bearing on this study made use of respondents from two different areas with different characteristics. In this study there were more men using modern contraceptive methods in semi-urban than those in rural areas. These men could have higher socio-economic status than other men in rural area. Those women, who wished to use contraceptives, were restricted because there is no approval from their spouses/partners partly because of their cultural and religious beliefs. The gender roles that the society has assigned to women, which gives them less control over their reproductive lives, may be more pertinent in the study area as revealed by this study. Finally, it was realized from this study that friends and family members had little or no influence on women's choice of and use of different contraceptive types rather spousal disapproval and religious beliefs especially in the rural area. These women mostly lived in their nuclear homes with their husbands and children and occasionally visit their family members. In semi-urban areas, on the other hand, some of the men and women lived within the same compound with members of the extended family as uncles, aunties, parents and in-laws. There is therefore some form of influence from these family members regarding the women's reproductive lives and hence choice of and usage of contraception.

4.4.2. Test of hypothesis

In this section, the hypotheses earlier stated are tested for significance which will eventually lead to either their rejection or acceptance.

4.4.2.1 Hypothesis one posited that: There is no significant difference between male and female respondents in the knowledge of modern contraceptives which shows the following results = x^2 value 3.082, df =1, P-value 0.56. Based on the decision rule, alternative hypothesis is rejected while Null hypothesis is accepted.

Table 4.4.2.Differences between Respondent's Knowledge of Modern Contraceptives by Gender

Variable	**χ^2- Value**	**Degree of Freedom**	**P-Value**	**Remarks**
Knowledge of Modern Contraceptives by Gender	3.082	1	.056	Not Significant

Source: Field Survey, 2014

It can therefore be maintain that, there is a no significance difference between male aand female respondents in the knowledge of modern contraceptives in the study area.

Hypothesis two on the other hand posited that: There is no significant difference between male and female respondents in the use of modern contraceptives which shows the following results = x^2 value 1.451, df =1, P-value .276. Based on the decision rule, alternative hypothesis is rejected while Null hypothesis is accepted.

Table 4.4.3 Differences between Respondent's Use of Modern Contraceptives by Gender

Variable	**χ^2- Value**	**Degree of Freedom**	**P-Value**	**Remarks**
Use of Modern Contraceptives by Gender	1.451	1	.276	Not Significant

Source: Field Survey, 2014

It can therefore be maintain that, there is a no significance difference between male and female respondents in the use of modern contraceptives in the study area.

CHAPTER FIVE:

SUMMARY, CONCLUSION AND RECOMMENDATIONS.

5.1 Summary of Findings

The study is on comparative analysis of knowledge and use of modern contraceptives among men and women in Okpokwu local government area of Benue State, Nigeria. Data were collected using structured questionnaires and Focus Group Discussions (FGDs) from a sample of 384 comprising male and female of reproductive aged. The analysis reveals that, the level of knowledge of modern contraceptive is almost universal; unfortunately, this high level of knowledge does not translate to use as majority are not using any form of modern contraceptives as of the time the research was conducted. The level of knowledge is slightly higher among females than males while male are the major users. Semi urban residents are more knowledgeable of contraceptives than their rural counterpart thereby, reflecting their exposure to media and identification with social media. The major sources of contraceptive knowledge are electronic media, family members and hospitals. From the analysis, it was discovered that, spousal approval is the major determinant of contraceptive use and majority are using contraceptive to delay the next pregnancy while others stopped using contraceptives because of their spousal disapproval and male are the major decision makers on the use of modern contraceptives. Thus, unequal decision making power between partners in a patrilineal system established in this research could be the cause of high fertility in this area. Women who mainly bear the burden of child bearing are often ill-equipped to personally make fertility decisions that will be to their advantage.

5.2 Conclusion

The study is on comparative analysis of knowledge and use of modern contraceptives among male and female of child bearing ages. The level of knowledge of modern contraceptive is high with

relative low practice. The chi-square tests show the following results: x^2 value= 3.082, df= 1,P=0.56 respectively have a significant difference between male and female respondent in the knowledge of modern contraceptives and also x^2 value of 1.451, df=1 and p=.276 respectively signifies a significant between male and female respondent in the in use of modern contraceptives. Contraceptive service utilization decision is a function of wide range of factors which include spousal disapproval and lack of spousal communication.

The role of men in promoting contraceptive utilization is generally low. Men are the major decision makers in the use of contraceptives. Involving men and obtaining their support and commitment to family planning is of crucial importance in Nigeria, given their elevated position in the African society. They hold positions of leadership and influence from the family unit through the national level. Male role in contraceptives methods means more than the number of men who encourage and support their partners to use contraceptive methods. The involvement of men in family planning would therefore not only ease the responsibility borne by women in terms of decision making in family planning matters, but would also increase the understanding and practice of family planning in general. There is need for a persistent drive against those social customs, beliefs, and traditions which belittle the importance of family planning in the society. Male involvement and support can help make contraception and family planning easier for the women and even widen the choice of methods that a couple can use since husband's opposition to contraceptive use can have serious consequences. Culturally, men find it difficult to seek family planning services from women therefore; male service providers should be employed and trained to attend to the men.

5.3 Recommendations

Having found that there is no significance difference between male and female respondents in the knowledge and use of modern contraceptives in the study area, there are a number of issues that could aid future study around this discuss. It is therefore recommended that:

- The content of contraceptive awareness programmes should focus more on male to increase their knowledge. This will enable them know the important and benefit of small family size as a tool to good health and socio-economic independence.
- Men should be encouraged to be interested and involved in family planning and contraceptive use as they are confirmed as the major decision makers on contraceptive use.
- There is need for a persistent drive against those social customs, beliefs, and traditions which belittle the importance of family planning in the society.
- Women should be allowed to take decision on contraceptives use instead of men restricting them in taking such decision.
- Religious organizations should be encouraged to teach and educate their members about the importance of family planning and contraceptive use especially during their sermon in the church or other related gatherings.
- Couples should be encouraged to space their children beyond two years to reduce frequent childbirth and large family sizes that expose women to health problems which can contribute to high maternal mortality.
- Greater political will from our national leaders, which includes more commitment in supporting family planning progammes, is needed and not just population policies on paper.
- In improving contraceptive usage, both men and women educational attainment needs to be improved upon because their educational attainment is the bedrock of their socio-economic

status. The improvement in education implies going beyond the primary school education which will in turn increases their level of exposure and enlightment on the issues of modern contraceptive methods.

- ❖ Men and women should be encouraged to use modern contraceptive method such as condom during pregnancy which aids in reducing the occurrence of infection that can leads to still birth (prenatal death) amongst undernourished women.
- ❖ There should be creation of skills and semi-skill employment for male and females to be engage in. This would bring about improvement in their earning ability and would go along to upgrade their income status and their standards of living and make them desire smaller family sizes.
- ❖ Men should be involved in the delivery of family planning services since men feel more comfortable discussing contraceptive issues with their fellow men than women.
- ❖ Improvement in the delivery of family planning services to all parts of the state will help make its adoption more appealing. The inclusion of men as targets of family planning campaigns will have an important influence in its acceptance and usage.
- ❖ In addition to a nationwide family planning campaign, religious leaders and traditional rulers should join hands with other forces in the society to persuade couples to utilize available and suitable contraceptive methods and also educate husbands on the relevance of involving their wives in family decision making as they are not slaves but help-mates.

5.4 Suggestions for Further Research

- There is need for further research on the demographic and socio-economic determinants of knowledge and use of modern contraceptives among single male and female in Nasarawa, Cross River, Kogi and Enugu state and the implications for national economy.

- More research is necessary to fully understand the impact of modern contraceptives on population dynamics.
- There is need for an assessment on the pattern of women visiting family planning clinics in Okpokwu L.G.A.

REFERENCES

Abiodun, P.A, Adisa., A.F., Aderemi I.M, (2001).Knowledge and previous contraceptive use by pregnant teenagers in Ilorin Nigeria. *Trop. J. Obstet. Gynecol.*, 2001, 18(2): 73-77.

Abubakar, M.(2012). *An Assessment of Men's role and Attitude Towards Family Planning in Zaria.* An Unpublished M.Sc Thesis, Dept. of Geography, A.B.U. Zaria.

Acharya, L.B. (1998). "Determinants of fertility in the 1970s and 1980s in Nepal." *Contributions to Nepalese Studies (Special issues)* 25:95-108.

Adanu, R.M.K., Seffah, J.D., Hill, A.G., Duda, R.B., Anarf, J.K. (2009). Contraceptive use by women in Accra, Ghana: Results from the 2003 Accra women's health survey. *Afri. J. Reprd. Health, 13(2): 146-8*

Adebayo, S., E. Gayawan, C. Ujuju, and A. Ankomah. (2012). "Modelling geographic variation in use of modern family planning methods among women of reproductive age in Nigeria."*Journal of Biosocial Science* 00:1 (28).

Adewuyi, A. and P. Ogunjuyigbe (2003). "The Role of Men in Family Planning: An Examination of Men's Knowledge and Attitude to Contraceptive Use among the Yorubas." *African Population Studies* 18(1):35-49.

Adeyoju, O.T (2013). *Fertility Intention and Contraceptive use among males in Nigeria*. A project submitted to the school of social sciences, university of Witwatersrand, Johannesburg.

Adiri, F., Ibrahim, H.I.,A jayi, V., Sulayman, H.U., Yafeh, A.M., Ejembi, C.L. (2011). Fertilty behavior of men and women in three communities in Kaduna State, Nigeria. *Afr.J Reprod. Health, 14(3): 97-105*

Adinma JI, Okeke AO (1995). Contraception: Awareness and practice among Nigerian tertiary school girls. *West Afr. J. Med.,* 14(1):34-38.

Agadjanian, V. (2005). Fraught with ambivalence: Reproductive intentions and contraceptive choices in a sub-Saharan fertility transition. *Population Research and Policy Review 24*, 617-645.

Ahmed, S., Q. Li, L. Liu, and A.O. Tsui. (2012). "Maternal deaths averted by contraceptive use: An analysis of 172 countries." *The Lancet* 380 (9837):111-125.

Alkema, L., V. Kantorova, C. Menazzi, and A. Biddlecom (2013). "National, regional, and global rates and trends in contraceptive prevalence and unmet need for family planning between 1990 and 2015: A systematic and comprehensive analysis." *The Lancet* 381:1642-1652.

Amazigo, U., Siliva N., Kaufman, J., Obikeze, D. (1997). Sexual activity and contraceptive knowledge and use among in-school Adolescent in Nigeria. *Journal of Obs and Gynea*.21(3): 298-302

Amin, R, Kabir, M., Chowhury, J. (1994). *Impact of poor women's participation in credit-based self employment on their empowerment, fertility, contraceptive use, and fertility desire in rural Bangladesh*, unpublished paper, presented at the annual meeting of the population association of America.

Amos, O.O (2007). Determinants of Contraceptive Usage: lessons from Women in Osun State, Nigeria. *Ife Social Sciences Review*,Vol.1, Issue 2 pp.1-9.

Ampofo, A.A (2001). When men speak Women listen: Gender socialization and young Adolescents Attitude, sexual and Reproductive Issues." *African Journal of Reproductive Health, 5(2) 196-212*

Anagbogu, M.A. (2005).Mainstreaming gender in community development. *Commissied paper delivered to community leaders in Ekwusigo Local Government Area, Anambra State*

Ankomah, J, A., and Muyiwa,O.(2011). Myth, misinformation and communication about family planning and contraceptive use in Nigeria. *Journal of contraception*, 2: 95-105.

Anonymous (2009). Nigeria: A thought for population and poverty. Daily Trust, September, 2010.(http.//www.allafrica.com) Retrieved 31/01/2010

Anyebe A, and Adam A. A (2014) An Assessment of the Perception of Christian Women of Family Planning Methods in Benue State. *Humanities and Social science letter* 2(4): 217-227

Apaisaria, H.M (2011). *Contraceptive Method Choice among women attending amtullbittu family planning clinic in Dares Salam*. A dissertation submitted to the Department Health and applied sciences

Auta, Z.S. (2006) The determinants of women's participation in decision- making about family Planning in Kaduna metropolis. An unpublished undergraduate project, Department of Geography, Faculty of Science, Ahmadu Bello University Zaria.

Araoye, M.O., O.O. Fakeye and E.T. Jolayemi,(1998). Contraceptive method choices among Adolescents in a Nigerian Tertiary institution.WAJM, 17(4): 227-230.

Asante-Sarpong, H. (2007). *Perceptions of Women about Modern and Natural /Traditional Methods of Contraception in Koforidua and Asokore in the Eastern Region of Ghana.* A Thesis Presented to the Department of Geography Norwigian University of Technology.

Ashraf, Q.H., D.N. Weil, and J. Wilde. (2013). "The effects of fertility on economic growth."*Population and Development Review* 39 (1):97-130.

Asekun-Olarinmoye, E.O., Adebimpe O.W., Bamidele, J.O., Odu, O.O., Ojofeitimi, E.O (2013)."Barriers to use of modern contraceptvies among women of inner city area of Oshogbo Metropolis, Osun State-Nigeria." *International journal of Women's Health*

Avidime, S.,Aku-Akai, L, Mohammad, A.Z., Adaji, S Shittu, O., Ejembi, C. (2010). Fertility intentions, contraceptive awarenessand contraceptive use among women in three communities in Northern Nigeria. *Afr J Health: 14:56-70*

Azikiwe, U.(2004). Eradication of gender violence and girl- child abuse. *Journal of Educational Foundation 1, 80-88*

Awusi, V.O.og(2012).Contraceptive choice amongst women in warri, Nigeria. *International Journal of life Science and Pharm Research* 2(2): 35-39

Badewole, O.C (2005). *A Comparative Study of Modern and Traditional Contraceptive Methods among Women. A Case Study of Kaduna North L.G.A Kaduna State, Nigeria.* An Unpublished B.Ed Project, Faculty of Education A.B.U Zaria.

Bankole, A. (1995). "Desired Fertility and Fertility Behaviour among the Yoruba of Nigeria: A study of Couple Preference and Subsequent Fertility". *Population Studies*, 317-328.

Bankole, A., G. Rodriguez, and C.F. Westoff. (1996). "Mass media messages and reproductive behaviour in Nigeria." *Journal of Biosocial Science* 28 (2):227-239.

Bankole, A., and S. Singh. (1998). "Couples fertility and contraceptive decision-making in developing countries: Hearing the man's voices." *International Family Planning Perspectives* 24 (1):15-24.

Bemard, H.R (2002). Research Methods in Anthropology Qualitative and Quantitative Methods 3rd edition, Altamira Press, Walnut Creek, California.

Bertrand, J.T., Seiber, E., Escudero, G. (2000). Contraceptive dynamics among the Mayan population of Guatemala: 1978-1998. Chapel Hill, North Carolina, University of North Carolina at Chapel Hill, Carolina Population Center [CPC], MEASURE Evaluation, 2000 Jun.[35] p. *MEASURE Evaluation Working Papers* WP-00-2; USAID Cooperative Agreement No. HRN-A-00-97-00018-00.

Bhaskar, R. (1979). The Possibility of Naturalism. Harvester Press, Hassocks.

Bhavnani, K., Foran J. & Kurian, P. (2003). Feminist Futures, Re-imagining Women, Culture and Development. Zed Books Ltd., London and New York.

Biney, A.A.E. (2011). Exploring Contraceptive Knowledge and Use among WomenExperiencing Induced Abortion in the Greater Accra Region, Ghana. African Journal of Reproductive Health, 15(1): 37-46.

Blanc, A.K., Wolff, B., Gage A.J., Ezeh., A.C., Neema, S., Sekmatte-Sebuliba, J.(1996). Negotiating Reproductive outcomes in Uganda:Makerere University.

Bongaarts, J. (1978). A Framework for Analyzing the Proximate Determinants of Fertility. *Population and Development Review* 4 (1):105-132.

Bongaarts, J.(2006). The Causes of Stalling Fertility Transitions, Studies in Family Planning. 37(1)1-16

Bordieu, P. (1977).Outline for a Theory of Practice. Cambridge University Press, Cambridge.

Briddlecom, A.K., Anne, E., Bolaji, M.F (1997). Convert Contraceptive Use Prevalence, Motivations and consequences. *Studies in family planning 29(4):360-372*

Bukar M, Audu BM, Usman HA, El-Nafaty AU, Massa AA, Melah GS, (2013). Gender attitude to the empowerment of women: An independent right to contraceptive acceptance, choice and practice. *J Obstetr Gynaecol, 33:180-183.*

Caldwell, J.C (1979). Education as a factor in mortality decline: An examination of Nigerian data". *Population Studies,* (November) 33: 395-413.

Caldwell JC and Caldwell P. (2002). The Fertility Transition in Sub-Saharan Africa. www.hsrcpress.ac.za Accessed 2005/04/14.

Caldwell, J., & Caldwell, P. (1987). The culture context of high fertility in sub-Saharan Africa. *Population and Development Review 13(3):* 409-437.

Chipeta, E.K., Chmwaza, W., Kalinlani- Phiri, L. (2010). Contraceptive knowledge, beliefs and attitudes in rural Malawi: Misinformation, misbelieves and misperceptions. *Malawi Med. J.* 22(2): 38-41

Cleland, J., S. Bernstein, E. Alex, A. Faundes, A. Glasier, and J. Innis. (2006). "Family planning:The unfinished agenda." *The Lancet* 368 (9549):1810-1827.

Cleland, J.G., R.P. Ndugwa, and E.M. Zulu. 2011. "Family planning in Sub-saharan Africa: Progress or stagnation?" *Bulletin of the World Health Organization* 89:137- 143.

Coale, A. J.,Watkins, S.C. (1986). *The decline of fertility in Europe.* Princeton (eds): Princeton University press.

Cochrane, S. (1997). *"Fertility and Education: What do we really Know?".* World Bank, Washinton, DC.: World Bank staff occasional paper 26.

Cho LJ. (1978). Fertility Preferences in Five Asian Countries. *International Family Planning Perspectives and Digest,* 4(1): 2-8.

Collumbien, M., M. Gerressu, and J. Cleland. (2004). *Non-use and use of ineffective methods of contraception*. Edited by Majid Ezzati, Alan D. Lopez, Anthony Rodger, and Chrstopher J.L. Murray. Vol. 2, *Comparative quantification of health risks: Sexual and reproductive health*. Geneva: World Health Organization.

Cunningham, W.P and Cunningham, M. (2008). Environmental Science: A Global Concern. 10th Edition, McGraw-Hill International, New York. Pp 148-151

Dabral, S., Malik, S.L. (2004). Demographic study of Gjjars of Delhi: IV. Kap of family planning. *J. Hum. Ecol.16(4): 231-237*

Danjuma, S.E (2012). Infant and Child Mortality Differentials in Chikun Local Government Area, Kaduna State. A Research Proposal Submitted to the Department of Geography. Ahmadu BelloUniversity, Zaria.

Drennan, M. (1998). Reproductive Health: New perspectives on men participation. Population Report, Series J.., No 46. Baltimore: John Hopkins University School of Public Health, Population in format program.

Dodoo, F., & vanLandewijk, P. (1996). 'Men, Women, and Fertility Question in Sub- Sahara Africa: An example from Ghana. *African Studies Review 39 (3):* 29-41.

Dodoo, N.-A. (1998). Men matter: additive and interactive gendered preference and reproductive behaviour in Kenya. *Demography Vol 35 (2),* 229-242.

Dynes, M., R. Stephenson, M. Rubardt, and D. Bartel (2012). "The influence of perceptions of community norms on current contraceptive use among men and women in Kenya." *Health and Place.*

Dudley, Kirk and Bernard Pillet (1998). Fertility levels, trends and differentials in Sub-Saharan Africa in the 1980s and 1990s. Studies in Family Planning, 29(1), 1-22.

Duze, M.C and Mohammed,I.Z (2006). Male Knowledge, Attitudes, and Family Planning Practices in Northern Nigeria. African Journal of Reproductive Health 10 (3): 53-65.

Dyson, T. and Moore, M. (1983). On kinship structure, female autonomy and demographic behavior in India. *Population and Development Review* (March) 9: 35-60.

Ebigbola, J.A and Ogunjuyigbe, P.O. (1998). Contraceptive Knowledge and Practice by women attending antenatal Clinic in Nigeria. *International Family Planning Perspectives* 27 (2):77-81.

Ebigbola, J. A. (1988): 'A Dilemma in National Population Policy: Evidence from Nigeria'. JANASAMKHYA: *A Journal of Demography*. (6) 2:169-182

Ebrahimi, R. (2005). Perceptions of Secondary school Girls on Sexual debut, Contraceptives and Family planning for their families in Uganda. *Journal of Biosocial Science*.32(3): 319-45.

Edewor, K (2001). Women right and Education in the society. *International journal of forum for African women Educationalist Nigeria 1 (2) 65-73*

Ehiozuwa, A.O (2011). *A Guide to Family Life and Emerging Health Issues.*Yabyangs Publishers.

Elaigwu, O.M. (2005). *Effect of culture on the none-practice of child-spacing among idoma ethnic group living in Angwa-Jukum area of Makurdi local government of Benue* State. Unpublished Project Submitted to the School of Nursing Makurdi, Benue State.

Ekabua, J.E., Ekabua, K.J., Ekanem, E.I., Iklaki, C.U,(2009). Is the process of diagnosing and tr eating incidental medical findings a barrier to contraceptive acceptance and use? *J Obstet Gynaecol,* 29(3):237-239.

Ekpo, R. (2011). *Comparative Analysis of the Influence of Socio-Economic variables on Women's Attitude to Family Planning in Makarfi and Jaba Local Government Area Kaduna*. An unpublished Thesis Submitted to the Department Geography Ahamdu Bello University, Zaria.

Envuladu, E.A., Agbo, H.A., Chia, L., Mohammed, A., Kigbu, J.H., and Zoakah, A (2009). Utilisation of modern contraceptives among female trader in jos south LGA of Plateau state, Nigeria. *Int J med Biomed*

Esabella J.M (2012). *Use of Contraceptives Methods Among Women in Stable Marital Relations Attending Health Facilities In Kahama District, Shinyanga Region,Tanzania*. A Thesis Submitted To The Department Of Public Health Muhimbili University Of Health And Allied Sciences.

Eggleston E. (1999). Determinants of Unintended Pregnancy among women in Ecuador. *International Family Planning Perspectives,* 25(1): 27-33.

Ezeh, A. (1993). "The Influence of Spouses over Each other's contraceptive attitudes in Ghana". *Studies in Family Planning. (24):3*.

Ezeh, A., Seroussi, M.,Raggers, H. (1996). "Men's Fertility, Contraceptive Use, and Reproductive preferences". *DHS Comparative Studies No. 18 Calverton, Maryland: Macro International Inc.*

Ezeh, A.C., J. Bongaarts, and B. Mberu (2012). "Global population trends and policy options." *The Lancet* 380:142-148.

Federal Republic of Nigeria. (1988). *National policy on population for development, unity, progressand self-reliance*. Lagos-Nigeria: National Population Commission.

Federal Office of Statistics (1990). Nigeria Demographic and Health Survey, 1990 Macro International Inc. Calverton, Maryland.

Federal Government of Nigeria (2004). National Policy on Population for Sustainable Development. *Policy Document*. 68p.

Federal Republic of Nigeria. (2014). *National Hiv and Aids and reproductive health survey2012*. edited by Department of Reproductive Health. Abuja-Nigeria: Federal Ministry of Health.

Federal Office of Statistics (1990). Nigeria Demographic and Health Survey, 1990 Macro International Inc. Calverton, Maryland.

Feyisetan, B.J. and Ainsworth, M. (1984). The impact of the availability of price, and quality services on the demand for contraception in Nigeria. The World Bank, Policy Research Department, Washington. D.C.

Feyisetan, B.J Bamiwuye, S. (1998). Postpartum Counseling and Contraceptive Use in Nigeria. *Ife Social Sciences Review*,15(1):30-41.

Feyisetan, B., Casterline, J. (2000). Fertility preference and contraceptive change in developing countries. *International Family Planning Perspective vol.26,No. 3*, pp. 100-109.

Feyisetan, B., Ainsworth, M. (1996). Contraceptive use and the quality, price, and availability of family planning in Nigeria. *World Bank Economic Review*, Volume 10(1)159-187.

Fikree F.F., Khan A, Kadir MM, Sajan F, Rahbar MH. (2001). What influences contraceptive use among young women in urban squatter settlements of Karachi, *Pakistan? International Family Planning Perspectives*, 27:130-6.

Gadalla, S., McCarthy, J., Campbell, O. (1985). How the number of living sons influences contraceptives use in Menoufia governorate, Egypt. *Stud Fam Plann*, 16 (3):164-9.

Ghana Demographic and Health Survey (1998). *Contraceptive use.* Ghana Youth Reproductive and Health Survey, Accra, Afram Publishers Limited, Ghana.

Ghosh, R. (1999). "Male involvement in Family Planning: An analysis based on NFHS. *M. Phil Dissertation, Jawaharlal Nehru University, New Delhi*.

Gillespie D, Ahmed S, Tsui A, Radloff S. (2007). Unwanted fertility among the poor: an inequity? *Bulletin of the World Health Organization*. 85(2): 100–107.

Graff, M., and J. Bremner (2014). *A practical guide to population and development* Washington: Population Reference Bureau.

Greanga, A.A., D. Gillespie, S. Karklins, and A.O. Tsui (2011). "Low use of contraceptive among poor women in Africa: An equity issue." *Bulletin of the World Health Organization* 89:258-266.

Gizaw A and Regassa N.(2011). Family planning service utilization in mojo town, Ethiopia: a population based study. *Journal of Geography and Regional Planning* 4(6).

Haberland, N., E. Chong, H. Bracken, and C. Parker. (2005). Early Marriage and Adolescent Girl Available at http://www.popcouncil.org/pdfs/Early_Marriage.pdf, accessed 14 January 2013.

Hemmings, J., Wubshet, T., Lemma, S., Antoni, T., & Cherinet, T. (2008). Ethiopian Women's Perspectives on Reproductive Health: Results from a peer study in the Guraghe Zone. London: Marie Stopes International.

Hermime, P. (2007). *Beliefs and Attitudes of Rural Nurses in Lori Marz, Armenia Toward Modern Contraceptive Methods: A Qualitative Study.* A Thesis Presented to the Department of Public Health American University of Armenia.

Henshaw, S.(1998). Unintended Pregnancy in the United States. *Family Planning Perspectives* 30(1): 24-29 & 46.

Hollerbach, P.E (1983) "Fertility decision making processes: A critical essay''. In: R.A. Bulatao and R.D. Lee et al. (eds.), *Determinant of Fertility in Developing Countries* Washington, D.C. National Academy Press Pp. 797-828.

Ibisomi, L., Odimegwu, C. (2011). 'Understanding resolution of differential fertility preferences among couples in Nigeria". *Centre for promoting ideas (www.ijbssnet.com).*

Ibisomi, L. (2014)."Are differences between partners associated with contraceptive use among married couples in Nigeria?" *International Perspectives on Sexual and Reproductive Health* 40 (1):39-45.

Ibisomi LDG and Odimegwu CO. (2007). Predictors of Unintended Pregnancy Among South African Youth. *Eastern Africa Social Science Research Review*, 23(1): 61-80.

Idonije, B.O.1, Oluba, O.M. and Otamere,H.O (2011). knowledge, attitude and practice of contraception among secondary school students in Ekpoma, Nigeria. *JPCS* Vol 2: 22-27

International Planned Parenthood Federation (1984).Male involvement in family planning.London: IPPF

Isiugo-Abanihe, U.C (1994). Reproductive Motivation and Family Size Preferences among Nigerian men. *Studies in Family planning 25*, 149-161.

Isiugo-Abanihe, U.C (1996). Fertility in Nigeria. Occasional paper of the Department of Sociology, University of Ibadan. Ibadan: University of Ibadan.

Islam, S., Khan, A. (1995). 'Influences of Selected Socio-Economic and Demographic variables on fertility in Bangladesh". *Asia Pacific population Journal (10):2*, 51- 63.

Islam, M.A. and Kabir, M. (2000). Does mass media program has any impact on the pregnancy status of rural women. *Jahangirnagar University Journal of Science*, 22 (23): 245- 255.

Jimmy, E.E., Osonwa, O.K., Osuchukwu, C.N., Dominic.,A.O (2013). Prevalence of Contraceptive use among Women of reproductive age in Calabar Metropolis. *International Journal of Humanities and Social Science Invention 2 (6)*

Josaphat B, Florence M, Elisabeth F, Kristin G: Emergency contraception and fertility awareness among university students in Kampala, Uganda. *East Afr. Med. J*., 2006, 6(4): 194-200.

Jejeebhoy, S. (1995). *Women's Education, Autonomy and Reproductive Behaviour: Experiences from Developing Countries.* Oxford United Kingdom: Claredon Press.

Jones, R.,Dreweke, J. (2012). 'Countering Convetional Wisdom: New Evidences on Religion and Contraceptive use. Guttmacher Institute, New York. Retrieved fromhttp://www.guttmacher.org:http://www.guttmacher.org/pubs/religion- and Contraceptiveuse.

Khan M.E, Patel B.C.(1997). Male involvement in family planning: KAPB study of Agra District. The Population Council, India. Churchgate: SNDT.

Khan, M. E., Patel, B. C. (2005). Male involvement in faily palnning: A KABP study of Agra District, Indian.http//www.popcouncil.org/pdfs/frontiers/OR_TA/Asis/India_MI .pdf. (April, 24, 2011).

knodel, J. (1996). "Reproductive preferences and family Trends in post transition Thailand". *Studies in family Planning*, 27 (6), 306-318.

Krejcie, P.V and Morgan D.W (1970). Determining Sample Size for Research Activities. *Journal of Education and psychology.* 30, 607-610.

Laah,J.G.(2003). *Demographic and socio-economic influence of HIV/AIDS in Kaduna State.* Unpublished ph.d Thesis, Ahmadu Bello University, Zaria.

Lasee, A., Becker, S. (1997). Husband –Wife Communication about family planning communication and contraceptive use in Kenya. *International family planning perspective* 3(2)

Laurie, F.D., Dodoo, F.N-A., Ezeh, A.C.(2004).Does Discussion of family improve knowledge of partner Attitude towards contraceptives? *International family planning perspective*. 23(1): 87-93 Guttmacher institute

Lutz W (2002). The World's Changing Human Capital Stock: Multi-State Population Projections by Educational Attainment. Population and Development Review, 27(2): 323-339.

Macellina, Y. I.,Titilayo, C. A., Kayode, T.I., Olusegun,T. A.,Olapeju, A.E., Funmilola, M.O (2010). Male Involvement in Family Planning Decision Making in Ile-Ife, Osun State, Nigeria *Afr J Reprod Health* 14[4]: 45-52.

Martin E. P (2013) Socio-Economic and Demographic Factors Affecting Contraceptive use in Malawi. *Africa Journal of Reproductive Health* 17 [3]

Mathe, J.K., Kasonic, K.K., Maliro, A.K. (2011). Barriers to adoption of family planning among women in eastern democratic republic on Congo. *Afr. Reprod. Health, 15(1): 69-77*

Monjok, E., A. Smesny, J.E. Ekabua, and J.E. Essien. (2010). "Contraceptive practices in Nigeria: Literature review and recommendation for future policy directions." *Open Access Journal of Contraception* (1):9-22.

Monnier, A. (1989). fertility intention and actual behaviour; A longitudinal study:1974,1976 and 1979. *Population:An English selection (44):1,* 237-259.

Mbando, A.M (2011). *Contraceptive Method Choice among Women attending at Amtullabital Family Planning Clinic in Dares Salaam.* A Thesis Presented to the Department Health and Allied Sciences Muhimbill University of Health and Allied Sciences.

Mburugu, E., Adams, B.N. (2004). Chapter 1: Families in Kenya. In B.N. Adams & J.Trost (Eds.) Handbook of World Families. (3-24).Thousand Oaks CA, Sage Publications.

Mensch, B., J. Bruce, and M. Greene. (1998). *The Uncharted Passage: Girls' Adolescence in the Developing World.* New York, NY, USA: Population Council.

Merckx M, Donders GG, Grandjean P, Van De Sande T, Weyers S, (2011).Does structured counseling influence combined hormonal contraceptive choice? Eur J Contracept Reprod.Health Care, 16(6):418–429.

Molokwu, N. (2007) Gender Analysis paper delivered at the step down training on gender mainstreaming.

Nigerian Demographic and health survey Report (1992). Federal Office of Statistics, Federal Ministry of Health and Human resources, Lagos, Nigeria.

National population commission (2007). *Provisional Result of the 2006 Population and Housing Census*. Abuja : National Population Commission.

National Population Commission Nigeria, (2013). Nigeria MEASURE DHS ICF International Nigeria demographic and health survey. Preliminary report. Abuja, Nigeria: 2013.

National Population Commission and ICF International (2014). *Nigeria demographic and health survey (NDHS)*. edited by National Population Commission. Abuja- Nigeria, Rockville, Maryland USA National Population Commission and ICF International.

National Population Commission Nigeria, (2000). Nigeria Demographic and Health Survey 1999. National Population Commission, Abuja, Nigeria.

National Population Commission Nigeria, (2008). ICF Macro. Nigeria demographic and health survey. Abuja, Nigeria.

NPC and ORC Macro (2004). Nigeria Demographic and Health Survey 2003. Calverton, Maryland: National Population Commission and ORC Macro. 333p.

Nganga, T.W.K. (2009). Family size, economics and child gender preference in the Nyeri District of Kenya. *Paper Presented at the 18th Annual IAFFE Conference at Simmons College, Boston, Massachusetts.* USA. June 26, 2009.

Nnadozie, G. (2007). Gender and Constitution Making. Nation light.Thursday March 1 Pg 17

Nwachukwu, I and Obasi, O. (2008). Use of Modern Birth Control Methods Among Rural Communities in Imo State, Nigeria. *African Journal of Reproductive Health* 12(1): 101-108

Obong O. (2003). Cultural Diversity and Population in Nigeria. *Population and Dev. Rev.*, 29 (1): 101-111.

Odhiambo, O. (1997). Men's Participation in Family Planning Decisions in Kenya: *Population Studies* 51(1).

Odimegwu, C., Ojo, M., & Siyangade, A. (1997). Regional correlates of choice of contraceptive methods in Nigeria. *Korea Journal of Population and Development. Vol 26 No 1* .

Odusina, E. K, Ugal D. B. Olaposi O. (2012) Socio-Economic Status, Contraceptive Knowledge And Use Among Rural Women In Ikeji Arakeji, Osun State, Nigeria. *Afro Asian Journal of Social Sciences 3 3.2 Quarter* II

Ogunjuyigbe P.O, Ojofeitimi E.O and Liasu A (2009). Spousal communication, changes in partner attitude, and contraceptive use among the Yorubas of Southwest Nigeria. Indian.*Journal of Community Medicine*, 34(2):112-6.

Orji, O., Onwudiegwu, U. (2002). Contraceptive practice among married market men in Nigeria. http//www.cat.inist.fr/ (August, 8, 2011).

Oke, R.O. (2001). Inheritance in Africa and the right of the female Child in Akintunde, D.O.African Culture and the Quest for Women's right. Ibadan: Sefer Books Ltd

Okomma, A. (2008). *Fertility regulation and the society.* A radio Nigeria audience participation programmed, Radio Link. June 28

Okonofua F. E.(1999).'Assessing the Prevalence and Determinants of Unwanted Pregnancy and Induced Abortion in Nigeria'. *Studies in Family Planning* 30(1) 67 – 77.

Olaleye, D.O. and Bankole, A.(1994). The Impact of Mass Media Family Planning Promotion on Contraceptive Behaviour of women in Ghana. *Population Research and Policy Review,* 13:161-

Olawepo, R. A. Okedare, E. A. (2006). Men" s attitudes towards family planning in a traditional urban centre: An example from Ilorin, Nigeria. J. Soc. 13(2): 83-90

Olugbenga Bello,A.I., Adekanle D.A.,Ojofeitimi E.O,Adeomi,A.A.,(2010).Barrier of con trace ption among adolescents and young adults in a tertiary institution in Southwestern Nigeria: a cross-sectional descriptive study. *Int J Adolesc Med Health*, 22(2):321-329.

Osemwenkha, S. 2004. Gender Issues in Contraceptive Use among Educated Women in Edo State, Nigeria. *African Health Sciences* 4(1): 40–49.

Oyediran, M.A. (1969). "Family planning in Nigeria." *Journal of Medical Education* 44 (11):160-161.

Oyedokun A. O. (2007) Determinants of Contraceptive Usage: Lessons from Women in Osun State, Nigeria. *Journal of humanities and social sciences* 1(2)

Oye-Adeniran BA, Adewole IF, Umoh A.V, (2004). Community-based survey of unwanted pregnancy in Southwestern Nigeria. *Afr J Reprod Health*.8(3):103– 115.

Oye-Adeniran, B., I.F. Adewale, A.V. Umoh, A. Oladokun, A. Gbadegesin, and E.E. Ekanem. (2006). "Community-based study of contraceptive behavior in Nigeria." *African Journal of Reproductive Health* 10 (2):90-104.

Onuh, F., 2003. The practice of family planning methods in Benue State. Unpublished Handout.

Otoide, V.O, Orasaye, F. Okonofua, F.E (2001) Sexual Behaviour and Contraceptives use Among School Adolescent in Benin City Nigeria. *Journal of Obs.and Gynea* 21(3): 298-302

Ottong, J. G. (1991). The male factor in family planning in Nigeria: Implication for population education. In Ebong, M. O. (Ed.), *Mobilization of resources for rural development in Nigeria* (260-273). Calabar: Wusen Press.

Ozumba, B. O., O.S., Ijeoma W. (2005). 'Knowledge, Attitude and Practice of Modern Contraception among Single Women in a Rural and Urban Community in South East Nigeria'. *Journal of Obstetrics and Gynecology.* 25(3) 292-295.

Peter O. O, Ebenezer O. O, Ayotunde L (2009). Spousal Communication, Changes in Partner Attitude and Contraceptive use among the yorubas of southwest Nigeria. Indi an Journ *al of Community Medicine* 34(2)

Ringheim, K. (1993). Factors that determine prevalence of use contraceptive methods for men. *Stud Fam Plan 24 (2):* 87-99.

Ringheim, K. (1996). Male involvement and contraceptive methods for men. *Present and Future social change*, September-December 1996, 26(3-4), 88-99.

Rutstein, S.O. (2005). Effects of Preceding Birth Intervals on Neonatal, Infant, and Under-Five Years Mortality and Nutritional Status in Developing Countries: Evidence from the Demographic and Health Surveys. *International Journal of Gynecology and Obstetrics* 89 (Suppl 1): S7–S24.

Sahoo, H. (2007). "Determinants of contraceptive use in Orissa:an analysis from national family health survey 111'. *Health and Population Perspectives and Issues 30 (3)*, 208- 221.

Shah, N.M., M.A. Shah, and Z. Radovanovic. 1998. "Pattern of desired fertility and contraceptive use in Kuwait." *International Family Planning Perspectives* 24 (3):133-138.

Saluja,N., S. Sharma, S. Choudhary, D. Gaur, S. Pandey. (2011). Contraceptive Knowledge, Attitude and Practice Among Eligible Couples of Rural Haryana. *The Internet Journal of Health*, 12(1).

Samandari G, Speizer IS, O'Connell K. (2010). The role of social support and parity in contraceptive use in Cambodia. Int Perspect Sex Reprod Health. Sep;36(3):122-31.

Singh, S., and J. Darroch (2012). *Adding it all up: The cost and benefits of investing in family planning - estimates for 2012* New York: Guttmacher Institute and United Nations Fund

Singh, S., J.E. Darroch, L.S. Ashford, and M. Vlassoff (2009). *Adding it up: The costs and benefits of investing in family planing and maternal and newborn health* New York: Guttmacher Institute.

Stephenson, R., and A.O. Tsui. (2003). "Influences on reproducitive wellness in northern India." *American Journal of Public Health* 93 (11):1820.

Stephenson, R., A. Baschieri, S. Clement, M. Hennink, and N. Madise (2007). "Contextual influences on modern contraceptive use in Sub saharan Africa."*American Journal of Public Health* 97 (7):1233-1240.

Stephen, A.A., and P.M. Enoch. (2014). "Modern contraceptive use, sex refusal, spousal difference in level of education among married women in Nigeria: Are they interrelated?" *International Journal of Humanities* 4 (6):217-230.

Stokes, B. (1980). Men and Family Planning. World watch paper 41. World watch Institute, Washington DC

Tawiah, E. (1997). Factors affecting contraceptive use in Ghana. *Journal of biosocial Sciences, 29*, 141-149.

Tsedekel, T. Wagar, and Davey (2004). The Role of Men in Contraceptive use and Fertility Preferences in Hosanna Town, Southern Ethiopia. *Ethio.J.Health Dev.20(3)152-159*

Toure, L. (1996). Male involvement in family planning. A review of the literature and selected programme initiative in Africa.http//www.sara.aed.org/publications/reproduc etive_he alth/fami ly-planning/html/male.htm. (April, 24, 2008).

Tsui, A.O., and A. ACreanga. 2009. *Does contraceptive use reduce neonatal and infant mortality?Findings from a multi-country analysis*. Maryland: John Hopkins Bloomberg School ofPublic Health.

Tyoden, C.L(2010).*Gender Roles and Responsibility in Zaria*. An unpublished M.S.c Thesis submitted to the Department of Geography, Ahmadu Bello University, Zaria.

Uchindi, J.M. (2001). "Spouse's socio-economic characteristics and fertility differences in Subsaharan Africa: Does spouse's education matter?" *Journal of Biosocial Science* 33 (4):481-502.

UNDESA. (2008). *United Nations E-government Survey 2008 Report From e- government to Connected Governance.* New York: Department of Economic and Social Affairs Division for public Administration and Development Management, .

UNESCO,(2011). Education counts towards millennium development goals.

United Nations Children's Fund (UNICEF). (2005). *Early Marriage: A Harmful Traditional Practice.* New York, NY, USA: UNICEF.

United Nations Agency for International Development (1999). Gender and HIV/AIDS. Taking Stock of Research and Programming. Washington D.C: UNAID Best practices series 996E

United Nations. (1994). *International Conference on population and Development*.Draft progrmme of Action of the conference, Cairo, Egypt,15th September.

United Nations. (2013). *World population prospects, the 2012 revisions: Key findings and advance.* New York: United Nations.

UNFPA,(2010)Ensuring that Every Pregnancy isWanted Retrieved from:http://www.unfp a.org/r h/planning.htm

UNFPA, and PATH. (2008). *Reducing unmet need for family planning: Evidence-based strategies and approaches*. Outlook. New York: UNFPA

Ushie, M.A, (2009). *Fertility Differential in Urban and Rural Nigeria: A Comparative Study of Calabar and Bendi Communities in Cross River State, Nigeria*. Unpublished Ph.d Thesis of the University of Calabar , Calabar – Nigeria.

Varma, G. R. & Rohini, A. (2008). Attitude of spouse towards family planning. A study among married men and women of a rural community in West Godavari District, Andhra Pradesh. http//www.krepublishers.com (October, 3, 2011).

Valentine, O., Frank, O.,Friday, O. (2001). Why Nigerian Adolescent Seek Abortion rather than Contraception:Evidence from Focus-Group Discussions.*International Family Planning Perspectives* 27 (2): 77-81.

Vivin, T (2012). Urban Differences in the use of Modern Contraceptive Methods among the people in the republic of yemen. *International Family Planning Perspectives* 21(1):15 20.

Wada, I.(2012).Every woman. *A Radio Magazine Programme on Radio Nigeria* (2nd Sep. ed.).

Warwick, Donald P. (1986). The Indonesian family planning program: Government influence and client choice. *Population and Development Review* 12 (3): 453-90.

Wickley, M.A (1992). Socio-Economic Status and Health: How Education, Income and Occupation Contribute to Risk for Cardio-vascular Disease. *American Journal of Public Health* 82: 816-820

Wiegratz I, Galilaer K, Sanger N, Rody A, Kuhl H, Schleubner E, (2010).Prescribing preferences and personal experience of female gynaecologists in Germany and Austria regarding use of extendedcycle oral contraceptives. The Euro J Contracept Reprod Health Care, 15(6):405-412.

Withers, M., Tavrow, P., & Adinata, N. (2011). Do ambivalent women have an unmet need for family planning? A longitudinal study from Bali, Indonesia. *Women's health issues 21 (6),* 444-449.

World Bank. World Development Indicators. Washington, DC. 2009.

Worldemecael, G., Beaujot, R.(2011). Currently married women with an unmet need for contraception in Eritrea: profile and determinants, *Can. Stud. Popul., 38(1-2): 61-81*

WHO, UNICEF, UNFPA and The World Bank. (2007). Maternal Mortality in 2005: Estimates developed by WHO, UNICEF, UNFPA and The World Bank. Geneva:

WHO, UNICEF, UNFPA, and the World Bank. (2010). *Trends in Maternal Mortality: 1990 to 2008. Estimates Developed by WHO, UNICEF, UNFPA, and the World Bank.* Geneva, Switzerland: WHO.

WHO. 2012. Millenium Development Goal (MDG) 5: Improve Maternal Health. Availabl at http://www.who.int/topics/millennium_development_goals/maternal_h ealth/ en/index.htl, accessed 2 January 2013.

World Health Organization. 2014. *Family planning fact sheet*. WHO

Yahya, A.A (2007). *Knowledge, Attitude and Practice of Husbands towards Modern Family Planning in Mukalla, Yemen.* A Thesis Presented to the Department of Family Health University, Mala.

Yihunie, L., A.A. Reda, H. Tamene, S. Benedict, and K. Deribe. 2013. "Geographical variation and factors influencing modern contraceptive among married women in Ethiopia:Evidence from a national population based survey." *Reproducitve Health* 10:52.

APPENDIX A

DEPARTMENT OF GEOGRAPHY, FACULTY OF SCIENCE, AHMADU BELLO UNIVRSITY, ZARIA

Dear Respondents,

This questionnaire is designed as part of a study on A comparative Analysis of knowledge and use of modern contraceptives among male and female in Okpokwu local government Area, Benue state Nigeria. This exercise is purely academic and so any information supplied would be used strictly for that purpose and thus treated strictly as confidential. I sincerely request your cooperation in completing this questionnaire. Please tick the appropriate option.

MALES BACKGROUND

SECTION A

DEMOGRAPHIC AND SOCIO-ECONOMIC CHARACTERISTICS

1.What is your age? (a) 15-19 [ ] (e) 35-39 [ ]
(b) 20-24 [ ] (f) 40-44 [ ]
(c) 25-29 [ ] (g) 45-49 [ ]
(d) 30-34 [ ]

2. Gender? male [ ] female [ ]

3.What is your ethnic group? (a) Tiv [ ] (b) idoma [ ] (c) Ibo [ ] (d) Yoruba ( ) (e) other specify…….4. R eligious affiliation? (a) Islam [ ](b) Christianity [ ] (c) Traditional/Pagan [ ] (d) Other specify ……

4b.if Christian, what denomination or church do you belong to?

(a) Catholic [ ] (b) Protestant [ ] (c)Anglican [ ] (d) Pentecostal [ ] (e) Others specify ……

5. What is your highest educational attainment? (a) Primary education [ ] (b) Secondary (c) Qur'anic (d) Post-secondary [ ] (e) None [ ] (f) Other specify…….

6. What type of occupation do you engage in? (a) None [ ](b) Civil servant [ ] (c) Farming [ ] (d) petty trader/Business [ ](e) Casual laborer [ ](f) Student [ ] (g) Other specify……..

7. What is your income per month? (a) Less than N5000 [ ] (b) N500-N9000 [ ] (c) N10,000-N14,0000 [ ] (d) N15000-19000 [ ] (e) N20,000-24,000 ( ) (f) 25,000-29,000( ) (g) 30,000-34,000 (h) 35,000-39,000 ( ) (i) 40,000 and above

8. Location of respondents: Rural (a) ( ) (b) Semi-urban ( )

MARRIAGE HISTORY

8a.What is your marital status? (a) Single [ ](b) Married [ ] (c) Widow [ ] (d) Divorce (e) Separated](f) Others specify …….

9b.If married, what is your age at first marriage? (a) 15-19 [ ] (b) 20-24 [ ] (c) 25-29 [ ] (d) 30-34 ( ) (e) 35 – 39 [ ](f) 40 -44 [ ] (g) 45-49 [ ]

10. Type of marital union? (a) Polygamy [ ] (b) Monogamy [ ] (c) Other specify ……

11. If polygamy union, how many wives do you have? (a) 2 [ ] (b) 3 [ ] (c) ( ) (d) 5 and above [ ]

FERTILTY PREFERECES

12. How many children do you have? (a) Female …….. (b) Male ……

13. How many children do you prefer? (a) 1-2 [ ] (b) 3-5 [ ] (c) 6 and above [ ] (d) None [ ]

14. Who decides on the number of children to have? (a) Husband [ ] (b) Wife [ ](c) Jointly [ ] (d) Others specify …….

15. Number of living children (a) None [ ](b) 1-2 [ ] (c) 3-4 [ ] (d) 5-6 [ ](e) 7-8 [ ] (f)> 9 [ ]

16 Do you practice child spacing? (a) Yes [ ] (b) No [ ]

17. How long do you space children? (a) < 1 [ ] (b) > 1 [ ] (c) 2 years [ ] (d) Others specify ……

18. Do you practice exclusive breastfeeding? (a) Yes [ ] (b) No [ ]

19. How long do you breastfeed your child/ children? (a) 1-6 months [ ](b) 7-12 months[ ] (c) 18 months [ ] (d) 22 months [ ] (e) 24 months and above [ ]

SECTION B

CONTRACEPTIVE KNOWLEDGE AND USE

20.Have you ever heard of any contraceptives (a) Yes [ ] (b) No [ ]

21If yes, what was your source of information? (a) Friends [ ] (b) Family members [ ] (c) Electronic media [ ](d) Hospital [ ] (e) Print media [ ](f) Schools/Offices [ ]

(g) Others specify……

22. Are contraceptives services readily available in your locality? (a) easily available [ ](b) Not easily available [ ] (c) Others specify ……

23Does location of contraceptive service center stand as a barrier towards access to its methods? (a) Yes (b) No [ ]

24. What is the distance of the service center to your home? (a) Very far [ ] (b) Very close [ ] (c) Not too far from my home [ ]

25. Are the available contraceptive services readily affordable in your locality?

(a) Easily affordable [ ] (b) Not easily affordable [ ] (c) others (specified)-------

USE OF CONTRACEPTIVES

26. Did you approve any contraceptive usage (a) Yes [ ] (b) No [ ]

27. Why do you approve of contraceptive usage? (a) To delay pregnancy [ ] (b) Achievement of desired number of children [ ] (c) Health of respondents [ ] (d) Lack of economic resources [ ] (e) To complete education [ ] (f) No response [ ]

28. indicate which of the methods you know and make use of?

	Methods	Methods known	Methods use	
i.	None	[ ]	[ ]	
ii.	Pills	[ ]	[ ]	
iii.	Injectables	[ ]	[ ]	
iv.	Intra-uterine device (IUD) Loop	[ ]	[ ]	
v.	Diaphragm	[ ]	[ ]	
vi.	Female sterilization	[ ]	[ ]	
vii.	Vasectomy (Male sterilization)	[ ]	[ ]	
vii.	Douche	[ ]	[ ]	
viii.	Condom; Female/Male	[ ]	[ ]	
x.	Breastfeeding/LAM	[ ]	[ ]	
xi.	Others; specify:	[ ]	[ ]	

28.a.If No, why not?

(a)Spousal disapproval [ ] (b) Have reached menopause [ ] (c)I don't want to use it [ ](d) My religion disapproves it [ ] (e) I am afraid of side effect [ ] (f) I don't want more children [ ] (g) Others (specify)……..

29b. If No, would you like or wish to use contraceptive in future? Yes [ ] (b) No [ ]

30. If you have ever used but stopped why? (a) My body reacted to it [ ](b) I wanted to have more children [ ] (c) My spouse disapproved of it [ ] (d) There was no regular supply[ ] (e) Expensive [ ](f) Others (specify) …….

31. Where do you obtain these services from? (a) Pubic hospital [ ] (b) Private hospital [ ] (c) Herbal medicine practitioner [ ](d) Medicine vendors [ ](e) Pharmacy [ ] (f) Others (specify)……..

32. Who pays for the contraceptive services? (a) Husband [ ] (b) Wife [ ] (c) Jointly [ ] (d) Others (specify) ……

33a. Are you currently using any contraceptive method? (a)Yes [ ] (b) No [ ]

34.b If yes, give reason for continuous usage? (a)Preference [ ] (b) Living standard [ ] (c) Spousal approval (d) Health of client [ ] (e) Spacing of birth [ ] (f) Desired family size [ ]

35. What determines the use of contraceptive services? (a) Spacing of birth [ ] (b) Spousal approval [ ] (c) Desired family size [ ] (d) Preference [ ] (e) Prevention from Sexually Transmitted Diseases [ ] (f) Living standard [ ] (g)Health of client [ ] (h) Stage of Life [ ] (i) For termination of child bearing (j)Others (specify)……..

SECTION C

DECISION MAKING PROCESS

36. Who made the decision to practice of contraceptive in the family?

(a) Wife [ ] (b) Husband [ ] (c) Jointly: husband and wife [ ] (d) Medial professional [ ] (e) Others: (specify)

37. What determine the method of contraceptive method adopted?

(a) Cost [ ](b) Convenience [ ](c) Spouse approval [ ] (d) Availability [ ] (e) Effectiveness [ ] (f) Others specify……..

38. You have never practice contraceptives before? (a) Yes [ ] (b) No [ ]

39. Whose decision is/was it? (a)Wife [ ] (b) Husband [ ] (c) Jointly [ ] (d) No idea[ ]

40. Are you satisfied with the existing contraceptive methods/services offered at source supply centers? (a) Yes [ ] (b) No [ ] (c) No response [ ]

41. If No, what is your reason? (a) Inadequate knowledge and information provided by service provider [ ] (b) Inadequate trained service provider [ ] (c) Health post too far away [ ]

(d) Female gender as service provider should be preferred [ ] (e) Inadequate facilities [ ] (f) Others (specify)…… …….

APPENDIX B

FOCUS GROUP DISCUSSION GUIDE

Introduction: I am a student from Geography Department, Ahnadu Bello University, Zaria undertaking a research on comparative analysis of knowledge and use of modern contraceptives. You have been selected for a group discussion. I want us to discuss the issues I will raise, frankly. I want to understand the community's belief and perspectives on these issues. Please feel free to talk and express your views. The information you provide is strictly for academic purpose is confidential. Please tell us your name and your educational qualification before you respond. Thanks for your participation.

Questions	Probe for
General questions Why is modern contraceptives frowned at in this society?	Explain the reasons
Desire family size With regard to children, who do you think usually wants more children?	Explain the reasons
With respect to your home, who wants more children?	Husband or wife, explain the reasons
What are some of the actions a man will take to ensure he has the desire number of children?	Explain the reasons
What are the reasons why men want a large family?	Explain the reasons
Decision making in family life Who do you think should have the final say about whether or not to have more children	Husband or wife, explain the reasons

FEMALE BACKGROUND

SECTION A

DEMOGRAPHIC AND SOCIO-ECONOMIC CHARACTERISTICS

1.What is your age? (a) 15-19 [ ] (e) 35-39 [ ]
(b) 20-24 [ ] (f) 40-44 [ ]
(c) 25-29 [ ] (g) 45-49 [ ]
(d) 30-34 [ ]

2. Gender? male [ ] female [ ]

3.What is your ethnic group? (a) Tiv [ ] (b) idoma [ ] (c) Ibo [ ] (d) Yoruba ( ) (e) other specify……

4. Religious affiliation? (a) Islam [ ](b) Christianity [ ] (c) Traditional/Pagan [ ] (d) Other specify ……

4b.if Christian, what denomination or church do you belong to?

(a) Catholic [ ] (b) Protestant [ ] (c)Anglican [ ] (d) Pentecostal [ ] (e) Others specify ……

5. What is your highest educational attainment? (a) Primary education [ ] (b) Secondary (c) Qur'anic (d) Post-secondary [ ] (e) None [ ] (f) Other specify…….

6. What type of occupation do you engage in? (a) None [ ](b) Civil servant [ ] (c) Farming [ ] (d) petty trader/Business [ ](e) Casual laborer [ ](f) Student [ ] (g) Other specify……..

7. What is your income per month? (a) Less than N5000 [ ] (b) N500-N9000 [ ] (c) N10,000-N14,0000 [ ] (d) N15000-19000 [ ] (e) N20,000-24,000 ( ) (f) 25,000-29,000( ) (g) 30,000-34,000 (h) 35,000-39,000 ( ) (i) 40,000 and above

8. Location of respondents: Rural (a) ( ) (b) Semi-urban ( )

MARRIAGE HISTORY

8a.What is your marital status? (a) Single [ ](b) Married [ ] (c) Widow [ ] (d) Divorce (e) Separated[ ](f) Others specify……

9b.If married, what is your age at first marriage? (a) 15-19 [ ] (b) 20-24 [ ] (c) 25-29 [ ] (d) 30-34 ( ) (e) 35 – 39 [ ](f) 40 -44 [ ] (g) 45-49 [ ]

10. Type of marital union? (a) Polygamy [ ] (b) Monogamy [ ] (c) Other specify ……

11. If polygamy union, how many wives did your husband have? (a) 2 [ ] (b) 3 [ ] (c) ( ) (d) 5 and above [ ]

FERTILTY PREFERECES

12. How many children do you have? (a) Female …….. (b) Male ……

13. How many children do you prefer? (a) 1-2 [ ] (b) 3-5 [ ] (c) 6 and above [ ] (d) None [ ]

14. Who decides on the number of children to have? (a) Husband [ ] (b) Wife [ ](c) Jointly [ ] (d) Others specify …….

15. Number of living children (a) None [ ](b) 1-2 [ ] (c) 3-4 [ ] (d) 5-6 [ ](e) 7-8 [ ] (f)> 9 [ ]

16 Do you practice child spacing? (a) Yes [ ] (b) No [ ]

17. How long do you space children? (a) < 1 [ ] (b) > 1 [ ] (c) 2 years [ ] (d) Others specify ……

18. Do you practice exclusive breastfeeding? (a) Yes [ ] (b) No [ ]

19. How long do you breastfeed your child/ children? (a) 1-6 months [ ](b) 7-12 months [ ] (c) 18 months [ ] (d) 22 months [ ] (e) 24 months and above [ ]

SECTION B

CONTRACEPTIVE KNOWLEDGE AND USE

20. Have you ever heard of any contraceptives (a) Yes [ ] (b) No [ ]

21 If yes, what was your source of information? (a) Friends [ ] (b) Family members [ ] (c) Electronic media [ ] (d) Hospital [ ] (e) Print media [ ] (f) Schools/Offices [ ] (g) Others specify……

22. Are contraceptives services readily available in your locality? (a) easily available [ ] (b) Not easily available [ ] (c) Others specify ……

23. Does location of contraceptive service center stand as a barrier towards access to its methods? (a) Yes (b) No [ ]

24. What is the distance of the service center to your home? (a) Very far [ ] (b) Very close [ ] (c) Not too far from my home [ ]

25. Are the available contraceptive services readily affordable in your locality?

(a) Easily affordable [ ] (b) Not easily affordable [ ] (c) others (specified)-------

USE OF CONTRACEPTIVES

26. Did you approve or use any contraceptives (a) Yes [ ] (b) No [ ]

27. Why do you approve of contraceptive usage? (a) To delay pregnancy [ ] (b) Achievement of desired number of children [ ] (c) Health of respondents [ ] (d) Lack of economic resources [ ] (e) To complete education [ ] (f) No response [ ]

28. indicate which of the methods you know and make use of?

	Methods	Methods known	Methods use
i.	None	[ ]	[ ]
ii.	Pills	[ ]	[ ]
iii.	Injectables	[ ]	[ ]
iv.	Intra-uterine device (IUD) Loop	[ ]	[ ]
v.	Diaphragm	[ ]	[ ]
vi.	Female sterilization	[ ]	[ ]
vii.	Vasectomy (Male sterilization)	[ ]	[ ]
vii.	Douche	[ ]	[ ]
viii.	Condom; Female/Male	[ ]	[ ]
x.	Breastfeeding/LAM	[ ]	[ ]
xi.	Others; specify:	[ ]	[ ]

28.a.If No, why not?

(a)Spousal disapproval [ ] (b) Have reached menopause [ ] (c)I don't want to use it [ ](d) My religion disapproves it [ ] (e) I am afraid of side effect [ ] (f) I don't want more children [ ] (g) Others (specify)……..

29b. If No, would you like or wish to use contraceptive in future? Yes [ ] (b) No [ ]

30. If you have ever used but stopped why? (a) My body reacted to it [ ](b) I wanted to have more children [ ] (c) My spouse disapproved of it [ ] (d) There was no regular supply[ ] (e) Expensive [ ](f) Others (specify) …….

31. Where do you obtain these services from? (a) Pubic hospital [ ] (b) Private hospital

l[ ] (c) Herbal medicine practitioner [ ](d) Medicine vendors [ ](e) Pharmacy [ ] (f) Others (specify)……..

32. Who pays for the contraceptive services? (a) Husband [ ] (b) Wife [ ] (c) Jointly [ ] (d) Others (specify) ……

33a. Are you currently using any contraceptive method? (a)Yes [ ] (b) No [ ]

34.b If yes, give reason for continuous usage? (a)Preference [ ] (b) Living standard [ ] (c) Spousal approval (d) Health of client [ ] (e) Spacing of birth [ ] (f) Desired family size [ ]

35. What determines the use of contraceptive services? (a) Spacing of birth [ ] (b) Spousal approval [ ] (c) Desired family size [ ] (d) Preference [ ] (e) Prevention from Sexually Transmitted Diseases [ ] (f) Living standard [ ] (g)Health of client [ ] (h) Stage of Life [ ] (i) For termination of child bearing (j) Others (specify) ……..

SECTION C

DECISION MAKING PROCESS

36. Who made the decision to practice contraceptives in the family?

(a) Wife [ ] (b) Husband [ ] (c) Jointly: husband and wife [ ] (d) Medial professional [ ] (e) Others: (specify)

37. What determine the method of contraceptive method adopted?

(a) Cost [ ](b) Convenience [ ](c) Spouse approval [ ] (d) Availability [ ] (e) Effectiveness [ ] (f) Others specify……..

38. You have never practice contraceptives before? (a) Yes [ ] (b) No [ ]

39. Whose decision is/was it? (a)Wife [ ] (b) Husband [ ] (c) Jointly [ ] (d) No idea[ ]

40. Are you satisfied with the existing contraceptive methods/services offered at source supply centers? (a) Yes [ ] (b) No [ ] (c) No response [ ]

41. If No, what is your reason? (a) Inadequate knowledge and information provided by service provider [ ] (b) Inadequate trained service provider [ ] (c) Health post too far away [ ]

(d) Female gender as service provider should be preferred [ ] (e) Inadequate facilities [ ] (f) Others (specify)…… …….

APPENDIX B

FOCUS GROUP DISCUSSION GUIDE

Questions	Probe for
General questions Why is modern contraceptives frowned at in this society?	Explain the reasons
Desire family size With regard to children, who do you think usually wants more children?	Explain the reasons
With respect to your home, who wants more children?	Husband or wife, explain the reasons
What are some of the actions a man will take to ensure he has the desire number of children?	Explain the reasons
What are the reasons why men want a large family?	Explain the reasons
Decision making in family life Who do you think should have the final say about whether or not to have more children	Husband or wife, explain the reasons