AN ASSESSMENT OF MEN'S ROLE AND ATTITUDE TOWARDS FAMILY PLANNING IN ZARIA LOCAL GOVERNMENT AREA OF KADUNA STATE, NIGERIA

BY

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Declaration

I hereby declare that the work in this thesis titled "**An Assessment of Men's Role and Attitude towards Family Planning in Zaria LGA, Kaduna State, Nigeria**" was carried out by the researcher, Abubakar, Mairo under the supervision of Professor M. M. Mamman and Dr. 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 thesis has been previously presented for any degree or any diploma at any university.

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ABUBAKAR, MAIRO DATE

Certification

This thesis titled "**An Assessment of Men's Role and Attitude towards Family Planning in Zaria LGA, Kaduna State, Nigeria**" by Abubakar, Mairo meets the regulations governing the award of degree for Masters in Science, in Ahmadu Bello University, Zaria. It is also approved for its input to knowledge and literary presentation.

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Dedication

This thesis is dedicated to my beloved children Zayyad, Muhammad Ghali, Yaaqub and Ikram, my granny and mother who have been my source of comfort and inspiration in life and all women, the world over whose husbands do not support them to practice Family Planning.

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My body and soul is always full of gratitude to the Supreme Lord of all Creations, the Lord Majesty, without Whom nothing is possible.

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Abstract

Many studies carried out on family planning focused immensely on women neglecting men's role and attitude. Despite Government programmes and facilities to encourage family planning in Nigeria, the uses of such facilities are still low in Zaria LGA. Results were presented in the form of frequency tables, percentages, charts and Chi square analysis. The research was carried out among men and women between the ages of 15 and 50+ years. These men and women were purposefully selected, based on respondents who were willing to take part in the study. A sample of 0.1% of the total population (408,198) of the study area was taken. The Hausa/Fulani is the largest ethnic group, followed by northern minority and Yoruba; Muslims are the major religious group. The findings also revealed that more than half of the respondents have tertiary education, followed by secondary and Quranic education. A greater proportion of the respondents were civil servants and those doing business. More than one quarter of the respondents did not disclose their income. More than half of the respondents want to have additional number of children. In spite of high knowledge of FP, only 121 out of 354 respondents are currently practicing FP. Ever use of FP by respondents was slightly higher than current use. While injectables and oral contraceptive pills were the most used methods by women, condom was the most used method by men. Decision making regarding the practice of FP is made jointly followed by husband only. The main reasons for adopting any FP method are spousal approval, effectiveness and availability. Majority of respondents not practicing FP do not intend to use FP in the future. The Chi square analysis (X^2) revealed a significant association between marital status, educational attainment and knowledge of FP. Age, religion, ethnicity, education and income have statistically significant relationship with family planning practice. Religion, marital status and income also have statistically significant relationship with who made the decision to practice FP. Family planning programme in northern Nigeria should focus on Muslim men more to participate as joint decision makers in modern FP practice. This can be achieved through targeted family planning education and promotion programme to husbands. Religious leaders must be involved in clarifying religious misconceptions on issues regarding family planning. By practicing FP, the rates of maternal and child mortality will be reduced in Nigeria, especially in Northern Nigeria where such rates are very high.

Definition of Terms and Abbreviations

Child spacing: Delaying pregnancies between child births.

Infertility: The inability of couples to achieve pregnancy in 1 or 2 years of unprotected intercourse or couples who do not have/never had a child.

Patrilineal: Descent traced through paternal line or family relations traced through the male line.

Unmet need: Women would prefer to stop having children or delay their next birth, but are not using any method of family planning.

DHS: Demographic Health Survey

FP: Family Planning

FGD: Focus Group Discussion

FRN: Federal Republic of Nigeria

ICPD: International Conference Population Development

IPPF: International Planned Parenthood Federation

LGA: Local Government Area

NDHS: National Demographic Health Survey

RH: Reproductive Health

UN: United Nations

UNAID: United Nations Agency for International Development

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CHAPTER ONE: INTRODUCTION

1.1 Background to Study

The end of the last century witnessed increased recognition of the need to involve men in sexual and reproductive health (RH) issues and initiatives, and to understand their needs and perceptions in reproductive health matters. Before the current concern for male involvement began, reproductive health issues and services had become synonymous with women's RH, and men were assumed to have no special interest in such matters. The tacit exclusion of men from active involvement in these issues in many developing societies, particularly Africa, represents a lack of appreciation of the social reality of daily living in these societies. Indeed the characteristic lack of male involvement in reproductive initiatives, including family planning, is a major obstacle to sustained fertility decline in sub-Saharan Africa, given the considerable authority and power vested on men as decision makers in the home and society. However, the opinions of men in family planning were considered secondary even in patriarchal African societies, which view the society as men's world (Isiugo-Abanihe, 2003).

Patriarchy, the control of the family by men, which often involves patrilineality and patrilocality or marital residence with husband's kin, is at the root of both gender socialization and male dominance in sexual, reproductive and productive issues. For most of Africa, socio-cultural and ethnic realities form the basis for patriarchal and gendered socialization of children, and confer privileges on men by defining appropriate male and female roles as opposite and polarized. The socialization process makes Nigerian men influential and dominant in all spheres of life, giving them the final say on various family issues. They are at the center of decision-making in the traditional political economy and are important agents of change. Therefore, any successful attempt at social engineering must begin with men. They should also be well informed on the reproductive process and responsible parenthood so that they can positively impact on the lives of their wives and children (Ibid).

Irrespective of culture or ethnic orientation, and whether under Islamic, Christian or traditional African beliefs and precepts, the socialization process and role system in Nigeria generally confer on husbands the authority and role of making decisions on matters affecting marital and family life, which certainly will include the use and non use of family planning services, and indeed childbearing itself. Above all, Nigerian men enjoy enormous educational, occupational and economic advantage over women. Implicitly, they wield power and influence in the home and society and dictate the pattern and trend of events in a cultural environment where male values hold sway. More so, there are some social and institutional factors that favor men in matters affecting the family. This is related to the fact that they control economic resources and the significant role they play as household heads, custodians of their lineage, protectors and providers of the family (Ibid).

African family structures affect individual perception of child-related processes and affect reproductive decision-making and actual fertility behavior. Men play an instrumental role in every aspect of sexual and reproductive dynamics, from the timing of intercourse and contraceptive use to sexually transmitted disease treatment and antenatal care. They also function as ‘gatekeepers’ to women’s sexuality and reproductive health because of many powerful roles they play as husbands, fathers, uncles, religious leaders, doctors, policy makers, local and national leaders (Varga, 2001; Drennan, 1998). This is because men in these societies contribute more resources in running the family, which gives them more authority to control the sexuality of their wives among other matters. Thus, the perceived wishes of the husband may influence the behavior of the wife (Duze and Muhammad, 2006).

Taking cognizance of the increasing realization of the role of men in family life, the International Planned Parenthood Federation (IPPF) staff consultation on male involvement in family planning stressed that men have a basic human right and responsibility to family planning services (IPPF, 1984). This is because reproduction cannot take place without them and male involvement will also encourage male responsibility in sexual behaviour (Isiugo-Abanihe, 2003).

In 1988, the Federal Government of Nigeria announced a population policy, which aimed at achieving lower population growth through reduction of fertility rates. The Nigerian population policy document stated that appropriate information and education programmes shall be designed and implemented to promote awareness in men of their responsibility for adequate caring and for having appropriate family sizes (FGN, 1988). The policy rightly emphasized the importance of men in family life; hence one of its eight implementation strategies was devoted to men. The document succinctly summarized the position of men with respect to family life in Nigeria thus:

"In our society, men are considered the heads of the families and they take far-reaching decisions including family size, subsistence and social relations….The average man bears greater burden in caring for the family. Special information and enlightenment programmes are necessary to increase awareness of men as to the need of having the appropriate size of family they can foster within their resources. (FGN, 1988:19)"

During the past 15 years, many in the reproductive health field have come to appreciate the need for the constructive involvement of men in family planning programmes and services. The 1994 International Conference on Population Development (ICPD) held in Cairo, Egypt articulated why and how male involvement should occur. Recognition is growing that men are interested in and need reproductive health information and services, both for themselves and for their partners (Drennan, 1998; Reingheim, 2002; AGI, 2003) and that reproductive health of individuals depends heavily on the relationship between the people concerned. Awareness has increased that services should not only be directed towards women but also towards men and couples (Reingheim, 2002).

In recent years, the Government of Nigeria has intensified efforts to educate the generality of her population on the need for reproductive health and responsible parenthood in particular. However, in spite of the introduction of family planning services as a means of curbing high fertility rates, the population still increases because of the attitude of the people involved. This is noticed especially in men and the role they play in reproduction (Olawepo and Okedare, 2003). From the results of the National Demographic Health Survey (NDHS) of 2008, the North-West (NW) zone ranks lowest in male use of family planning methods with 0.1%, the North-East is 0.2%, the North-Central (1.9%), the South-West has the highest (6.1%), the South-East (4.6%), and the South-South (4.4%). There is also an indication that FP practice is generally low in Nigeria with 31.7% in the South-West, 26.2% in the South-South, 23.4% in the South-East. In the North-Central it is 13%, North-East is 4.0% and 2.8% in the North-West (NDHS, 2008).

Zaria LGA, a Hausa society located in northern Nigeria is patrilineal with a strong male influence on many household decisions including those involving reproduction. This makes the attitudes of male toward family planning and contraceptive use a significant factor influencing the overall fertility level in the region. Given the decision-making powers of Nigerian men and the fact that they also control economic resources, it is important to consider their attitudes towards and willingness to use contraceptives to control family size.

1.2 Statement of the Research Problem

Both men and women have prominent roles to play in the decision to use family planning methods and in determining the number of children a couple should have. The man and woman are important factors in bringing children to life, yet demographic studies on reproduction have tended to focus on women alone. For long, programmes on family planning have been directed towards women only, overlooking men who exert greater influence on family size and family planning decisions. In the light of the current gender imbalances, it is inadequate to talk about the attitudes and involvement of only females in family planning without taking the male involvement context into account.

Of the six geo-political zones in Nigeria, the North-West zone (comprising of Kaduna, Kano, Katsina, Kebbi, Jigawa, Sokoto, and Zamfara States) has the highest population growth rate of 3.14%, accounting for the largest population size of over 35 million people. It also has the highest number of women in the reproductive ages (15-49 years) of 8.2 million or about 46.8% of the total female population and the highest fertility rate of 5.7. Overall, this zone constitutes the largest proportion of the age group (0-4 years) which is 19.9% of the total population and the highest percentage of the young population (0-14 years) of 47.4%, more than the national rate which is 41.8% (NPC, 2009). While Nigeria's infant mortality rate stands at 75 per 1000 live births; child mortality rate is 88 per thousand populations (PRB, 2009). Maternal mortality for Kaduna State also stands at 1,000/100,000 live births (Kaduna State Ministry of Health, 2007). The NW zone has the highest sex ratio of 104.1 in excess of males, more than the national sex ratio of 103.3. Although the overall adult literacy rates (age 10+) of the nation have improved, the NW ranks the second lowest with 55.7% compared to the highest of 81.9% in the South-East. However, Kaduna State has the highest adult literacy rate of 67.4% in the NW, with a gender gap of 11.5% between males and females.

The North-Western zone also has the highest percentage of disabled persons of 5.15% with Kaduna State having 4.9% of its total population (149,352 persons) with one form of disability or the other. The largest family size (number of people in a household) in Kaduna State, accounts for more than 8 persons in over 1.5 million households (NPC, 2009). One of the great impacts of such problems is the high level of poverty experienced in the northern region especially in the NW. Could these figures and levels observed, which are pretty high in the NW be due to the large population size of the northern region and the result of non-involvement of men in family planning?

Zaria LGA is predominantly made up of Muslims and a Christian minority. The negative perception of family planning by most people in this society (and to a larger extent northern Nigeria) is remarkably influenced by the Islamic religion, which is deeply rooted in their culture and tradition. Islam teaches that children are gifts from God. The negative view about family planning is also related to the external source of the programme. Muslims view the programme as an attempt by the West to curtail their population. Christians too, especially the Roman Catholic abhor family planning. Practicing it, is regarded a heinous act. However, this is not the only obstacle to the success of family planning. This study is determined to look into the problems associated with the rejection of family planning programmes, especially in northern Nigeria. The active participation of men in family planning is highly required so as to prevent unwanted pregnancies since they are considered to have absolute control over their households and women are expected to respect their husbands' decisions. There is also the need to remind men of the daunting tasks and responsibilities awaiting them as household heads of large family sizes.

The role of men in family planning decision-making in Nigeria has not always been recognized in the demographic literature. This is evident from the large volume of literature based on studies focused on women, seeking to know their family size intentions, FP practice among other issues. Often, information on husbands' attitudes towards family size and contraceptive use is obtained through their wives on whom most researchers have focused their interest. However, such information based on wives' perceptions of their husbands' attitude may indeed differ significantly from men's actual attitudes and perceptions, if reported by them (Isiugo-Abanihe, 2003).

Abdulazeez (1990) considered knowledge, attitude and practice of family planning among the Nigerian Army's wives in, Zaria. The study revealed that majority of women, has great awareness of family planning. However, practice of family planning was found to be very poor, with only 25% due to factors such as religion, educational level, and ethnicity.

Isakoto (2002) also studied the effect of family planning on reproductive behavior in Zaria and showed that despite the side effects of contraceptives, women were not deterred to practice family planning. They were determined to limit their family size and space their children for the health of mother and child.

Omotolani (2002) studied people's perception of family planning methods in Zaria and focused types of family planning methods, knowledge of, attitude towards and level of usage of contraceptive methods. The study revealed that contraceptive knowledge is high but the level of usage is very low in urban Zaria. More than 80% have the knowledge and less than 5% of the people use more than one method. Furthermore, a positive relationship between educational attainment, family planning knowledge, and use of family planning methods were noted.

Similar studies have been carried out in Kaduna metropolis by Auta (1998); in Offa, Kwara State by Oyeniyi (2000); in Iyara, Kogi State by Akinwunmi (2002). Until recently, few studies in Nigeria have examined men's role and attitude in FP and fertility decision making process. Ignoring men in fertility research weakens efforts both to motivate and change their attitudes on population matters. It is against this background that this study seeks to address the following research questions:

- What role do men play in family planning in Zaria LGA?
- What are the socio-economic factors that affect family size in the study area?
- What are men's attitudes towards family planning in the study area?

1.3 Aim and Objectives

The aim of this study is to assess the role of men in and their attitudes toward family planning in Zaria LGA. This would be achieved through the following objectives, which are to:

i. assess the nature of family planning facilities available in Zaria LGA.
ii. examine the socio-cultural factors that determine family size in the study area.
iii. examine the socio-economic factors influencing men's role in FP in the study area.
iv. assess the role of men in family planning in Zaria LGA.
v. assess the attitudes of men towards family planning in the study area.

1.4 Hypotheses

H_0 There is no significant relationship between socio-economic factors and the use of family planning in Zaria LGA.

H_1 There is significant relationship between socio-economic factors and the decision to practice family planning in Zaria LGA.

1.5 Scope of the Study

The study covered Zaria LGA, which has thirteen wards (six and seven wards from within and outside the city wall respectively): Angwan Juma, Angwan Fatika, Kaura, Kwarbai A, Kwarbai B, Dembo, Dutsen Abba, Gyallesu, Kufena, Limancin Kona, Tudun Wada, TuKur Tukur and Wuciciri. This study focused on men and women between the ages of 15-50+ years. It also covered issues on male involvement in reproductive health decisions and socio-economic factors affecting the utilization of family planning services within and outside the city wall.

1.6 Significance of the Study

The attitudes of men and women have direct effects on family planning practice. Understanding the role of men in inhibiting or promoting family planning could affect the design of family planning promotion programme and also the success of the programme in Nigeria and other African countries. The lack of success of the family planning revolution is attributable to the failure of the programme to recognize the importance of male attitudes and attributes in fertility decision-making (Duze and Muhammad, 2006).

Most family planning programmes that continue to focus solely on women will continue to achieve only limited success in Nigeria and the many patrilineal societies where similar programmes are pursued. The implications of not involving men in family planning are the high morbidity and high mortality rates of women and children associated with closely-spaced births. Fertility rate is also high, translating into large family sizes and a rapidly growing population, which all have a negative impact on sustainable population growth and developments. Thus, the involvement of men will give family planning a better chance of success in the future, since they exert greater influence on family size and family planning decisions. In addition to reducing the fertility of women and slowing population growth, family planning 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.

1.7 Limitations

The collection of data from the study area was not without complications both for the researcher and research assistants. Most of the respondents were curious about why the researcher was interested in the role of men as well as their attitudes towards family planning. They assumed the researcher was being influenced by the western culture of having very few numbers of children; and also the ideology that Nigeria's population is very large, thus requires the help of family planning programmes, to curb high population growth. Some even thought the researcher was spying for the government as such refused to disclose their personal information. For some of the respondents who were not educated and unaware of family planning, the researcher and her assistants expended so much time explaining some questions that were not clear to respondents. Translating questions from English to Hausa languages was difficult also; the researcher had to seek the help of a good translator who could capture the essence of those questions written in English language. Questions about age, income and spousal communication were regarded offensive by some respondents, because they felt the researcher was invading their privacy. Distance to some of the wards consumed resources in terms of time and finance. The issue of family planning especially in a Muslim and Hausa dominated area is not without controversies, thus the researcher had to be extra careful in communicating to respondents, more importantly where the researcher, who is a female, was directly involved with the respondents who were male. Some respondents were surprised at the researcher's courage to carry out this kind of study, particularly when Islam frowns at the issue of family planning. Some respondents even questioned the legality of such study in Islam and one respondent openly asked if the researcher was not committing a sin. This contributed to low response to some questions. It took the researcher a long period of time to obtain data from the study area, and this eventually reduced the total return of questionnaires with 54 unanswered.

1.8 Ethical Issues

Informed consent of respondents to participate in the research was sought. Participants were provided with broad outline on issues the research will be exploring such as questions to be asked, the amount of time required to complete an interview etc. Confidentiality and privacy of participants were assured as well as the anonymity of informants. Where respondents were illiterates or unaware of FP; the researcher highlighted the motives of family planning to clarify misconceptions. This helped encourage respondents' participation in the research. Although the FGDs of men and women were conducted separately, the men talked more than the women. As such women were interviewed independently to ensure secrecy and full participation. The researcher and research assistants tried convincing respondents who were reluctant to give the required information that the research was purely for academic purpose. The FGDs and IDIs were conducted simultaneously in English and Hausa languages to allow full contribution of participants.

CHAPTER TWO: CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW

2.1 Introduction

Family planning refers to a conscious effort by a couple to limit or space the number of children they want to have through the use of contraceptive methods (NDHS, 2008). Furthermore family planning involves the provision of birth prevention information, services, and appliances thus it educates people on how to prevent births, usually with contraceptives but sometimes with abortion or sterilization. It also includes teaching men and women about the transmission of HIV/AIDS, other sexually transmitted infections and how to protect themselves from such infections (Upadhyay and Robey, 1999).

According to Mamman (2008), family planning implies a conscious and deliberate attempt by couples to check unwanted pregnancies so that they can have only the number of children they want. This means individuals and couples can decide “when” and “how many” they want. Family planning further targets couples with problems of infertility and tries to help them have children. It deals specifically with one population event which is “birth”. Family planning and birth control are not necessarily the same. While family planning is aimed at controlling births and promoting child spacing, birth control covers all the means of fertility control and implies measures that only affect the determinants of reproductive performance. The rationale for FP programme is that it allows couples to choose the size of families, in addition to providing substantial health benefits for mothers and children and contributing to socioeconomic development.

2.2 Family Planning in sub-Saharan Africa

Hatcher *et al.* (1997) opined that family planning is now seen as a human right basic to human dignity. People and governments around the world understand this. For several decades, demographers working in Africa have focused their attention largely on women's attitudes and behaviour in matters concerning reproduction forgetting men. Although men and women are biological partners in the reproductive processes, greater emphasis has been placed on the role of women, who bear the physical and emotional strains of pregnancy and childbirth. This preoccupation with women has tended to minimize the reproductive motivation of African men, thereby ignoring the social significance of people who are dominant not only within the family, but also at community and governmental levels. On account of the patriarchal system in Nigeria, fertility attitudes of women are mostly dictated by masculine values (Isiugo-Abanihe, 2003). This female bias in formal FP began with the first birth control clinics, which were established in Great Britain by Maria Stopes and Margret Sanger in the United States. These two pioneers were concerned with the suffering of women, who had too many children too close together. They lived in an age when women had few FP options other than dangerous illegal abortions. So, it was only natural that Stopes and Sanger championed women's roles in FP (Stokes, 1980).

The respect for high fertility, the horror of barrenness, and the belief that births are necessary to reincarnate one's ancestors, central to most African religions, at first impeded FP message and caused governments to be uncertain of how successful a programme, promoting contraception would be (Caldwell, 1992). A potential threat to African FP programmes is the achievement of fertility declines throughout the rest of the world. African FP programmes, and the health systems upon which many of them depend, cannot be erected or extended without massive international aide that must be obtained in an era when global interest is on "the end of the population explosion" and the coming "population implosion".

Although the situation in sub-Saharan Africa is dire, western governments may well continue to reduce their technical aid budgets for FP even though decades may pass before the region's economy can support fertility control by itself (Caldwell and Caldwell, 2002).

Sub-Saharan Africa constitutes the most important family planning frontier of the twenty-first century, because fertility is still high in all sub-regions except Southern Africa, home to less than one-thirteenth of its population. This is because FP practice is far lower than that of any world region, partly due to low level of socio-economic development and also strong cultural resistance to FP. In such circumstances, FP programmes modeled on Asia and North Africa have not been successful in the region, and modified or alternative models have yet to be developed. The process has been slow because most governments have not given FP strong support. The situation is changing, but even if FP programmes achieve greater efficiency to maintain the unprecedented steep fertility decline, posited by the United Nations (1999 and 2000) medium population projection, the lateness of the sub-Saharan African fertility decline will mean that this region will treble its numbers and double its proportion of the world's population from just over one-tenth to one-fifth during the twenty-first century (Ibid).

The persistence of high fertility in sub-Saharan Africa has been the subject of considerable investigation during the past two decades. Social forces sustaining high fertility and impeding FP programmes are well understood (Isiugo-Abanihe, 2003). For instance, Adamchak and Adebayo (1985) found that pronatalist pressures are reinforced by males over females which preclude women from controlling their own fertility. They observed that the rapid increase in Nigeria's population growth is accentuated by pronatalist attitudes of men. In addition, men's perception of their fecundity and their actual paternity status can have a dramatic impact on their definition of sex and their subsequent behaviour, especially if the culture associates reproductive prowess with masculinity, as is common among many ethnic groups in Nigeria. Fapohunda and Todaro (1988) have observed that the African family structure shapes individual spousal perceptions of child-related processes and affects individual reproductive decision-making and actual fertility behaviour. They found, from a Lagos data set that expected parental benefits from having children are far from equal between men and women. Furthermore, spouses in Nigeria rarely follow joint household financial management practices, the locus of fertility decision is determined by who controls and allocates economic resources within the family. Their study concluded that men's negative attitude is a major reason why their wives fail to practice FP, even when the latter are motivated to do so.

Ezeh (1992) observed in Ghana that women's fertility preferences and behaviour are strongly influenced by their husband's reproductive motivation. In most developing countries, women also carry the burden of responsibility on contraceptive use often with little or no support and sometimes with great resistance from their male partners (Oni and McCarthy, 1991; Salway, 1994, Lasee and Becker, 1997). Not surprisingly, African men generally desire larger families than do their wives, as a result of the institution of polygamy and because children enhance men's status and prestige of their lineage. As the main opinion leaders, efforts to influence the attitudes of men on population issues, and motivate them towards FP use would form the bedrock of a successful FP programme. Reaching men with messages and methods that encourage them to use FP will also motivate them to support their wives in FP decisions. It is imperative that men should be an integral part of FP programme to facilitate its receptivity (Isiugo-Abanihe, 1994).

Danforth (1999) indicated that overwhelming reliance on female FP methods has led to the assumption on the part of many women and men that contraception is only for women. This also resulted in women being the most family planning users, not men due to the perception or belief that men want large families to prove their virility. In spite of all these realizations, there is paucity of demographic data on male knowledge, attitude and practice of contraception in Nigeria. In other words, there is need to know the reproductive intentions and expectations of Nigerian men more than ever before. Ignoring men in fertility research and programmes undermines effort both to change their attitudes on population matters and to motivate them, and through them, their wives, toward FP.

This study is, therefore, significant because, for any population control activity to be effective there is the need to address the family life and sexual behaviour of men. These are very important because they are issues that have impact on fertility directly. The knowledge and practice of FP, men's approval of FP, and other fertility issues deserve serious consideration. Again, there is dire need to investigate the gender power relations in reproductive health decision-making processes. Who decides when to adopt FP and which FP methods to use? All these questions are important for channeling and direction of action programmes.

2.3 Cultural Roots of Male Dominance

In sub-Saharan Africa, patriarchy and patrilineal traditions influence all aspects of social life and relations. Men are at the apex of family and societal hierarchy; as such women owe them deference in several ways. In fact, many feminist theorists see patriarchy as the original form of social hierarchy from which all other forms of stratification and domination have evolved. Within this sexual order, men as heads of households, claim ownership over both women and children (Bandarage, 1997). Men are dominant in the society and family, they play many powerful roles as husbands, fathers, uncles, religious leaders, policy makers, local and national leaders, doctors and much more (Varga, 2001).

The values and practices that subjugate women are also deeply rooted in religious belief. Christianity, Islam, and indigenous Nigerian religions, share a rare agreement with respect to the position of the woman in the home. These religions prescribe that women should obey their husbands, should be submissive to them and feed the family members. In Nigeria, patriarchy promotes high fertility by providing incentives among women for a large family size; for instance, "Ewu-Ukwu" is a ceremony held for mothers of ten or more children in the Igbo culture. Women who attain this position of distinction enjoy some privileges with high esteem. Patriarchalism also encourages high fertility by maintaining a system of familial structure that relegates women to subordinate position in family decisions. Prevailing marriage factors: male initiation and selection of their partners, type of marriage, arranged marriage, payment of bride wealth and the virilocal norm, give men a great deal of influence over their wives. Women are therefore, expected to fulfill a traditional sex role, as good wives and mothers. Women view these roles and functions as primary and moral responsibilities. Much more, socioeconomic realities confer on men the status of providers of the family, and women, generally depend on men for their sustenance and well being. Some men as a result, disapprove of their wives working outside the home or acquiring property, in a bid to ensure women's dependence on men; thereby maintaining women's compliance to the whims and caprices of men (Isiugo-Abanihe, 2003). These traditional values continue to shape conjugal relations, notwithstanding the forces of modernization.

2.4 Gender and Sex Roles

United Nations Agency for International Development (UNAID, 1999) defines gender as the widely shared expectation and norms within the society about appropriate male and female behaviour, characteristics and roles, which ascribe to men and women differential access to power, including productive resources and decision making authority. 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 recourses 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 (Ibid).

The roles men and women can play in FP are at the most basic level, the product of human biology. Women have more of a stake in FP, 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 FP 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 FP 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 imbibed 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 behavioural 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 behaviour. 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 (Ibid).

Ampofo (2001) observed that gender socialization, sexual attitudes and behaviours 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. Often such gender socialization develops within the context of gender inequalities and the tendency for social arrangements to reinforce the position of the dominant male group or the dependence of females on males. In Ghana, gender norms dictate that while girls should remain uninformed about sexual matters, boys are instructed on sexual matters by peers and family members; they are raised to see male aggression as a virtue 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 initiation rites for boys. All these help to buttress the ideology of male dominance over females, and give males sexual latitudes 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 heard. Studies that have focused on couples' reproductive 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). 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 behaviour as a prelude to a positive change in family relationships and behaviour, which have deep cultural roots. For FP to succeed, it is important that men lend it their utmost support.

2.5 Nigeria's Population Policy and Family Planning

In 1988, as a result of deepening economic crisis, the Government of the Federal Republic of Nigeria launched its first National Population Policy for Development, Unity, Progress and Self Reliance. One of the major objectives of this population policy was to "promote awareness among citizens of this country of problems associated with large population and the effects of rapid population growth on development, within the shortest time possible" (FGN, 1988). This policy was designed to improve standards of living and quality of life, promote maternal and child health and address the questions of internal migration and population distribution. In part, because of protracted political instability and poor governance, limited progress was made in implementing the policy; and also due to the technical problems posed by polygamy, because the policy emphasized on four children to a couple. This will be difficult to achieve in polygamous settings as competition exists among co-wives. Generally, polygamy promotes large family sizes.

These shortcomings prompted the review of the 1988 policy in 2004, which is the Nigerian Population Policy for Sustainable Development. The population policy, however, encouraged men to be involved in planning the family, since they care for the home. The new policy was designed to influence population-related policies, strategies and programmes that contribute to the sustainable development of the country. The policy recognized that population factors, socio-economic development and environmental issues are irrevocably entwined and are all critical to the achievement of sustainable development in Nigeria. Two of the objectives for achieving the policy's goals were to enhance the involvement of men in RH and; to strengthen and expand a comprehensive FP and fertility management programme that ensures all couples/individuals who want them, have uninterrupted access to a reasonable range of contraceptives methods at affordable prices, and also adequately respond to the needs of infertile and sub fertile couples (NPC, 2004).

In spite of the introduction of FP services as a means of curbing fertility rate, the population of Nigeria still rises because of the attitudes of the people involved. This is noticed especially in men and the role they play in reproduction. More so, in a country where culture and religion are deeply rooted in people's lives, achieving the four children per couple is almost unrealistic. It is particularly urgent, however, for men on account of their dominant role in the society as heads, community, religious and political leaders to assume an active role in planning the family. Men have virtually been ignored in past attempts to promote FP, putting so much stress on women, who as mothers bear the physical strain and burden of child bearing and rearing. Programmes should be targeted at men as means of reaching and altering their wives' reproductive behaviour. This will prove more rewarding than the current one focused on women as a means of reaching their husbands (Isiugo-Abanihe, 2003).

2.6 Male Roles and Responsibility in Family Planning Decision Making

Men's potentially positive role in FP has often been neglected because of the negative attitudes many men may hold towards birth control. In the industrialized world, men frequently use the availability of effective female contraceptives as an excuse for not using any birth control themselves. In the third world, some men still insist on having the sole right to decide whether and when to have a child; many deny their wives access to contraception because they fear it will encourage promiscuity. And everywhere, there are men who oppose birth control and a woman's changing roles in society because it takes from them, their power to father an unlimited number of children and seems to leave them with a diminished position in the family (Stokes, 1980). Most couples operate under the unilateral decisions influenced by the kinship group or lineage concerns. Ordinarily, a woman does not stand alone in confronting her husband; usually she confronts him only when supported by her husband's relatives, especially his parents, or by her own relatives (Isiugo-Abanihe, 2003).

The importance of male responsibility and active participation in the reproductive health of the family was re-echoed at the 1995 United Nations Fourth World Conference on Women in Beijing, China, which encouraged men to take steps toward achieving gender equality and better reproductive health (UN, 1995). Most countries of the world, particularly developing countries, still have male dominated cultures. In sub-Saharan Africa, ancestral customs give men rights over women's procreative power. In such situations, the husband's approval is often a precondition for a woman to use FP. Even in developed societies, studies have shown important effects of the husband's desires on a couple's fertility. Many men feel they are losing their role as the head of the family, because FP gives women greater economic empowerment. So they dig their heels and refuse to cooperate in FP matters, even though they may acknowledge that taking responsibility for FP would be in their own and family's best interest. In attempting to broaden men's role in FP, there is nothing the society can do about human biology. However, society can refuse to be satisfied with stereotypical male behaviour and can encourage men to assume greater responsibility and a more positive role in FP (Stokes, 1980).

The role of men in fertility and FP in sub-Saharan Africa is becoming increasingly important in the context of raising FP use and reducing levels of fertility. Fertility studies in the recent past, however, have been dominated by findings almost exclusively from women (Adamchak and Adebayo, 1985; Orubuloye, 1993; Bankole, 1995; Ottenberg, 1995, Mbizvo and Basset, 1996; Danforth and Jezowski, 1999). Regrettably, policies and programmes based on such findings have not had expected success in increasing contraceptive prevalence and simultaneously reducing overall fertility in sub-Saharan Africa. Men's involvement could assume an essentially prominent role in the individual couple's FP effort. It is assumed in the African context that women do not have control over their own reproductive behaviour. Most studies carried out in Nigeria and other African countries (Mbizvo and Adamchak, 1991; Oni and MacCarthy, 1991; Isiugo-Abanihe, 1994; Lasee and Becker, 1997) have all asserted the domineering position of men in reproductive health matters. According to these studies, men are dominant decision makers within the family.

Another example is a Sudanese study that examined the attitudes and role of men in family life decisions and found that men dominate decision-making process regarding FP; the decision not to use FP is male-dominated, and husbands are often responsible for providing contraceptives when FP was practiced (Khalifa, 1988). However, this study is interested in finding out the real situation about the attitude of men towards FP practice and the role they play in FP in Zaria LGA, a predominantly Hausa and Muslim setting.

2.7 Men's Involvement in Family Planning

Historically, men have provided a major impetus for the practice of birth control. As the European experience suggested, the demographic transition was achieved not through the use of present day female contraceptives, but mainly through widespread use of *coitus interuptus* or withdrawal, which is essentially a traditional method of FP (Van De Walle and Knodel, 1980). Apart from withdrawal, many couples relied upon periodic abstinence and later condoms, long before the super-efficient female methods made their appearance in the 1950s and 1960s. The increasing popularity of male surgical methods in the developed world clearly suggests that men, not only play important roles in fertility and FP decisions, but also are willing to take responsibility for planning the family (Gallen *et al.*, 1986).

Relative to Europe, the spread of FP followed a different route in developing countries, guided mainly by the development of modern female methods which were initially offered in the context of maternal and child welfare programmes. Implicitly, these programmes promote female methods ignoring male methods, since clients are usually females. In line with this approach, surveys on attitude to fertility were typically focused on females as bearers of children. The female bias of knowledge, attitude and practice (KAP) type studies in FP programmes in Africa is only beginning to be challenged (Isiugo-Abanihe, 2003).

To promote harmony and compatibility in the home, with men still retaining their privileged position, it is imperative for Nigerian men to move with time. Channeling reproductive health and family life education on men would increase their level of awareness of changes around them; more specifically, it would improve their knowledge and understanding of population issues, encourage male support for female practice of FP and population programmes, and promote contraceptive acceptance and practice by men themselves. Therefore being well informed, men will communicate meaningfully with their wives, and take decisions that are in the best interest of their families and society (Ibid).

2.8 Attitude towards Family Planning

The attitudes towards FP held by men in many parts of the Third World 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 a FP method. In few societies are men expected to share equally the tasks of childrearing. It is true that many of these societies are pronatalist. 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 journalists 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 long-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 FP methods among married men to be higher than that of the females. The proportion of current users of FP methods was 32.3% among males to 27.6% of females. While 63% of men compared to just 35.7% of women would approve the use of FP; 36% of the respondents (37.3% males and 35.5% females) indicated that their spouses would not stop them from using FP methods. About 50% of women and 38.1% of men indicated that they had talked about FP matters with their spouses on three or more occasions; more than 30% of the respondents had ever discussed FP matters with other persons other than their spouses.

When couples have a positive attitude towards FP, they are most likely to adopt a FP method. In the 2003 (NDHS) report, married women were asked whether they approved of FP and what they perceived as their husband's attitude toward FP. This information is useful in the development of FP policies because it indicates the extent to which further education and publicity are needed to gain general acceptance of FP. If there is widespread disapproval of contraception, this can be a major barrier to adoption of contraceptive methods. More than half, (55%) of married women, who know a contraceptive method approved of FP. Almost two-thirds of women who approved of FP, which is 33% of the total number of respondents, reported that their husbands also approved of FP. However, one-third of women who approved say their husbands disapproved. Almost all of the 39% of women who disapproved of FP reported that their husbands also disapproved of FP. There is a significant regional variation. In particular, 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 Nigeria, the attitudinal disposition of the 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 84.7% were not willing to or allow their spouses practice FP on economic grounds, only 15.2% expressed their willingness.

2.9 Family Planning in the Developing Countries

Men have long been an underserved audience in family planning programmes in the developing countries. However, over the past decade, increased recognition of men's influence on reproductive decisions and family planning practices has given rise to new communication projects promoting male involvement in family planning. It is important to know why family planning is effective or ineffective and whether its use varies according to people's characteristics and geographical location (Bauman *et al.*, 1994).

In the 1950s, China's Chairman Mao Zedong rejected the need for FP programmes, saying China needed more labour power (Mao, 1967). However, by 1979, China had begun implementing the world's most stringent anti-fertility policy (the one-child policy) which led to assault on China's system of gender norms and roles. This strong FP programme has been most strictly implemented in urban areas and semi urban areas in prosperous provinces (Poston and Gu, 1987). As a result of the one-child policy and overall socioeconomic changes, China has experienced a rapid decline in fertility, particularly in urban areas. The country's total fertility rate fell from more than six in the 1950s to approximately two and continued to fall throughout the 1990s (Karen, 2004).

India also launched the National Family Welfare Programme in 1951 with the objective of reducing the birth rate to the extent necessary to stabilize the population, consistent with the requirements of the national economy. Since its inception, the programme has experienced significant growth in terms of financial investment, service delivery points, type of services and the range of contraceptive methods offered. The National Family Welfare Programme in India has traditionally sought to promote responsible and Planned Parenthood through voluntary and free choice of contraceptive methods best suited to individual acceptors (Ministry of Health and Family Welfare, 1998). Currently, India is the second most populous country in the world, contributing about 20% of births worldwide

(WHO, 2006). It also continues to have one of the most rapidly growing populations in the world. However, the third National Family Health Survey (NFHS-3) reported that fertility continues to decline in India with a current total fertility rate (TFR) of 2.7; which is slightly down from 2.9 children per woman at the time of the second National Family Health Survey (NFHS-2). But, it is still well above the replacement level of just over two children per woman (IIPS and ORC Macro, 2007). In the National Population Policy of the year 2000; the Government of India set as its immediate objective, the task of addressing unmet need for contraception to achieve the medium range objective of bringing the TFR down to replacement level by 2010. One of the socio-demographic goals identified for this purpose is to achieve universal access to information/counseling and services for fertility regulation and contraception with a wide range of choices (Ministry of Health and Family Welfare, 2000). In India as a whole, current contraceptive rate of currently married women is 56%. Female sterilization, with prevalence of 37%, accounted for 71% of all contraceptive use in India (IIPS and ORC Macro, 2007). Nonetheless, there is need to change the scenario of contraceptive use in India.

In the West, it is often assumed that religion (especially Islam) and contraception are mutually exclusive. Yet, the Islamic Republic of Iran has one of the most successful FP programme in the developing countries, and is often looked up to as a potential model for other Muslim countries. Although Iran's FP programme has been extremely successful among Iranians, it has been far less successful among Afghan refugees and other ethnic groups. Afghans and Iranians both seek services in Iran's public health sector for family health care, treatment of infectious diseases and childhood vaccinations. On these occasions, all married patients are strongly encouraged to use FP programme to reduce the number of their off springs. In the face of a rapidly growing population, Iran reframed its prior pronatalist policies to a more liberal stance on contraceptive use. Iran's current FP programme emphasizes how, in Islam, God prioritizes having a healthy family over a plentiful one. Furthermore, Iran has made great efforts to include men in FP promotion. Although women remain the primary users of contraception, a survey data in 2000 indicated that male methods make up 34% of contraceptive use with some rural-urban and regional variations (Tober *et al.,* 2002).

In contrast, Pakistan which is also a Muslim nation, has achieved meager success over the past four decades, despite the nation being one of the first countries in south Asia to make a commitment to fertility reduction as a national planning objective and to develop a national FP programme (Sather and Casterline, 1998; Fikree *et al.*, 2001). Although 95% of married Pakistani women have some knowledge of modern methods of contraception, only 20% of married women of reproductive age currently use a modern method (NIPS, 2001). This level of use contrasts sharply with that of Pakistan's neighbours, India and Bangladesh, where more than 40% of couples surveyed, practice contraception and where the average family size is about three (IPS and ORC Macro 2000).

However, family planning in some parts of Asia has been relatively more successful than in sub-Saharan Africa. One reason is that Asia has experienced significant socio-economic change. In addition, vigorous population campaigns in the region have involved local community leaders and other influential people. The campaigns were aimed at creating the desire to limit family size. Typically, concerted efforts were made to increase the desire for small families and then to provide contraceptives and FP services as a means of controlling fertility. Similar efforts have gained momentum in sub-Saharan Africa but with little results. The economy in the region continues to be agriculture based, with populations that are predominantly rural. Early marriage and low levels of contraceptive use continue to be normative. In fact, until quite recently there was no apparent sign of fertility decline in 45 countries of the region, with the exception of Zimbabwe, Botswana, and Kenya. Another reason is that most Nigerians are still far from an adequate FP service-delivery point, a problem in many African countries that is unlikely to be solved without an expansion of the rural health system, current widely stalled. These service points must be efficiently staffed to meet clients FP needs and organized and staffed even better in order to implement the ICPD reproductive agenda. Nearly every study of African FP services complains of poorly motivated staffs that are inadequately led and supervised (Fatusi *et al*., 1998).

By 1988, the national family planning programme that began in Zimbabwe in the late 1960s had been so successful that contraceptive prevalence reached 36%, the highest rate in sub-Saharan Africa. However, family size remained large, with the average woman bearing 5.5 children. More than four-fifths of all contraceptive users relied on a single, short-term method, the pill. In addition, FP programmes have been directed towards women only, overlooking men even though surveys showed that men exerted great influence on family size and family planning decisions. Recognizing that the man has great influence on a couple's family planning decisions, the Zimbabwe National Family Planning Council (ZNFPC), a pioneer in this area, successfully implemented its first male motivation campaign in 1988-1989 to promote male involvement in FP and increase contraceptive use. In September l993, a second male motivation campaign was launched with technical assistance from the Johns Hopkins University Population Communication Services (JHU/PCS). This is because, only men were surveyed during the original campaign, so there were no data on how communication directed towards men affected women; the second campaign, therefore, surveyed women as well as men. The objectives of this second campaign were twofold: to increase men's participation in FP and to promote the use of long-term and permanent methods. To make the campaign appealing to men, planners took advantage of the surge of interest in football in Zimbabwe before the World Cup and sponsored a four-game tournament called the "Family Planning Challenge Cup". Football provided a source of images and analogies for campaign materials of all kinds. Campaign rhetoric promised to show men how to win the FP game by reaching the goal of a small family with the help of their team mates (spouses/partners) and coaches, that is, service providers (Kim *et al.*, 1996).

Although the use of modern FP methods is slowly increasing in sub-Saharan Africa, the growing popularity of hormonal injections is having an especially notable effect on prevalence throughout the region. The experiences of Malawi and Rwanda illustrate how different strategies to better women's reproductive health needs can contribute to advances in FP use. Between 1992 and 2008, contraceptive use in Malawi rose remarkably, from 7% to 39% of married women. This increase is largely due to a surge in the use of injectables contraceptives from 1.5% to 29%. Rwanda has also experienced rapid growth in the use of modern FP methods. The use of modern methods increased from 4% to 27% between 2000 and 2008. This accomplishment is due to a combination of factors including commitment to FP by political leaders, adequate supplies and improvements to its logistic system; and coordination between donor and government agencies (Soto, 2008).

Although Islamic solidarity may be a factor in northern Nigeria that explains resentment toward Western-sponsored family planning initiatives, in southwestern Nigeria, where perhaps half of the Yoruba-speaking population are Muslims (Eades, 1980), fertility appears to be declining. Strictly speaking, Islamic belief and practice do not explain northern Nigerians' responses to federal population policy and US-based NGO family planning programmes; rather, these reflect a complex combination of political, economic, historical, and sociocultural factors (Caldwell *et al.*, 1992).

Northern Nigeria, in particular, is lagging behind in the practice of FP. Men are the key decision makers in all facets of life, including the adoption of FP. Since they play a major part in the use or non-use of FP methods, it will be important to create awareness in them of the urgency to fully become involved in FP. Thus, the study will focus on the relevance of involving men in FP programmes in order to pave way for the success of FP especially in northern Nigeria, which makes up a greater percentage of the country's population.

2.10 Spousal Communication

From a family perspective, the first step in a rational process of fertility decision making involves communication between spouses. 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) show that the percentage of women using modern contraceptives is consistently higher in the group that had discussed FP with their husbands in the year before the interview than in the group that had not (JHU/PIP, 1994).

While discussion between couples about FP 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 FP 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 FP services, because sizeable minorities of women cite their husbands' non-approval as a reason for non use, despite having never discussed FP with their husband. The anticipated effect of spousal discussion on contraceptive uptake has strong policy relevance for sub-Saharan Africa, where reported levels of unmet need for FP- the discrepancy between individuals' sexual and contraceptive behaviour and their stated intention to space births and childbearing- are among the highest in the world. Understanding how spousal discussion affects the accuracy of reported participation or attitudes may help policy makers shape FP programmes designed to lower unmet need (Laurie *et al.*, 2004).

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). Discussions between spouses on sexual matters, FP, or number of children are still rare in Nigeria, especially in rural areas and among the Muslim population. The issue of communicating with wives over the number of children to have is strange, foreign and ridiculous (Isiugo-Abanihe, 2003). Due to lack of communication, many women do not know what their husbands think about FP. Many women think that their husbands disapprove of FP, when in fact the husband approves. In West Africa, about three quarters of the men and women had not discussed family planning with their spouse in the year preceding the survey, except in Ghana and Cameroon where the proportions were about one-half and two-thirds respectively. In East Africa, the figure is less than 40 percent, except in Burundi and Tanzania (Ezeh *et al.*, 1996). In Burundi, 94% of men surveyed approved of contraceptive use, but only 48% had discussed it with their wives in the preceding year (Population Reports, 1994). According to a 1993 DHS, 45% of married women in Tanzania either did not know what their husbands thought about FP 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 on FP 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 risk of conception 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 FP. When such psychological readiness is absent, even if such conversations are heard, men are simply not interested. Men therefore, become interested in FP 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 in the FP 'jargon'. A study in Mozambique found that men who are in the middle of their reproductive years are somewhat more likely to participate in FP- related discussions 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 infrequent discussion, may in fact wrongly perceive that their partners disapprove of FP, and may therefore feel inhibited from using a FP 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 woman 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 FP 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).

In a Kenyan study in 1996, in 83% of couples, one or both spouses reported having discussed FP with their partners in the previous year. In 85% of couples, both partners approved of FP, 6% each of either of the couples approved, and for 4%, neither of the couples approved (Ibid).

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 suggests 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 FP with their husbands. Women aged 15-19 years were the least likely to have discussed about FP. 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 had 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.

2.11 Knowledge of Family Planning

A prerequisite for the use of FP is adequate knowledge of FP methods. For a high rate of use to be attained, the population has to be very familiar with all the methods. Generally, a substantial proportion of both male and female populations know of at least one method of FP, but in some countries only a small proportion of those who know of a method are practicing family planning (UN, 1995).

A study by Petro-Nustas (1999) in Jordan found that 69% of respondents were aware of the presence of some male FP devices on the market, 60% opposed the marketing of male methods. Some 70% did not know of any source of information about male FP method; 35% stated that media and information programmes should be made available, including 26% who called for a special television programme addressing issues related to male methods.

Olawepo and Okedare (2003) in their study looked into men's attitudes towards family planning as they affect them and their spouses as well as general acceptability among men. From the survey carried out on men in Ilorin metropolis, it was observed that zones 1 and 5, which are traditional and peripheral areas respectively, are the least aware of FP of all the zones with over 84% and 80% of the respondents claiming ignorance or felt unconcerned about FP issues respectively. While this response was obtained here, other zones were better with greater percentage of awareness (over 65%). This may be attributed to the fact that accessibility to information in the zones with greater percentage of awareness is high. More so, people in the traditional and core areas are less informed due to the non-secularity of the locations. Tradition and cultural ethics act as catalysts to the low level of awareness of FP. The highest percentage of awareness among men was seen in zone 4 with about 92% of the respondents indicating some sort of awareness. In all, about 68% of the respondents wanted family planning information. The implication of this is that, contrary to popular belief many men are interested in the issue of family planning.

According to the NDHS (2003) report, knowledge of contraception among men is higher than among women. Knowledge of any modern FP method for all men is almost universal in urban areas, with 9 out of 10 men knowing at least one method. The most well known is the male condom (87%), followed by the pill (57%). Knowledge of any FP method among married women ranges from a low of 64% in the north east to a high of 97% in the south west. The same pattern is evident regarding knowledge of any modern method, from a low of 61% in the north east to a high of 97% in the south west. Similarly men's knowledge varies by region, although differentials are not so great. Women aged 25-39 years and women with secondary or higher education are more likely to know a method than the oldest and youngest women and those with no education.

Nigeria, being the world's fifth most populous country (PRB, 2009) and the most populous country in Africa, has a population of over 140 million people (NPC, 2009). Nigeria's rapid population growth is increasingly alarming. The world over, FP has attracted attentions, due to its importance in decision making about population growth and development issues. Geographers are more than ever before, concerned about the implications of FP on the nation's socio-economic development. There are a lot of shortcomings which negate the success of FP, especially when it comes to people of traditional, cultural and ethical differences like Nigeria. Population experts are now asking how men can be supportive and involved in family planning. Various States of the Federation have variability in the extent of the success of FP programmes. Thus, this study will focus on Zaria LGA which is a mixture of urban and rural settings, and also dominated by the Hausas who are deeply rooted in the Islamic belief. This will give an insight into some of the problems crippling the success of FP in Kaduna State, as well as northern Nigeria at large.

CHAPTER THREE: STUDY AREA

3.1 Location

Located on a plateau at a height of about 2200 feet above sea level in the centre of northern Nigeria, Zaria lies at latitude 11^0 13"N and longitude $7^0$68"E. Zaria Local Government Area is located in the northern part of Kaduna State, bordered by Makarfi on the northeast, to the east by Soba, to the west Giwa and to the south by Igabi Local Government Areas. Zaria is about 75km and almost an hour drive to Kaduna, the capital of Kaduna State (accessed on www.google.com). See figure 1.2 for the map of Zaria LGA.

3.2 Relief

The plains on which Zaria is situated are part of the vast undulating plains scenery which extends almost unbroken from Sokoto to Lake Chad and beyond, and from the south of Kaduna to the Tigueddi scarp near Agades. Such plains are characteristic of Africa as a whole. The plains are surmounted by hill features of rock inselbergs and lateritic ironstone-capped mesas. The inselbergs vary considerably in dimension and shape, from prominent landmark of Kufena to inconspicuous whalebacks. The Mesas are usually partly hidden by woody bushes and being of low eminence is less easily seen. The Mesas, which are tabular hills and generally inconspicuous on the vast gently undulating plains can be found along Kaduna and Funtua roads. Simple but asymmetric domical inselbergs are admirably exhibited at Tukur Tukur. Compound domical inselbergs or Bornhardts are exemplified in Kufena and Farakwai (King, 1948).

3.3 Drainage System

The drainage system focuses on a major tributary of River Kaduna, the Galma River which carries water throughout the year unlike many of its tributaries which dry up during January to June. The drainage patterns are commonly dendritic, reflecting an absence of structural control over drainage lines on the deeply weathered plains. The Galma River is fed mainly by the Kubanni and Saye rivers which are the main sources of water within and around Zaria used for domestic, agricultural and industrial purposes (Mortimore, 1970)..

3.4 Climate

Zaria possesses a tropical continental climate. The continentality of its climate is more pronounced during the dry season, especially December to January. The mean daily maximum temperature shows a major peak in April and a minor one in October. The daily maximum temperature rises gradually from 15.3^0 C in January and attains its highest value of 36.3^0 C in April. It drops rapidly to its lowest value in August 26^0 C and rises again to its secondary peak (34.1^0C) in October. The mean minimum temperature rises from its lowest value in December-January to its highest value in July-August. Zaria lies within a region which has a tropical savanna (Aw) climate with distinct wet and dry seasons. While the wet season occurs from May-October, which is the high-sun period; the dry season which is practically rainless occurs during November to April. Rainfall in Zaria ranges from 0.0mm from January-April, and then it reaches 180mm in May to the peak of 816mm in August. It then decreases to 150 mm in October and back to 0.0mm from November to December (accessed on www.google.com). This seasonal character of rainfall makes its mark on the vegetation of the area which assumes various shades of green in the wet season and turns brown, pale or yellow in the dry season (Hore, 1970).

3.5 Vegetation

The natural region in which Zaria lies is termed by plant-geographers the Northern Guinea Savannah zone, a designation which implies a woodland vegetation type characterised by the presence of Isoberlinia doka, Isoberlinia tomentosa and Upaca togonensis, with well developed grass layer of tufted and low ground cover of Andropogoneae. Also typical of the Savanna woodlands are a group of plants which generally flower before the onset of the rains and whose tops die back annually and are burnt off during the fires. These are the cryptophytes which include the bulbous and rhizomatous plants and the very typical sub-shrubs (suffrutices) such as Cochlospermum tinctorium and Adenodolichos paniculatus. Many of the savanna trees can also exist for years in a suffrutex form but unlike the suffrutices their shoots are perennial and will develop into trees when conditions are suitable (Jackson, 1970). There are also specific tree species, which are mainly found in the northern part of the country such as Tamarindus indica, shea butter, mango, cashew, baobabs, locust bean, neem, eucalyptus etc.

3.6 Soil

The soil type of Zaria is reddish ferruginous in nature. The lower part of the soil is derived in situ from underlying weathered gneiss and still contains pieces of quartz and mica. The upper part is a mixture of the same material together with transported, probably windblown particles. Across the soil profile, below the horizon of clay accumulation lays one of iron accumulation. The first sign of this is the appearance of red mottles and lower down, hard iron concretions are found. There are also the fadama soils which vary in texture and have been formed from alluvial materials along river valleys. These soils are mostly dark grey clays with poor to very poor drainage and are found along the banks of the rivers Galma and Kubanni (Klinkenberg, 1970).

3.7 Morphology of Zaria

The urban area of Zaria is made up of the old walled city, the colonial township, Tudun Wada, Sabon Gari and Samaru village. Each of these places has its characteristic form associated with the age in which it was built and the culture of its builders and occupants. Prior to the colonial regime, immigrants from other parts of Hausaland, usually resided within the walled city. However, these immigrants were later encouraged by the colonial authorities to settle in Tudun Wada. The completion of the railway from Zaria to Jos in 1911 also attracted a large number of immigrants from the southern, eastern and western parts of the country. This lead to the segregation of immigrants from the indigenous population, thus the establishment of Sabon Gari settlement. The Europeans on the other hand resided on the outskirts of the city, in areas known as "European Quarters" or the Government Residential Area {G.R.A} (Urquhart, 1970).

The old-walled city, known as 'Birnin Zaria' or Zaria-City serves as the political, administrative and market centre. The main physical expressions of these functions are the walls, the market place which is the hub of trade, the central mosque and the rulers compound (his residence, palace and administrative block), and the Zaria Local Government secretariat. The old part of the city was originally surrounded by walls; but the city has witnessed some changes because the great walls have almost disappeared as people excavate them to build houses. Some dual carriage roads and tarred roads have been constructed but narrow and un-tarred roads are very common. Also modern buildings are springing up, changing the traditional look of the city to an urban setting. The city is mainly occupied by the Hausa-Fulani and is the first place where settlement started in Zaria (Ibid).

The colonial township which was founded in the first decade of the twentieth century is the centre of provincial administration, the Nigerian Railway Corporation workshops, and modern commercial activities and industries. The GRA which forms the largest part of the old European location is composed of large plots with spacious houses and public offices surrounded by extensive plantings of ornamental trees and shrubs. It is separated from the residential houses of the senior railway officials by the Zaria club with its polo ground, race and golf courses (Ibid).

The Tudun Wada - Sabon Gari area, south of the GRA serve both commercial and residential functions. Business is at its highest during the day and becomes less in the night. The largest marketplace and probably the most vital spot in Zaria Township is in Sabon Gari. Being the major focal point of Sabon Gari, it is a bustling place. Samaru village like Sabon Gari, is an active place too. It is the residence of workers, students and traders which are all at least associated with the University or other nearby institutions. Like Sabon Gari, Samaru has unpaved streets and open drains and is expanding rapidly. Its focus is the daily market, the shops, mosques, churches and cinemas and above all the giant Ahmadu Bello University which has been instrumental in bringing together people of different ethnic diversity (Ibid). The presence of other institutions such as the Chemical Technology and Leather Research Institute, have brought so many changes to the old Samaru village. While Sabon Gari is mainly occupied by Nigerians of southern origin, Samaru is predominately occupied by northern ethnic groups. Other more recent neighbourhoods include: Danmagaji, Wusasa, PZ, Kongo, Hanwa, Bassawa and Shika (Field Survey, 2010).

3.8 Economic Activities

Zaria's economy is primarily based on agriculture. It is an important centre for the marketing and processing of agricultural products. Farming is the major economic activity in which much of the populace of Zaria engages in. Farmers produce and sell cereal crops such as maize, millet, guinea corn; root tubers such as yam, Irish and sweet potatoes, cocoyam; legumes like beans, groundnut, soyabeans; sugarcane, vegetables etc, both on small and large scales. There is also the aspect of livestock rearing (which is mainly the means of livelihood for the Fulanis), fish farming and fishing that provides meat to the increasing population of Zaria. Commercial activities such as banking transactions, 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 privately-owned parastatals and institutions. Small industries such as barbing, catering, tailoring, craftworks and large manufacturing industries provide the bulk of Zaria's population with employment such as the Nigerian British Tobacco Company (NTC), Zarinject and a host of others (Field Survey, 2010).

3.9 History of Zaria

Zazzau (for such was the ancient name of Zaria) was one of the Hausa Bakwai, the original seven Hausa States. It was one of the largest of the Hausa States. The name Zazzau derives its name from the sword which was honoured by Zaria people and gave them ethnic identity long before they recognized any king. The name Zaria is used to denote the capital city of the kingdom variously called Zazzau, zekzek or zegzeg. With a gradually increasing degree of political centralization and social control, the growth of more complex and larger settlements became possible, culminating in the emergence of the city or 'birni' of Zaria as the unchallenged head of a hierarchy of settlements grading from indisputably urban to rural. The 'birni' grew as a centre of government, over-riding previously held loyalties and having control over a substantial tract of territory (Mortimore, 1970). Birnin Zaria developed as a big centre for exchange in local ware such as slaves, pottery, sheep and textiles served as route junction for long distance trade from Yoruba and Nupe lands, Sahara and other parts into Zaria might have necessitated the expansion of the capital itself through the construction of a new outer wall (Mortimore, 1970).

The city of Zaria is surrounded by the large and long city wall with different gates, which were built in the early nineteenth century to provide protection against enemies, especially during war attacks. Today, these city walls have almost disappeared due to lack of preservation of traditional monuments; however the eight gates, central mosque and Emir's palace are still in existence. The ruler of Zazzau emirate is referred to as the 'Emir' or 'Sarki' (in Hausa) and has full authority in governing Zaria and beyond. His kingdom is large, including sub-ordinate leaders who form the ruling class of office holders or 'masu sarauta' and he has so much influence in socio-political issues of Zazzau.

3.10 Population and People

Zaria LGA has a population of 408,198 of which 210,900 are males and 196,090 females. Of the twenty three LGAs of Kaduna State, it has the second largest population, next to Igabi LGA. There is also a large young population (age 0-14 years) which is 47.4% of the population; this signifies an in built momentum for population growth (NPC, 2009). Zaria is predominantly made up of the Hausa/Fulani- a major ethnic group in northern Nigeria. The indigenous people are generally referred to as 'zazzagawa' or 'zage zagi', and they constitute 'Hausawa' and 'filani. They speak Hausa and Fulfulde - the major languages across northern Nigeria and some sub-Saharan African countries. There are other ethnic minorities such as Yoruba and Igbo among others, who have come as immigrants from the western, eastern and other parts of the country (Field Survey, 2010).

3.11 Religion and Culture

Islam is the major religion with Christianity and other traditional religions forming a minority group. The religion and culture of the Hausas are intertwined. There is a very thin line between Islam and the Hausa/Fulani tradition. This is due to the profound influence Islam has on the people's culture. Among the Hausa/Fulani ethnic group, men dominate familial and social relations, including production and reproduction. The husband, whose obligation is to his descendants and ancestry, decides most things and his wife is obliged to abide by his spoken decisions or his perceived wishes. By paying the bride prize, a man secures rights over his wife and her children; a wife is expected to bear children as her contribution to the continuity and viability of her husband's line. A woman comes under the authority of her husband and takes instructions from him by virtue of this payment of bride prize. Irrespective of a man's status, age or accomplishment, he remains the head of the family even if his wife subsequently rises to a position of influence in society, she acts as his subordinates. Traditionally, it is highly regarded disrespectful for a woman to refer to her husband by his name. He is referred to as 'maigida', 'alhaji' or 'mallam' -an appellation that underscores his high position because he is the 'provider' or 'breadwinner' (Isiugo-Abanihe, 2003).

Men are at the apex of societal hierarchy, they are the leaders of the society. They control the society economically, politically, socially and religiously. Women practice *purdah, 'kulle'* or female seclusion among the large Muslim population and must cover their bodies properly, as a religious injunction. They are not allowed to go out of their homes without their husbands' permissions and are confined within the households. Socio-cultural factors serve as constraints undermining the female position in the family and also relegate women to prolific child bearing. Men control the sexuality of their spouses, wives are bound to comply with their husbands sexual demands; refusal is a major source of strife such as taking other wives, domestic violence or divorce. It is also regarded a great sin in the religion, punishable by God. In Islam, the husband's position is higher than that of a woman's parents. It is men who have the sole right to marry out their daughter(s) or even the naming of a child. Women are commanded by the religion to be subservient to their husbands in all facets of their lives. The husband makes the final decision; he controls the wife and the entire family. No matter the educational qualification a woman achieves in her father's house, she is not permitted to work without her husband's approval. Generally, a woman's life is restricted by confining her to domestic activities. Socio-cultural institutions have made men potentially polygamous. Although polygamy has some benefits, it often breeds family conflict and discord among children and unhealthy rivalry among wives. This has also encouraged men to desire and have large family sizes, and often find it difficult to adequately care for their children and educate them. With the nation in economic constraints, co-wives are saddled with the responsibility of providing for their children (Ibid).

In the old city and the adjacent Tudun Wada neighbourhood, people typically reside in traditional adobe compounds. These two neighbourhoods are predominately occupied by the indigenous Hausa people. Zaria LGA is characterized by compound settlements with different households including monogamous and polygamous families living together. These settlements which are closely built together are headed by husbands or the most elderly man such as father, uncle or grandfather, who controls the affairs of the families. It is the man who gives instructions on what to eat, where and when to make visits, how long a woman breast feeds and so on (Mortimore, 1970).

According to tradition and religious doctrine, men have a higher status in the home and society. Planning the family for economic reasons is abhorred in the Islamic belief. However, the Hausa culture and Islamic religion do not object to child spacing and discourage short birth intervals. This is supported by the Qur'anic verse that encourages women to breastfeed for complete two years, for the health of both mother and child. This will give the mother time to recover before the next pregnancy and the proper growth of the newborn. Nonetheless, women still have closely spaced births; and with early marriage deeply rooted in the Hausa custom, so many young girls are unable to complete even primary school education. This explains why the population of Zaria LGA is very high (Field Survey, 2010).

3.12 Basic Infrastructure

Zaria has witnessed tremendous changes and developments due to its profound influence as an educational centre. With the influx of people from different parts of the world, the provision of basic amenities such as water, electricity, well tarred and dual carriage roads by government has increased immensely over the years. Zaria as a nodal town serves as a link to other parts of Northern Nigeria. Government-owned hospitals such as the Ahmadu Bello University Teaching Hospital, Gambo Sawaba General Hospital, St. Lukes Chapel hospital among others and privately-owned health centres and pharmacies provide effective and affordable medical services. There are also accommodation lodges such as Zaria Hotel, New Zaria Motel, Kongo Conference Hotel, Jim Harrison Hotel, Zazzau Royal Chalets and Tee Jay Palace Hotel; and many guest inns are scattered around the town. First and new generation banks such as First Bank PLC, United Bank of Africa, Bank PHB, Guaranteed Trust Bank, Zenith Bank, Oceanic Bank, Stanbic IBTC, Intercontinental Bank etc, are available for business and financial transactions; more banks are being built for greater efficiency. Also major markets of Sabon Gari, Samaru, Zaria city, departmental stores, restaurants, filling stations provide commercial services (Field Survey, 2010).

Despite being an administrative, commercial, transportation and manufacturing centre; it is Zaria's educational function that today most influences its character and gives it distinction as an urban settlement. The most important central place activity of all is education, for which Zaria is the greatest centre of Northern Nigeria. Zaria is home to educational institutions such as Ahmadu Bello University, the largest university in Nigeria and the second largest on the African continent, but by no means the oldest institution in Zaria. The institution is very prominent in the fields of Agriculture, Science, Finance, Medicine and Law. Zaria is also the base for the Federal College of Aviation Technology and Training Centre, Federal Colleges of Education, Kaduna State Polytechnic, Research

Institutes and Ahmadu Bello University Teaching Hospital among others offer so many people from different cultural backgrounds, sources of livelihood in and around Zaria. Zaria is also home to the great Barewa College which was the best secondary school in the whole of Northern Nigeria. It formed a solid educational foundation for our great leaders of yester-years such as Sir Ahmadu Bello among many. The number and variety of institutions is an evidence of the general importance of education in Zaria. All these institutions can be considered as ‘city- forming’ as the greater portion of students come from outside Zaria. The presence of the only Federal Government Girls College in Kaduna State, the only Nigerian Military School in Northern Nigeria, the Army Depot and other military outfits cannot be ignored (Field Survey, 2010).

In terms of communication, Zaria has its own broadcasting station of the Nigeria Television Authority (NTA) and radio stations that keep people well informed. The Nigerian Telecommunications (NITEL) has been the sole provider of telephone services for decades, mostly restricted to homes and offices. However, with the advancement in world technology, privately-owned Global Satellite Media (GSM) has pioneered to provide services, reaching most of the populace. Mobile phones have made communication affordable and more effective, making life much easier for people (Field Survey, 2010).

3.13 Research Methodology

3.13.1 Reconnaissance survey

A reconnaissance survey was carried out in order to be well acquainted with the study area and the selected wards in particular, as well as to be familiar with the culture and tradition of the people.

3.13.2 Sources of Data

3.13.2.1 Primary Source

Primary data were obtained through the use of qualitative and quantitative research techniques. The main source of primary data collection was through structured questionnaires, In-depth interviews (IDIs) and focused grouped discussions (FGDs). The questionnaires were self-administered to those sampled. However, they were translated into Hausa language for respondents who do not understand English. The structured questionnaire consists of four sections, made up of close-ended questions. Section A focused on socio-economic and demographic characteristics of respondents such as age, marital status, religion, ethnicity, educational attainment, income, livelihood activities, family size etc. Section B is concerned with knowledge, attitude and use of family planning and section C contains information about spousal communication and decision making process on reproductive issues.

The FGDs were conducted separately among men and women of two age categories, educated and uneducated discussants of 15-39 years and 40-65 years educated and uneducated, involving ten men and women in each group. The FGDs were particularly useful for obtaining qualitative attitudinal data and information on beliefs, myths and misconceptions, especially on sensitive and controversial issues as examined in this study. Research assistants were recruited to help the researcher.

3.13.2.2 Secondary Source

Data was obtained from unpublished projects, journals, text books, newspapers and websites which were relevant and helpful in generating ideas, facts and issues relating to the study.

3.13.3 Sampling Design

Zaria LGA has a population of 408,198 (NPC, 2009) with 13 administrative wards. There are six wards within and seven wards outside the city wall. Arranging these wards alphabetically, the even numbered wards were chosen, from within and outside the city wall to ensure geographical spread across the study area. This will give a total of six wards which are: Angwan Juma, Kwarbai A, Limancin Kona, Dutsen Abba, Kufena and Tukur Tukur (Table 3.2).

Table 3.2 List of wards within and outside the city wall

Wards within	Wards Outside
Angwan Fatika	Dembo
Angwan Juma	Dutsen Abba
Kaura	Gyallesu
Kwarbai A	Kufena
Kwarbai B	Tudun Wada
Limanin Kona	Tukur Tukur
	Wuciciri

Angwan Juma, Kwarbai A, Limancin Kona, Dutsen Abba wards are all homogenous in nature, comprising mainly of Hausa/Fulani and Muslims. The inhabitants are a mixture of uneducated and educated, low, medium and high income earners. Kufena and Tukur Tukur are a combination of semi urban and rural settlements, and more or less heterogeneous societies with people from the two major religions (Islam and Christianity) and different ethnic groups.

A sample of 0.1% of the total population of the study area was taken, giving a total of 408 respondents. The 408 questionnaires were distributed uniformly among these selected wards, with 68 in each ward. The reason for this is due to the non-availability of population figures for each ward from the 1991 and 2006 census results. These questionnaires were administered using the purposive sampling technique, which only targeted those respondents who were willing to be a part of the survey.

3.14 Data Analysis

Questionnaires retrieved from the study area passed through different stages of compilation such as:

a) The answered questionnaires were numbered serially to enable the researcher know the actual number of questionnaires retrieved from the survey.

b) All questions in the questionnaire were entered and the options to these questions were coded and entered into computer software using the Special Package for Social Sciences (SPSS) for the analysis.

c) The SPSS was used for both descriptive and inferential statistical analysis of data gathered in the study.

The descriptive statistics which include frequency tables, percentages and figures in form of pie and bar charts were employed for the purpose of summarizations of data. Results were presented in the form of frequency tables, percentages and charts. Cross tabulation which is a joint frequency distribution of cases according to two or more classification of variables, was used. These joint frequency distributions can be statistically analyzed by certain tests of statistical significance such as Chi square. The (X^2) inferential statistical technique was used in testing for the significant relationship between variables and it was calculated using SPSS Statistics 17.0.

CHAPTER FOUR: DATA ANALYSIS AND DISCUSSIONS

4.1 Demographic and Socio-economic Characteristics of Respondents

4.1.1 Introduction

Demographic change is a function of interrelated social, economic and demographic factors, and the general level of economic development. In assessing the attitude of any population towards the practice of family planning, it is very crucial to look at the demographic as well as the socio-economic characteristics of the people under study. Several studies agreed that the socio-economic characteristics of respondents influence their use and utilization of FP. This chapter discusses the social, demographic and economic characteristics of respondents which are used to measure their attitudes toward FP. These characteristics include age, sex, religion, ethnicity, educational attainment, income, type of occupation, number of wives, number of children and much more.

4.1.2 Age and Sex of Respondents

Table 4.1 shows the distribution of respondents by age. The age group 25-29 years has the highest proportion of 20.1%, followed by age group of 30-34 years with 19.8% and 50+ years have the lowest distribution of 2.3%. In all 86.0% of the respondents are within the age bracket of 20-49 years. This is a clear indication that the population sampled is a youthful population. This pattern of age distribution is not abnormal because the younger age groups are more open to give information about FP issues. This corresponds to Ekpo's finding (2011) in Makarfi and Jaba LGAs, Kaduna, where the age group 25-29 years had the highest proportion of 28.9%, followed by age group 20-24 with 26.3% and the least proportion of 4.2% is age group 45-49 years. The age group 20-49 accounted for 92% of the respondents.

Table 4.1: Distribution of Respondents by Age

Age in years	Number of respondents	Percentage
15-19	42	11.9
20-24	46	13.0
25-29	71	20.1
30-34	70	19.8
35-39	48	13.6
40-44	43	12.1
45-49	26	7.3
50+	8	2.3
Total	**354**	**100.0**

Source: Field Survey, 2010

Figure 4.1 shows that 69.5% of the respondents are males and 30.5% are females. This implies that there were more males than females. This is to be expected as men were the main target in this study, thus there was a higher number of men compared to women who took part in this survey. This corresponds with Joshua's finding (2010) in Sabon Gari, Zaria where

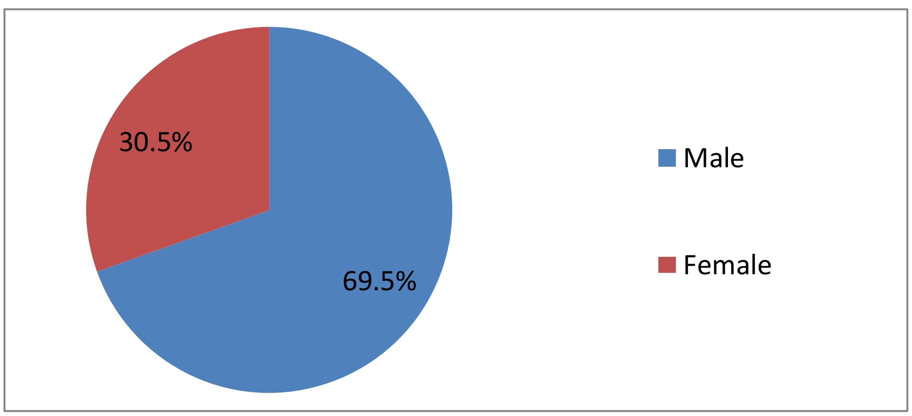

Figure 4.1: Percentage Distribution of Respondent by Sex
Source: Field Survey, 2010

66.2% were males and 33.8% were females. This might be because the predominant religious group in the study area practices 'purdah' where a woman is not allowed to move out of the house except with her husband's permission.

4.1.3 Religion and Ethnicity of Respondents

Figure 4.2 indicates that Islam is the dominant religion with 82.5% of respondents who are Muslims and only 17.5% are Christians. The result is as expected since Zaria LGA is located in the northern part of the country which has a predominantly Muslim population.

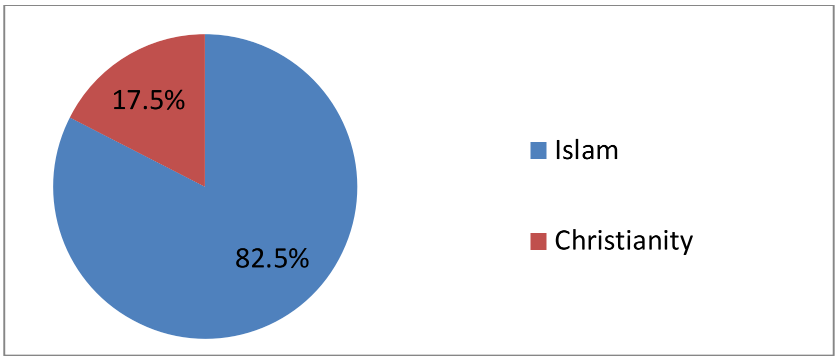

Figure 4.2: Percentage Distribution of Respondents by Religion
Source: Field Survey, 2010

The Hausa/Fulani, being the single largest cultural group in the study area constitute 77.1% of the respondents, followed by 8.5% each of Yoruba and northern minority ethnic group respondents (Figure 4.3). While the Hausa/Fulani are the predominant people of Zaria who

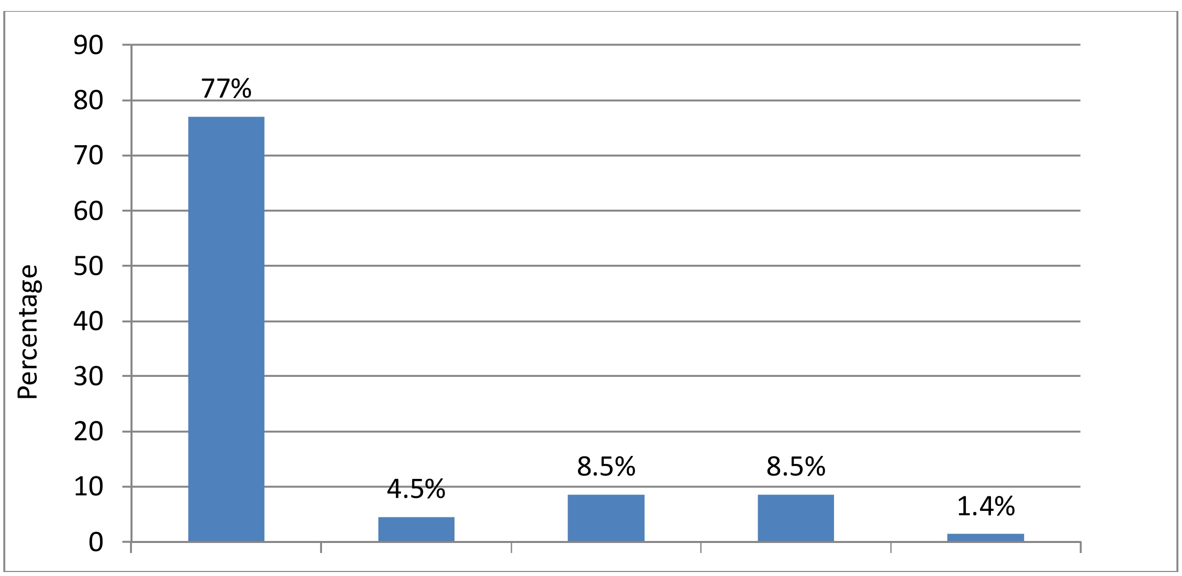

Figure 4.3: Percentage Distribution of Respondents by Ethnicity
Source: Field Survey, 2010

live within the city wall commonly known as ‘Zaria city’, other tribes are mainly migrants from different parts of the country. This also corresponds to Tyoden’s findings (2010) in Zaria with Hausa/Fulani constituting 50.6% of the respondents, followed by 20% and 10.7% of northern minority and Yoruba respectively.

4.1.4 Marital Status and Marital Union of Respondents

Table 4.2 shows that 91.8% of the respondents are married and 5.9% is single. The incidence of divorce and separation appears rather low (1.4%) in Zaria LGA which suggests a fair stability of the marriage institution. This low percentage of single parenthood due to both voluntary dissolution (divorce) and involuntary dissolution (widowhood) could be as a result

Table 4.2 Distribution of Respondents by Marital Status

Marital status	Frequency	Percentage
Married	325	91.8
Single	21	5.9
Separated	4	1.1
Divorced	2	0.6
Widowed	2	0.6
Total	**354**	**100.0**

Source: Field Survey, 2010

of high remarriage rates in the study area. These findings are similar to the NDHS (2008) report, where a little more than two-thirds (69%) of all women are currently married, and an additional 2% are in informal unions (“living together”).

Marriage is a population phenomenon and is known to be universal in Nigeria as revealed by the results of the 1991 census (NPC, 1998). It is also associated with fertility because it is correlated with exposure to the risk of pregnancy (NDHS, 2008). Marital status constitutes a demographic characteristic which involve biological, economic, legal, cultural and in many cases religious aspects. It is the most important factor in population dynamic since it affects fertility tremendously (Mamman, 1992). In this study, "married" refers to legal or formal unions and separation, divorced and widowed make up the "ever married".

About 51.7% of respondents are in monogamous unions and 48.3% in polygamous unions (Figure 4.4). Although, most respondents in the study area practice Islam which allows polygamous marriage, the number of respondents in polygamous union is comparatively less than that in monogamy.

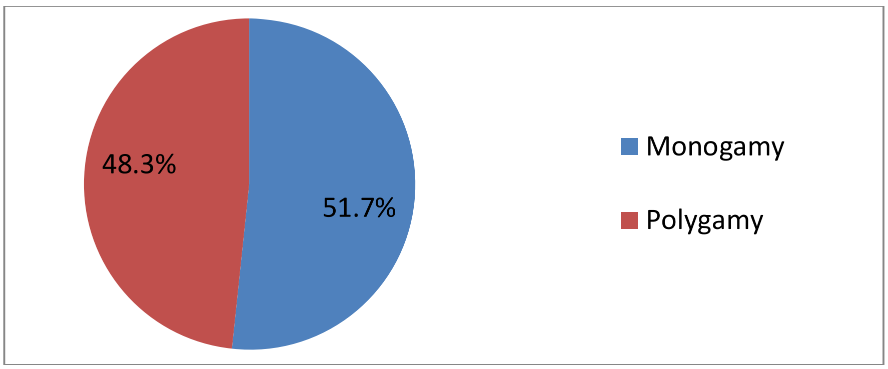

Figure 4.4: Percentage Distribution of Respondents by Type of Marital Union
Source: Field Survey, 2010

Figure 4.5 reveals that within the polygamous setting, 65.6% of the men in polygamous unions are married to only two wives, 19.7% are married to three wives and 14.6% have up to four wives. Respondents with just two wives make up a greater percentage than those with

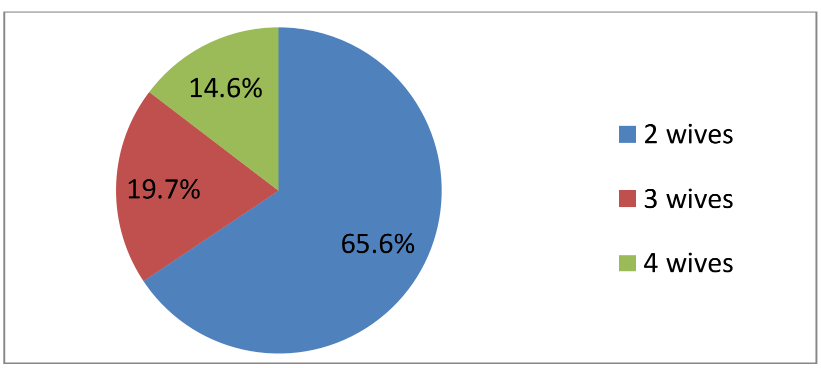

Figure 4.5: Percentage Distribution of Respondents by Number of Wives
Source: Field Survey, 2010

three or four wives. During IDI, a male respondent from Zaria city emphasized the wisdom in Islam's encouragement of polygamous marriages, saying:

"*Almighty Allah's wisdom in polygamy goes beyond human reasoning; it brings solutions to many societal problems such as extra marital relationships."*(Malam Magaji, Angwan Juma)

The NDHS (2008) report indicates that 33% of women are in polygamous unions, 26% of women reported having one co-wife and 7% have two or more co-wives. Polygamy, having more than one wife at the same time, has implications for the frequency of sexual intercourse, and thus, may have effect on fertility.

4.1.5 Educational Attainment of Respondents

Table 4.3 reveals that 57.6% and 18.1% of the respondents have attained Tertiary and Secondary education respectively; only 0.6% has attained adult literacy education. This is not surprising as Zaria is home to many tertiary institutions as well as an Islamic educational centre and ranks the second highest in educational facilities in the whole of Kaduna State that provide education for a huge population of the study area.

Table 4.3: Distribution of Respondents by Educational Qualification

Educational Attainment	Frequency	Percentage
Adult literacy	2	0.6
None	5	1.4
Primary	19	5.4
Quranic	60	16.9
Secondary	64	18.1
Tertiary	204	57.6
Total	**354**	**100.0**

Source: Field Survey, 2010

Education is a key determinant of the lifestyle and societal status an individual enjoys. It does not only provide opportunities for personal advancement, awareness of social opportunities and higher non-familial aspirations but also new outlook, freedom from tradition, willingness to analyze institutions, values and patterns of behavior and growth of rationalism. Educational attainment is perhaps the most important characteristic of respondents because many phenomena such as reproductive behavior, use of contraception, child's health, and proper hygienic habits are related to the education of respondents. It also has strong effect on people's health behaviors and attitudes (NDHS, 2008).

4.1.6 Occupation and Income of Respondents

Table 4.4 shows that respondents in the public/civil service constitute 45.0% of the sample, followed by 15.3% of those doing business. Only 7.3% are engaged in farming; this low response is because Zaria LGA is a semi urban area with limited access to farmland due to population pressure. The table further shows that respondents are involved in one form of

Table 4.4: Distribution of Respondents by Occupation and Income

Type of occupation	Number of respondents	Percentage
Farming	26	7.3
Civil/public service	159	44.9
Business	54	15.3
Student	33	9.3
Trading	21	5.9
Housewife	19	5.4
Unemployed	19	5.4
Others	23	6.5
Total	**354**	**100.0**
Income		
No response	97	27.4
< 5,999	17	4.8
6,000 - 15,999	37	10.5
16,000-25,999	60	16.9
26,000-35,999	46	13.0
36,000-45,999	29	8.2
46,000 and above	68	19.2
Total	**354**	**100.0**

Source: Field Survey, 2010

economic activity or the other. Employment, whether formal or informal, is one source of empowerment for men and women alike. It has significant implications on who has control over decision making on family matters including issues related to reproductive health (NDHS, 2008).

About 27.4% of the respondents did not disclose their monthly earnings. Only 19.2% of the respondents earn 46,000 Naira and above (Table 4.4). The high percentage of no response is not surprising because studies have shown that a lot of Nigerians do not like to disclose their actual earnings. For example, Tyoden (2010) also observed 15.8% of no response which is similar to that of Ekpo (2011) where 43.8% of the respondents did not disclose their income.

4.1.7 Actual and Preferred Family Size of Respondents

Some 39.0% of the respondents have 4-6 children, 10.7% have no children and 3.7% have 7-9 children (Table 4.5). About 70.4% of the respondents have 1-6 children. Having children is very vital in the study area due to the importance attached to having a large family.

Table 4.5: Distribution of Respondents by Number of Surviving Children

Number of surviving children	Frequency	Percentage
None	38	10.7
1–3	111	31.4
4–6	138	39.0
7–9	13	3.7
10 –12	23	6.5
13 and above	21	5.9
No response	10	2.8
Total	**354**	**100.0**

Source: Field survey, 2010

Table 4.6 shows that 40.1% of the respondents prefer to have 7 children and above. About 17% are undecided about the number of children they desire to have thus leave the decision to God; which is not surprising as people in the study area want as many children as God grants them. This is supported by a man during the FGD who said:

> *"FP should be stopped because children are gifts from God and every child has his/her own destiny/wealth"*. (29 year old Aminu, Angwan Juma)

Table 4.6: Distribution by Preferred Number of Children

Preferred Number of Children	Frequency	Percentage
1–3	32	9.0
4–6	104	29.4
7–9	93	26.3
10 –12	22	6.2
13 and above	27	7.6
Up to God	59	16.7
No Response	17	4.8
Total	**354**	**100.0**

Source: Field survey, 2010

There is a wide gap between actual and desired family size in Zaria LGA, which implies that fertility, still remains high. Consequently, FP practice remains low with high population growth. This corresponds to Tyoden's (2010) result in Zaria where respondents' desire for 7 children and above was 31.9%, followed by 29.7% wanting 3-4 children. It also agrees with Solomon's *et al* (2010) finding in northern Nigeria where 80% of the respondents reported their desire for 6 or more children.

4.1.8 Desire for more Children of Respondents

Figure 4.6 reveals the African culture of wanting to have many children, especially by men, who regard large family size with so much importance. And also with polygamy, there is a greater chance of couples giving birth to too many children, especially due to sex preference for male children. Respondents who want to have more children make up 65.8% and 13.0% said they leave the decision to their Creator. A male discussant gave his reason for wanting more children during the FGD thus:

"*Allah, The Lord of Majesty (SWT) gives children to whom He wills, there are couples yearning to have children. Will we now become so ungrateful to reject our Lord's mercy on us, children are gifts from Him?* (49 years old Malam Adamu, Kufena)

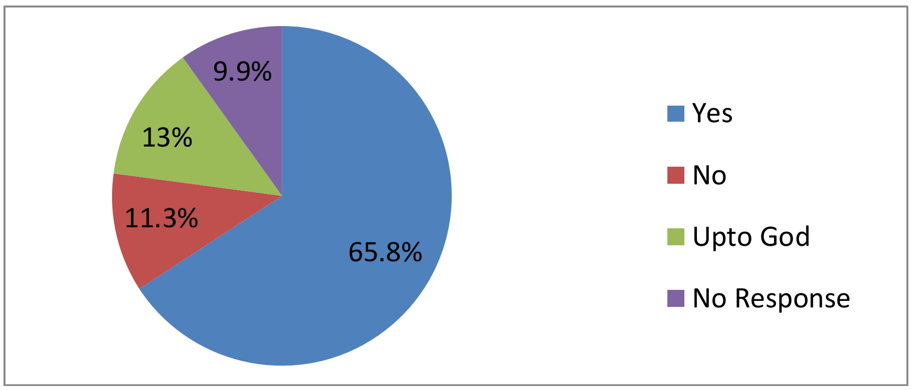

Figure 4.6:Percentage Distribution of Respondents by Who want to have More Children
Source: Field Survey, 2010

Caldwell and Caldwell (2002) have observed that African men want to have more children because they thought they gain socially and economically from having a large number of children. 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. More so, Islam emphasizes the importance of having children who would offer prayers for their parents before and after death. Izugbara and Ezeh's (2010) study in northern Nigeria also revealed that men are considered to be responsible for high number of children as women in the region reported deliberately giving birth to many children to inhibit men's tendency to divorce them or engage in polygamy.

4.1.9 Reasons for Having Children

Table 4.7 shows respondents' reasons for having children. In all, 27.0% and 21.2% of respondents said children provide them with financial support and are a source of happiness and fulfillment in life. During the FGD, a male discussant emphasized the need to have many children saying:

> *"The Prophet Muhammad (pbuh) said to Muslims marry and regenerate so that I will be proud of your large population on the Day of Judgement".*(34 year old Hashim, Kwarbai)

Table 4.7: Distribution of Respondents' Reasons for Having Children

Reasons for having children	Frequency	Percentage
Continuation of family name	89	25.1
For financial support	95	26.8
Source of joy/happiness	75	21.2
Provide child labour	21	5.9
To inherit wealth	8	2.3
Prove ones masculinity	3	0.8
Others	50	14.1
No response	13	3.7
Total	**354**	**100.0**

Source: Field Survey, 2010

This result corroborates Isiugo-Abanihe's study (2003) of male role and responsibility in fertility and reproductive health in Nigeria, where 25.1%, 24.0% and 20.1% of men said children are a source of joy and pride, provide old age support and help around the home and on the farms in that order. Nigerian men place high premium on children due to the tangible and emotional benefits derived from them. Given their dominant role in the family, men's reproductive motivations are expected to affect the reproduction preferences and behavior of their wives.

4.1.10 Child Mortality and Causes of Death

Table 4.8 shows that 27.1% of the respondents have lost their children, with 88% who have lost one or two children. The table further shows that 32.3% of the respondents' children died through child birth or natural death, followed by 28.1% of children who died of malaria. There is a low percentage of child mortality reported in the study. This is due to the fact that respondents might be reluctant to talk about their dead children either because it brings back

Table 4.8: Distribution on Child Mortality and Children's Causes of Death

Child mortality	Number of respondents	Percentage
Yes	96	27.1
No	242	68.4
No response	16	4.5
Total	**354**	**100.0**
Number of dead children		
1-2	84	87.5
3-4	12	12.5
Total	**96**	**100.0**
Causes of death		
Diarrhea	12	12.5
Malaria	27	28.1
Accident	15	15.6
Pneumonia	6	6.3
Measles	5	5.2
Others	31	32.3
Total	**96**	**100.0**

Source: Field Survey, 2010

sad memories or because their culture discourages mention of the dead. Another reason is that some respondents may forget events that happened in the more distant past, particularly if a child was alive only for a short time.

The study also investigated the types of diseases that lead to infant and child mortality through hospital records obtained in Zaria LGA. Interestingly, the hospital records indicate a high number of infant and child mortality compared to what was obtained from the field survey. Malaria and diarrhea are the major causes of child mortality with 35.0% and 13.3% respectively (Table 4.9). It is evident that malaria and diarrhea are the leading causes of infant and child mortality in Zaria LGA. The implication of this high infant and child mortality rate is that couples want to have many children since they are not sure of how many will survive to adulthood.

Table 4.9: Hospital Record of Infant and Child Mortality

Causes of death	Number of deaths	Percentage
Diarrhoea	60	13.3
Malaria	157	34.9
Anaemia	26	5.8
Pneumonia	24	5.3
Measles	25	5.6
Malnutrition	39	8.7
Sickle cell	2	0.4
Cerebra Spinal Meningitis	37	8.2
HIV/AIDS	40	8.9
Typhoid	35	7.8
Accident	5	1.1
Total	**450**	**100.0**

Hospital Records, 2010

4.2: Knowledge of, Attitude towards and Practice of Family Planning

4.2.1 Introduction

The role of men in making family life decisions in Nigeria has been recognized in the demographic literature. Husbands are often involved in making family planning decisions and wives are influenced by their opinions. In this survey, husbands and wives were asked separately, using structured questionnaires about their knowledge, attitude and practice of FP. This chapter presents results on a number of aspects of family planning including knowledge of family planning, attitudes regarding contraceptive use, ever use and current use, sources of contraceptive methods and much more.

4.2.2 Knowledge of Family Planning

Figure 4.7 shows that 97.7% of respondents reported they have been told or have heard of family planning heard of FP. This corroborates the finding of the NDHS (2008) report where 72% of all women and 90% of all men know of at least one FP method. Umoh's *et al* (2012) study in Uyo also had similar result where knowledge of FP by respondents was 92.6%. The

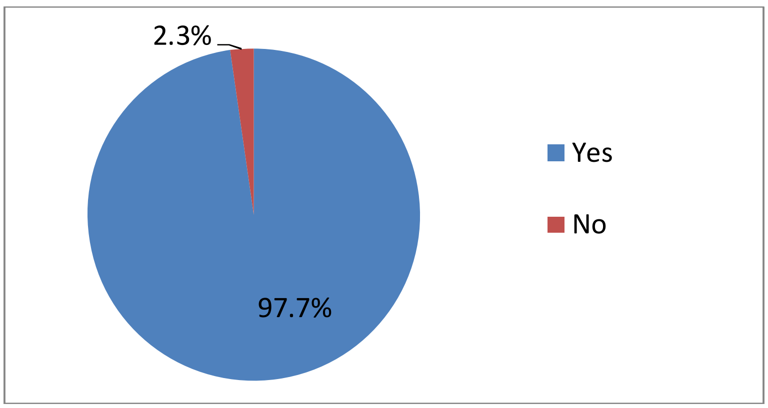

Figure 4.7: Percentage Distribution of Respondents by Awareness of Family Planning
Source: Field Survey, 2010

wide spread in knowledge of FP may be related to education, intensive campaign in the media (as the Nigerian government is putting immense effort in providing information about FP programmes, thus people are becoming more exposed to FP issues), and the state of the economy (harsh economic conditions) etcetera.

Knowledge of family planning is a key variable in any discussion of fertility regulation and in the evaluation of FP programmes. Acquiring knowledge on FP is an important step towards gaining access to and using a suitable contraceptive method in a timely and effective manner.

4.2.3 Sources of Information on Family Planning

Table 4.10 reveals the sources of information on family planning where 41.6% of respondents got information on family planning from radio and television. Exposure to mass media in family planning campaign increases contraceptive use; this is not surprising because the most effective and fastest means of communicating with people is through the use of mass media. The second major source of information is medical personnel such as doctors, nurses or midwives accounting for 32.4%. This corroborates the NDHS (2008) finding which showed that the radio is the most frequent source of FP messages for both men (59%) and women (40%) age 15-49 years. One-quarter of women and one-third of men reported seeing a FP message on the television. This is true regardless of age, residence, region, education or economic status. Newspapers and magazines are the least sources of FP messages for both men and women with 9% and 21% respectively.

Table 4.10: Distribution of Respondents by Sources of information on Family Planning

Sources of information	Number of respondents	Percentage
Radio / television	144	41.6
Medical personnel	112	32.4
School/institution	36	10.4
Friend	24	6.9
Family member	16	4.6
Magazine/newspaper	12	3.5
Others	2	0.6
Total	**346**	**100.0**

Source: Field Survey, 2010

Information on the level of public exposure to a particular type of media allows policy makers to use the most effective means of communication for various targets groups in the population. The media can be a major source of FP messages. Electronic media (radio and television), print media (newspaper, magazine, posters, and leaflets) and traditional folk media (town criers and mobile announcements) are the major potential sources of information about FP in Nigeria. Data on exposure of respondents to mass media are very important because they provide an indication of the extent to which Nigerians are regularly exposed to the mass media, which are used to disseminate messages on FP or other health topic (NDHS, 2003). For example, in Nigeria, one quarter of new clients attending a FP clinic identified a television and a radio campaign as their source of referral. Similarly, a mass media effort in the Phillipines promoting sexual responsibility substantially increased requests for contraceptive information among adolescents (Odimegwu, 1999).

4.2.4 Attitude towards Family Planning

Information on the attitude of respondents towards FP is very useful in the development of family planning policies because it indicates the extent to which further education and publicity are needed to gain general acceptance of FP. And if there is widespread disapproval of FP, this can be a barrier to the adoption of FP methods. When couples have a positive attitude towards FP, they are more likely to adopt a FP method.

4.2.4.1 Approval and Disapproval of Family Planning

Figure 4.8 indicates that 53.6% of the respondents approved of FP. This indicates that more than half of the respondents back the use of FP methods and supports Mamman's (1992) result of 65.8% of respondents who approved of FP.

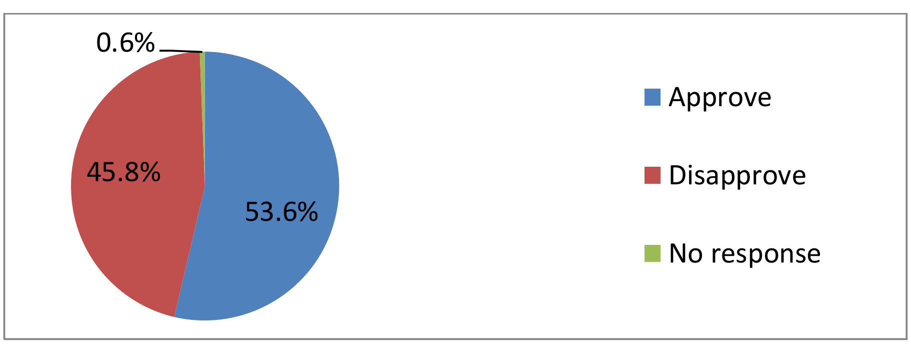

Figure 4.8: Percentage Distribution on Approval and Disapproval of FP by Respondents
Source: Field Survey, 2010

4.2.4.2 Reasons for Approval of Family Planning

All men and women in the sample were asked about their attitude towards FP. It is vital to know the reasons for respondents' approval of FP in the study area in order to understand what motivates people to use FP methods. Table 4.11 reveals that 29% of the respondents approve of FP methods because they want to promote the health conditions of their wives;

Table 4.11: Distribution by Reasons for Approval of Family Planning

Reasons for approval of FP	Frequency	Percentage
Promote family's health	55	29.0
Want to have the number of children one can properly cater for	33	17.4
Harsh economic condition	28	14.7
Child spacing	22	11.6
Reached the desired number of children	18	9.5
Complications during pregnancy and child birth	11	5.8
Spousal approval	7	3.7
Others	16	8.4
Total	**190**	**100.0**

Source: Field Survey, 2010

only 3.7% of the respondents said due to support for FP by either husband or wife. Husbands have great influence on women's ability to use FP methods, particularly in Northern Nigeria where wives are not allowed to use FP methods in some hospitals without approval from their husbands. During the IDI, a male respondent said:

"*Definitely FP is prohibited in Islam, but in our day to day life, it will be better to minimize the number of children in order to take care of them in a good way*".(44 year old Malam Jibril, Limancin kona)

According to Mamman (1992), 48.0% and 21.0% of the respondents approved of FP because they want to delay the next pregnancy and to terminate child bearing accordingly.

Reasons for the disapproval of FP in the study area are important because they explain why people shun the practice of FP. This will be of great help in finding solutions to the long lasting objection of FP programmes. Table 4.12 shows that contradiction with religious belief (39.5%) is the strongest reason because people here are Muslims and Islam is against FP. Not surprising too, the Catholic Christians strongly abhor FP, just as Muslims and they believe one commits a heinous sin by practicing FP. Lack of interest in FP with 32.1% is the

Table 4.12: Distribution of Reasons for Disapproval of Family Planning

Reasons for Disapproval	Number of Respondents	Percentage
Contradicts religious belief	64	39.5
Not interested	52	32.1
The desire for many children	18	11.1
Unwanted side effects	7	4.3
Spousal disapproval	5	3.1
Promotes promiscuity	4	2.5
Cultural abomination	4	2.5
Others	8	4.9
Total	**162**	**100.0**

Source: Field Survey, 2010

next reason. This is similar to the finding of Tyoden (2010) where 31.8% of the respondents reported religious objection as the major reason for disapproving FP, followed by lack of interest in FP with 30.2%. Some respondents' reasons for disapproving FP were:

> "*If my husband did not agree I cannot do FP"*. (28 year old Rabi, Angwan Juma)
>
> "*Men should not support anything related to FP, for it is best to emulate the Prophet of Allah (pbuh)"*. (33 year old Adamu, Limancin Kona)

4.2.5 Ever Use and Current Use of Family Planning

While ever use of contraception provides a measure for cumulative experience of a population with FP, the level of current use is a measure of actual contraceptive practice at the time of the survey. Current use is also the most valuable measure for the success of FP.

Furthermore, it can be used to estimate the reduction in fertility attributable to contraception (NDHS, 2008). In this study, ever use refers to use of a FP method in the past and current use connotes using contraceptives at the time of survey.

Figure 4.9 shows that 38.4% of the respondents have ever used one FP method or the other and 56.5% have not used FP at all. This result does not agree with Umoh's *et al* (2012)

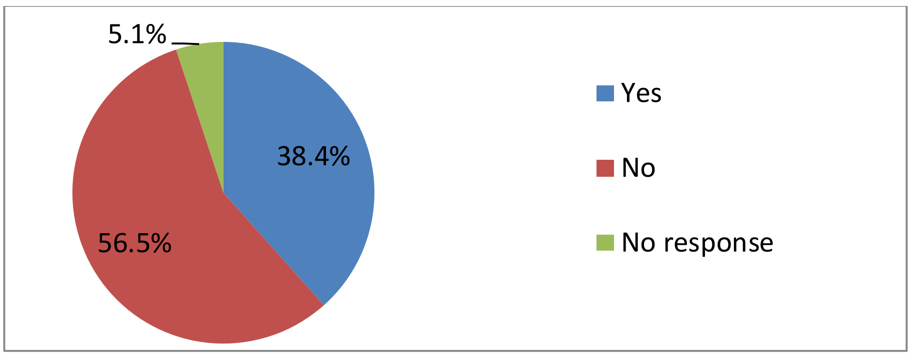

Figure 4.9: Percentage Distribution of Respondents by Ever Use of Family Planning
Source: Field Survey, 2010

study of fertility intentions of women in Uyo where 52.6% of respondents have used FP in the past and 47.4% have never used any form of FP method, might be because the study focused on women only.

For current use of FP, Figure 4.10 shows that only 34.2% of the respondents are currently using a FP method. The figures show that ever use is higher than current use of FP;

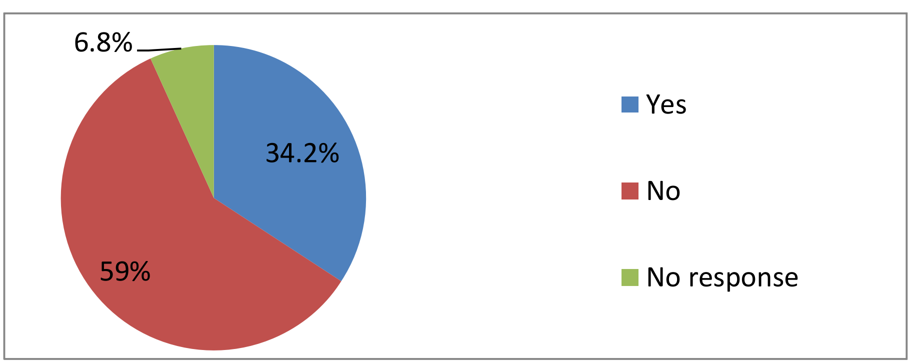

Figure 4.10: Percentage Distribution of Respondents by Use of Family Planning
Source: Field Survey, 2010

it also reveals that the use of FP is low, even though many respondents have high preference for modern methods of FP. The result corresponds with Ekpo's (2011) finding in Kaduna where 32.0% of respondents were currently using FP methods against 59.1% who were not using any FP method. It is very important to know that there is a wide gap between knowledge and use of FP methods. Considering the wide gap between the proportion of population that has ever heard of FP 97.7% on the one hand, and the proportion that has ever used (38.4%) or is currently using (34.2%) on the other, some doubts may be cast on the reliability of the responses on the question under review. It is obvious that some of those who reported having heard of FP may find it difficult to admit having ever used or currently using a method. Generally, questions on the practice of FP seem to attract a high degree of 'no' response. Given the moral background of many (who live in rural settings), a sense of guilt normally surrounds the practice of FP.

4.2.5.1 Distribution of Respondents' Ever Use and Current Use of FP by Methods

Family planning may be used by couples to either space births or limit family size. Contraception is used to space births when there is an intention to delay a possible pregnancy. In this survey, the use of modern FP methods exceeds that of traditional means of FP both in ever and current uses (Table 4.13). This might be because modern FP methods have more of female methods than male methods, which are sometimes regarded as a reason why FP is only women's concern.

The table also shows that injectables, oral contraceptive pills, and condoms are the most patronized modern methods of FP. For current use, the injectables has the highest patronage with 29.0%, followed by oral contraceptive pills (22.3%), condom (17.4%). Ameh and Sule (2007) in Zaria found injectables to be the most used FP method with (51%). Solomon *et al* (2010) in their study in northern Nigeria also revealed that injectables was the most used FP method with (50%), followed by pills (21%) and the least used were LAM, herbs and condom with 2.3% each.

LAM or Postpartum Amenorrheoa refers to the period between childbirth and the return of menstruation. This is the period during which a woman becomes temporarily unable to conceive following childbirth. A number of studies have established a direct relationship between the length and intensity of breastfeeding and the duration of postpartum Amenorrheoa. LAM is one method that is widely practiced in the study area because most

Table 4.13: Distribution by Ever Use and Current Use of Family Planning by Methods

	Ever Use		Current Use	
Response	**Number**	**Percentage**	**Number**	**Percentage**
Abstinence	14	10.3	8	6.6
Withdrawal	18	13.2	10	8.3
Condoms	31	22.8	21	17.4
Oral contraceptive pills	36	26.5	27	22.3
Injectables	22	16.2	35	29.0
Intra Uterine Contraceptive Device (IUCD)	4	2.9	9	7.4
Diaphragm	1	0.7	1	0.8
Tubectomy	0	0.0	1	0.8
Herbs	6	4.4	3	2.5
*LAM/Breastfeeding	4	2.9	6	5.0
Vasectomy	0	0.0	0	0.0
Ring	0	0.0	0	0.0
Total	**136**	**100.0**	**121**	**100.0**

Source: Field Survey, 2010
*LAM=Lactational Amenorrhea Method

infants are breast fed from child birth until the age of two. Breastfeeding is strongly supported culturally and religiously and it is particularly encouraged in hospitals during ante natal and post natal clinics because it is effective in delaying pregnancy. However, respondents might not know that LAM is a method of FP knowing that breastfeeding is a natural process of feeding an infant. This shows that women practice FP more than men, due to the reality that they bear the direct burden of childbearing and child rearing. While women make use of tubectomy for different reasons to stop child birth permanently, vasectomy or male sterilization has not gained acceptance in Nigeria, where men are given high societal recognition for having large family sizes as such they do not venture using it. Generally, there is greater awareness of tubal ligation or female sterilization than vasectomy. The condom is the most used male method, followed by withdrawal which may be due to religious encouragement, particularly in Islam, as a natural means of preventing conception. Abstinence from sexual intercourse during the fertile period of a woman which sometimes cannot be observed, especially by men in monogamous settings is low (6.6%). During the IDI, a respondent explained the importance of abstaining from sexual relationship with his wife saying:

"*I pay the bills for the injections given to my wife and try to abstain from sexual relationship with my wife when I don't have money to pay for the injections".* (29 year old Isa, Kufena)

From the hospital record, injectable is the most preferred accounting for 88.1% of the FP methods used (Table 4.14). Findings from the hospital record obtained reaffirm the result in this study of the predominance of injectables over other FP methods. This reflects its

Table 4.14: Hospital Records Showing FP Methods Used

Methods	Number	Percentage
Injectables	687	88.1
Pills	55	7.1
IUCD	30	3.9
Tubal ligation	7	0.9
Total	**779**	**100.0**

Source: Hospital Record, 2010
*IUCD-Intra Uterine Contraceptive Device

convenience and effectiveness for longer period of time which has encouraged women to adopt it as a modern FP method. It also allows women to keep their FP use confidential. More so the positive attitude of nurses/service providers has improved its popularity. This was reported during the IDI when a nurse was asked the reason why injectable is preferred by clients.

> *"Most women choose injectables due its ease and efficacy for longer durations, and sometimes women with medical conditions like hypertension who choose other methods are advised on a better alternative that suits their problems".*(Nurse, Kufena)

The nurse also confirmed that recently more people are using FP methods, because some men accompany their wives to the hospital secretly to obtain FP methods. And women also come for FP even when the husbands do not approve its use. This confirms that some people do not like to disclose their usage of FP.

4.2.5.2 Decision Making to Practice Family Planning

It is very important to know who makes the decision to practice FP, especially in patriarchal societies where the final say is given to men. Irrespective of couples' background characteristics, Figure 4.11 shows that 61.2% said the decision to practice FP was made jointly by husband and wife, because FP responsibility lies on both spouses. The question was put during the FGD session to participants on who should have the final say on FP issues and the response was:

> "*Men should consider women and take decisions together with their wives".*
> (24 year old Hadiza, Kufena)

However, 22.3% of the respondents reported that FP decision is the husband's responsibility, because he rules and is the breadwinner of the house. The desire to show that he has the final say may make a man report that he alone takes decisions (when the wife could be the decision maker in FP issues). This must be seen in the context of the traditional Hausa society where men are expected to have absolute control of their households; including the practice of FP or child spacing and women are expected to respect their husbands' decisions. This is supported by the FGD where responses supporting the position of men in decision making on FP were made clear, thus:

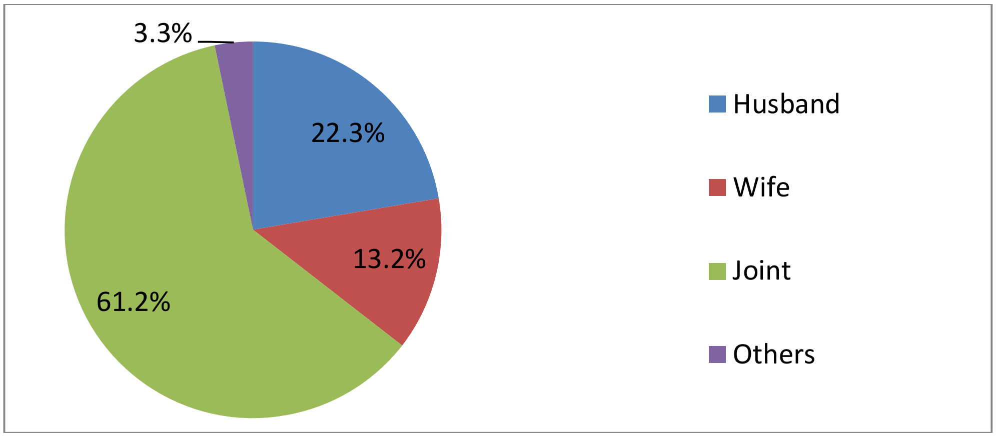

Figure 4.11: Percentage Distribution by Decision on the Practice of Family Planning
Source: Field Survey 2010

> "*It is men who decide the practice of FP or choose the method of FP*". (44 year old Abubakar, Limancin Kona)

> "*Men's decision is very important, their yes is yes and no is no. Since they marry women, decision making should be by the man but subjected to the approval of both of them*". (29 year old, Murjanatu, Kwarbai)

This is followed by 13.2% of the respondents who say the wife takes such decision even if she has to do it secretly, since she is directly affected. This is supported by two FGD participants who said:

> "*Men should allow their wives to make or take decisions by themselves*". (29 year old Emmanuel, Kufena)

"*With regards to my view about decision making on FP, they do not have anything to say, it is the woman who should think and choose what is best for her, if she makes the decision to use FP methods, she should tell her husband, and he will accept her decision. This is because from pregnancy, child birth up to the time a child matures; it is the woman who bears the greatest burden*". (37 year old Fatima, Kufena)

In addition, only 3.3% said the decision is made by neither the husband nor the wife but by medical professional, if there are health risks or relations such as the mother-in-law. This finding does not concur with that of Ekpo (2011) in Kaduna where 29.1% of the respondents reported joint decision making, followed by husband alone with 26.0%. This could be due to the fact that the research included only women.

4.2.6 Factors Determining the Adoption of Any Family Planning Method

Some 30.6% and 24.0% of respondents indicate spousal approval and effectiveness as the main reasons determining the adoption of any method of FP accordingly (Table 4.15).

Table 4.15: Distribution of the Determinants for Adopting any FP Method

Reasons	Frequency	Percentage
Spousal approval	37	30.6
Effectiveness	29	24.0
Availability	20	16.5
Convenience	19	15.7
Cost	7	5.8
Others	9	7.4
Total	**121**	**100.0**

Source: Field Survey, 2010

During the IDI, some respondents reiterated the significance of spousal approval in FP saying:

*"In my own understanding no woman will practice FP without her husband's permission, so it is very important to mobilise men especially Islamic scholars". (*29 year old Hajiya Hadiza, Kwarbai)

"FP is very important, men should practice it based on the approval of their wives". (29 year old Abdullahi, Kwarbai)

According to Mamman (1992), the determinants for using any FP method is convenience and approval by husband with 75.3% and 10.0% respectively. Ekpo (2011) also revealed that 27% and 26% said it is spousal approval and convenience.

4.2.7 Distribution on Who Obtains Family Planning Services/Methods

Information on who obtains family planning services/methods is very important because it reveals who is in support of practicing FP. Figure 4.12 shows 41.0% of husbands and 30.2% of wives paid the bills for FP services/methods. The high percentage of husbands paying for FP methods/services is not surprising in the study area since men are economically more

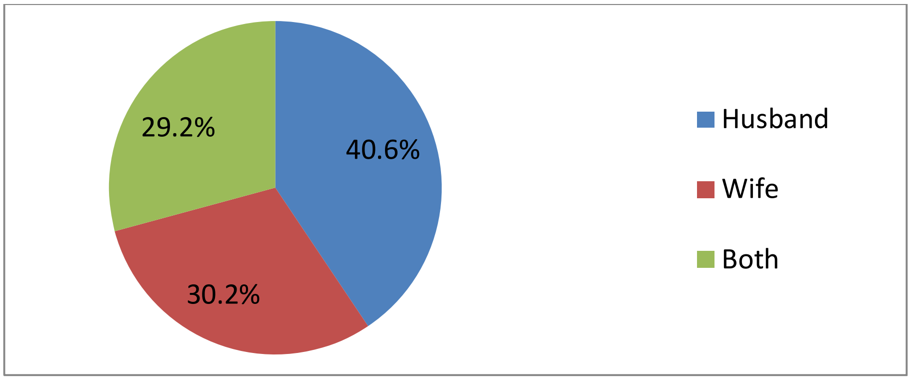

Figure 4.12: Percentage Distribution of Respondents by Who Obtains FP device
Source: Field Survey, 2010

advantaged than women; especially in a society where religion and culture have made men to be the providers of the home and some women are not even allowed to work to earn their own salary except with their husbands' approval. This reaffirms the finding by Ekpo (2011) in Kaduna, where 43% of husbands paid the bills for FP services/methods and 30.4% said payment was made jointly.

4.2.8 Future Use of Family Planning

Intention to use FP methods in the future is an important indicator of the changing demand for FP because it reveals the extent to which non users plan to use FP methods in the future. Respondents who were not using any FP method at the time of the survey were asked about

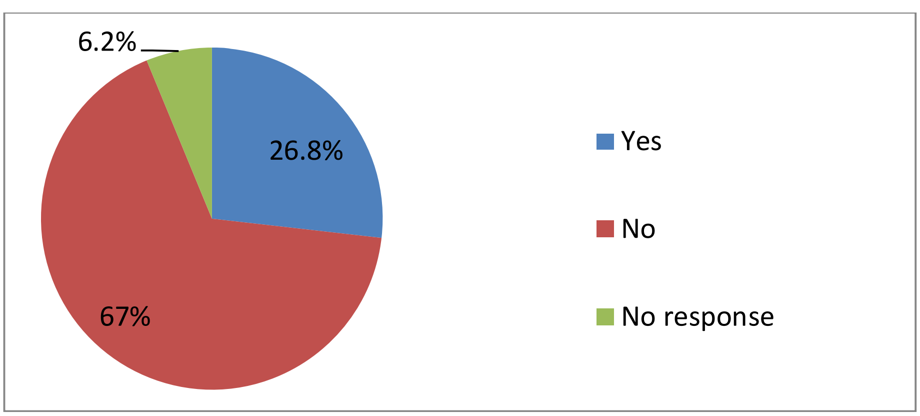

Figure 4.13: Percentage Distribution of Respondents by Future Use of FP
Source: Field Survey, 2010

their intentions to use FP in the future. Figure 4.13 reveals that 26.8% (56) of the respondents said they would want to use FP methods in the future. This corresponds with the result of NDHS (2008) report where only 21% of non users intend to use a FP method in the future.

4.2.8.1 Reasons for Future Use of Family Planning Methods

From the 26.8% (56) respondents who intend to use FP in the future, only 7.2% each of the respondents said they would practice FP in the future if child bearing poses health risk to spouse or if they reach the desired number of children (Table 4.16).

Table 4.16: Distribution of Respondents by Reasons for Future Use of Family Planning

Reasons for Future Use	Frequency	Percentage
No response	13	6.2
Don't intend future use of FP	140	67.0
Child bearing poses health risks to spouse	15	7.2
Reached the desired number of children	15	7.2
Economic hardship	13	6.2
Due to old age	5	2.4
Others	8	3.8
Total	**209**	**100.0**

Source: Field Survey, 2010

4.2.9 Men's Involvement in Family Planning Issues

About 55.1% of the respondents said men should be involved in FP issues, 35.6% answered no they should not (Figure 4.14). Involvement does not necessarily mean that men are actually using a FP method themselves. Men can be involved in FP by advising and financing their partners to use FP methods. They are also very helpful in decision making and in facilitating their partners visit to FP clinic since they play a major role in family matters. This indicates that many respondents recognize the importance of men's involvement in FP

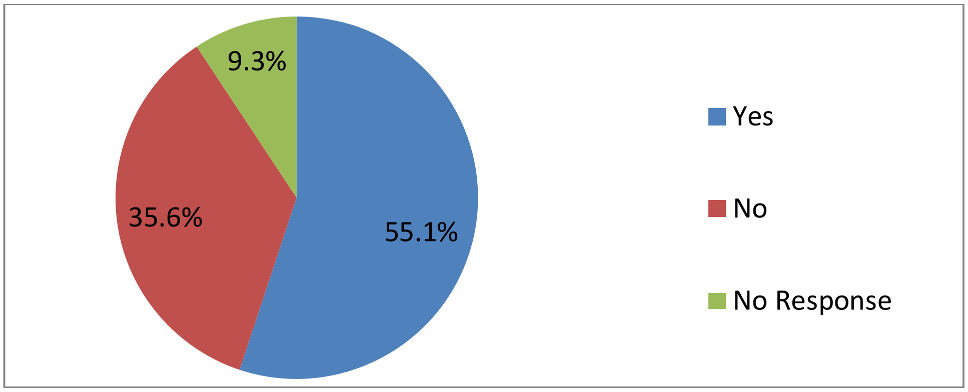

Figure 4.14: Percentage Distribution of Respondents Men's Involvement in FP Issues
Source: Field Survey, 2010

programmes just as women. Some respondents during the IDI had these to say:

> *"It is very important that men accompany their wives to the hospital to listen to the advice and warnings given, so that it will help couples".* (37 year old Tayo, Kufena)

> "*Family planning is supposed to be a two way thing; men should play a more active role, since they are the breadwinners of the home".* (34 year old Hadiza, Tukur Tukur)

However, men cannot share responsibility for reproductive health and be involved in family planning if services and information do not reach them. Men's lack of access to services has been a barrier to family-planning use. Most FP clinics cater for women only, so men are uncomfortable going to these clinics. Men must be reached in other ways or at least be encouraged to accompany their spouses for antenatal and postnatal clinics. This testimony from a male discussant during the IDI is a good illustration of that need:

"After having three children, my wife went on the pill for her contraception because we could no longer afford an accident with the natural methods we were using. Her blood pressure immediately shot up, and she was advised to discontinue. She tried other methods, but they had complications too. I felt I was unfair and it was my duty, too, to take part in family planning. One morning we went together to our local family-planning clinic. I will never forget how embarrassed I felt. There was not even a single man there, just queues of women and their babies. This was a woman's world and I felt totally lost." (42 year old Malam Jafaru, Kwarbai)

This confirms the assumption that no matter the desire for men to acquire knowledge about and utilize contraception, most family planning programmes have not yet given adequate attention to serving them. Some men are also discouraged from accompanying their wives to health centres when they are asked to donate blood either for their wives antenatal clinic or use of FP methods. Another reason is that some women are discouraged to acquire FP services when they are asked to obtain permission from their husbands. For example, Ahmadu Bello University Teaching Hospital, a government owned hospital seeks for husbands' approval to provide FP services to women.

4.2.10 Spousal Discussion on Family Planning

The degree of spousal communication between couples determines how much the couple can open up to talk about sexually related matters especially FP. Although discussion between a husband and wife about the use of FP methods is not a precondition for adoption, its absence

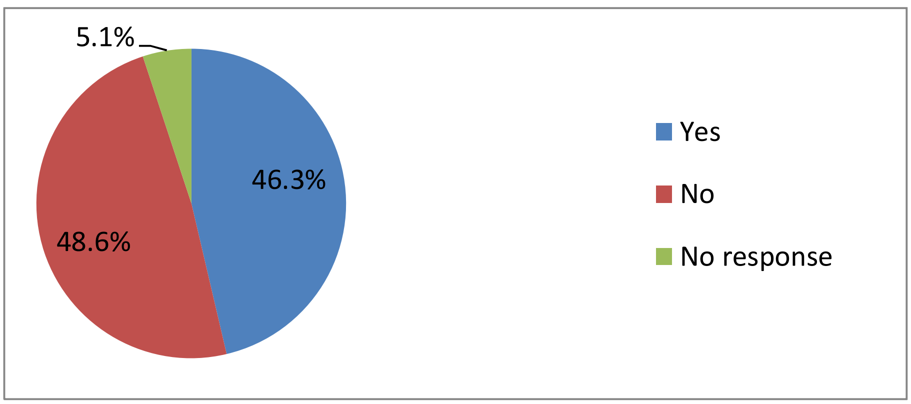

Figure 4.15: Percentage Distribution of Respondents by Spousal Discussion on Family Planning Issues
Source: Field Survey, 2010

may be an impediment for use. Inter spousal communication is thus an important intermediate step along the path to eventual adoption, and especially continuation of contraceptive use. Lack of discussion may reflect a lack of interest, hostility to the subject, or customary reticence in talking about sex-related matters (NDHS, 2003).

To gain insight into inter spousal communication on FP, currently married respondents in this survey were asked whether they have ever discussed FP issues with their spouses in the past. Around 46.3% (164) of the respondents discuss FP with their spouses and 48.6% (172) do not (Figure 4.15). Spousal communication on FP matters is encouraging and this shows that most couples now discuss FP so that they can be freed from fear of unwanted pregnancy and most importantly for spacing child birth to improve both mother and child's health. However, men should be encouraged to discuss such matters with their wives because culturally, a woman is seen as the shy one or is afraid to start up talks about FP and the man is assumed to be in total control of the number of children he desires. Responses on spousal communication from discussants during the FGD were thus:

> "*Men should discuss FP matters with their wives and also attend FP counseling together with their wives.* (27 year old Samuel, Kufena)

> "*My advice to men is that they should seek the opinions of their wives on FP matters, because they are directly affected by its side effects".* (40 year old Mr. Solomon, Kufena)

4.2.10.1 Reasons for Not Discussing Family Planning with Spouse

Table 4.17 shows the distribution by respondents' reasons for not discussing FP with their spouses where 70.3% said it is due to religious objection of FP. During the IDI, a woman said:

> "*Men do not play any role in FP, sometimes they avoid spousal communication".* (33 year old Hajiya Hassana, Kufena)

Table 4.17: Reasons for Not Discussing Family Planning with Spouse

Reasons	Frequency	Percentage
Religious objection	121	70.3
Cultural taboo	19	11.0
Spousal disapproval	4	2.3
Not of mutual interest	18	10.5
Others	10	5.8
Total	**172**	**100.0**

Source: Field survey, 2010

4.2.11 Spousal Discussion on Desired Number of Children

Figure 4.16 shows the distribution of respondents by spousal discussion on number of children desired. Only 36.2% of the respondents discuss the desired number of children with their spouses compared to 58.5% who did not. Spousal discussion on number of children desired by couples in the study area is low due to socio-cultural factors. This does not correspond with the result of Umoh *et al* (2012) in their study of fertility intentions of women in Uyo where 94% of the respondents discussed the number of children they desire with their spouses. This could be because the study was carried out in southern Nigeria where spousal

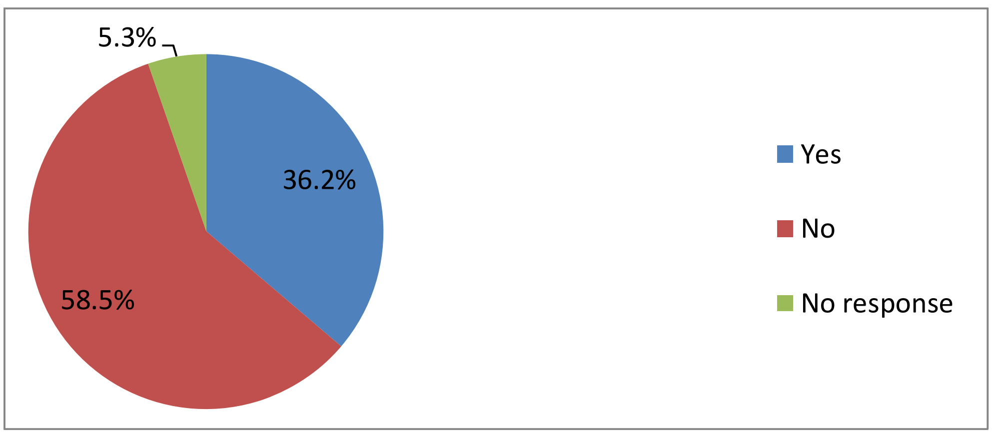

Figure 4.16: Distribution by Spousal Discussion on Desired Number of Children
Source: Field Survey, 2010

discussion on number of children desired is encouraged. Couples inability to discuss the number of children they desire to have may make them give birth to more children, particularly in a patriarchal society, where the perceived wishes of husbands are highly respected. This is supported by the IDI, where a respondent said:

> "*Men do have an important role to play in FP because they determine the number of children to have in the family".* (23 year old Muhammad, Kufena)

4.2.11.1 Reasons for Not Discussing Desired Number of Children

Table 4.18 shows that 53.6% of respondents said children are gifts/blessings from God. Many respondents' belief children are gifts from God; as such couples should not be ungrateful to

Table 4.18: Reasons for No Spousal Discussion on Number of Children

Reasons	Frequency	Percentage
Religious objection	17	8.2
Do not know how many will survive	34	16.4
Every child is born with his wealth	20	9.7
Want as many children as God grants	6	2.9
Children are gifts/blessings from God	111	53.6
Cultural taboo	5	2.4
Lack of spousal communication	4	1.9
Others	10	4.8
Total	**207**	**100.0**

Source: Field Survey, 2010

God for the blessings He bestows on them. This is supported by the sayings of some discussants during the FGD:

"*It is Almighty Allah Who grants children to Whom He wills, not our cleverness".*
(45 year old Ashiru, Kwarbai)

"Child birth is Allah's gift, He gives to whom he wishes irrespective of FP or not".
(40 year old Malam Adamu, Angwan Juma)

"*People should be patient and accept the gift of children Allah has given them".*
(39 year old Kabiru, Kwarbai)

According to Umoh *et al* (2012), 45.2% of the respondents reported economic condition and number of children they can cater for as their main reasons for spousal discussion on number of children desired, followed by 35.8% who said husband's desire for more children.

4.2.11.2 Decision Making on Desired Number of Children.

Figure 4.17 shows that 53.1% of the respondents make joint decision on the number of children they desire and 29.7% said it is made by husband. This corroborates the NDHS (2008) report where 47.3% of the respondents think that decision on the number of children

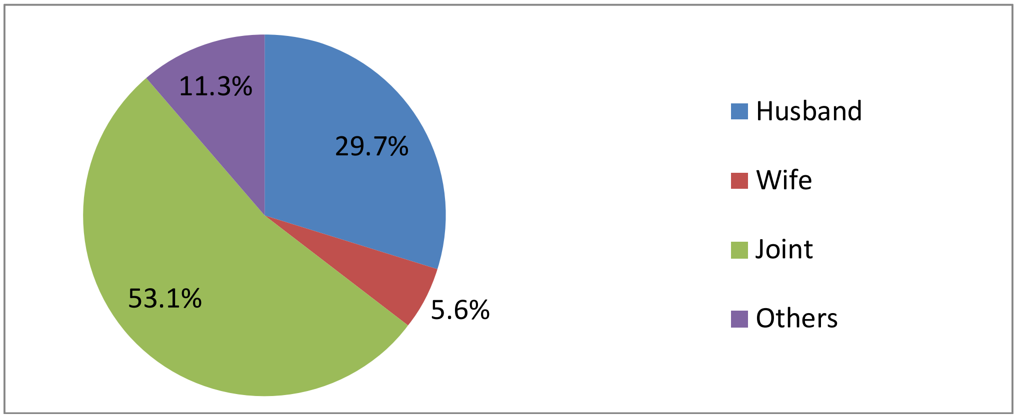

Figure 4.17: Percentage Distribution of Respondents by Decision Making on Desired Number of Children
Source: Field Survey, 2010

to have should be made jointly and 43% by husband. Decision making about fertility is often controlled by the husbands, women in many African societies are yet to gain autonomy that would enable them make decisions on the number of children they want (Morgan and Niraula, 1995).

4.2.12 Child Spacing

With regards to decision making on child spacing, Table 4.19 reveals that 67.8% of the respondents made the decision jointly by both. Nevertheless, men still dominate decision making on family matters. This is typical of the Hausa/Fulani culture where men control the sexualities of their wives and also determine how long their wives should breastfeed their children. Some 58.7% of the respondents give a gap of 1-2 years, only 4.5% give less than 1 year between childbirths. This result does not correspond with Ekpo's finding in Kaduna

Table 4.19: Distribution on Child Spacing and Duration of Child Spacing

Decision makers on the duration of child spacing	Frequency	Percentage
Husband	47	19.4
Wife	31	12.8
Both	164	67.8
Total	**242**	**100.0**
Duration of child spacing		
< 1year	11	4.5
1-2 years	142	58.7
> 2 years	89	36.8
Total	**242**	**100**

Source: Field Survey, 2010

where 14.2%, 11% and 24.2% had child spacing of 1 year, 18 months and 2 years accordingly. This is because her study focused on women who know the actual gap between their children.

4.2.13 Availability of Family Planning Facilities

Figure 4.18 indicates that 82.2% of the respondents have FP facilities near their residence. This is due to the fact that there are many health facilities scattered throughout Zaria. Thus, family planning facilities are easily accessible to people who want to use it. Information on the availability of family planning facilities in any society is an indication that family planning progarmmes are making huge efforts to provide the population with family planning services and methods.

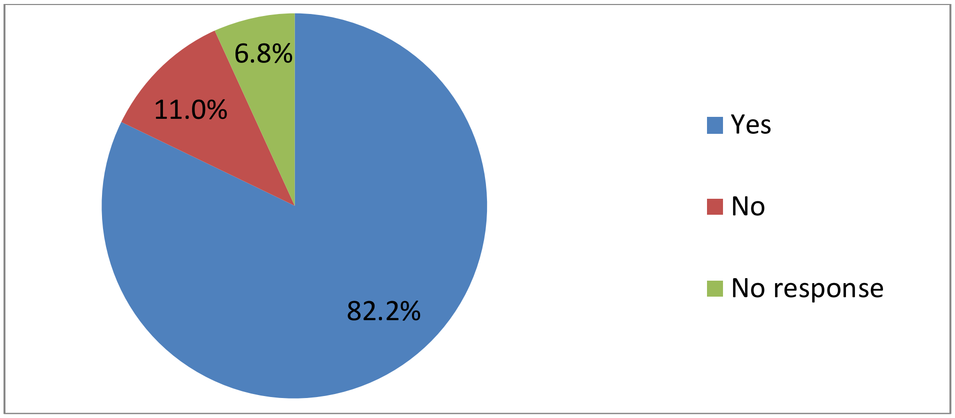

Figure 4.18: Percentage Distribution by Availability of Family Planning Facilities
Source: Field survey, 2010

4.2.14 Sources of Family Planning Facilities

Information on where respondents obtain their contraceptive methods is useful for family planning programme managers and implementers for logistic planning (NDHS, 2008). Figure 4.19 shows that for 73.5% of current users of modern contraceptive methods, hospitals (private and public medical sectors) are the major sources FP services and methods and

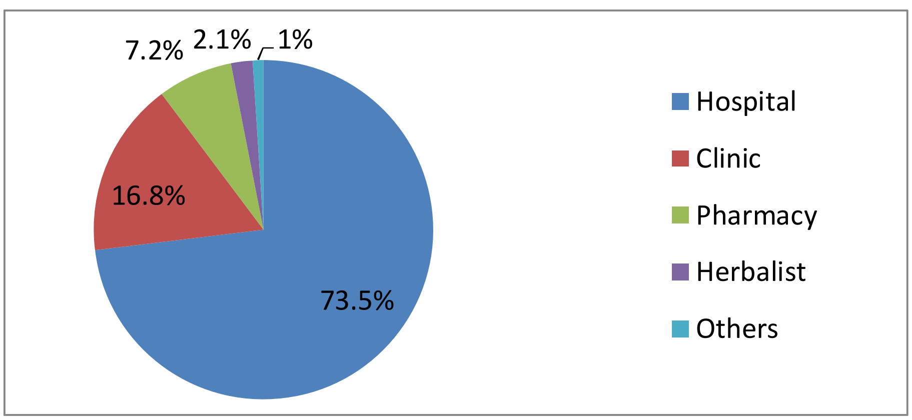

Figure 4.19: Percentage Distribution of Respondent by Sources of FP Services
Source: Field Survey, 2010

16.8% said clinics such as the maternal and child health or family planning clinics. Other sources are used by only 1% of the respondents. This is not surprising as Zaria has many government and privately owned hospitals that offer FP to its people such as Gambo Sawaba

General Hospital, Ahmadu Bello University Teaching Hospital, St Lukes Anglican Hospital to mention a few. This finding does not agree with that of Mamman (1992) in Kaduna where 37.5% obtained services and supplies from a hospital and 37.2% go to clinics. It also does not corroborate Tyoden's (2010) result in Zaria where general and teaching hospitals make up 39.2% and 32.8% respectively. This could because some respondents could not differentiate between a hospital and clinic.

Current users were also asked whether they were satisfied with the existing FP services offered to them at their supply centres. Satisfaction here means effectiveness of methods, whether users get appropriate counselling and adequate attention at service centres. Figure 4.20 reveals that only 38.1% of current users are satisfied with FP services and a high

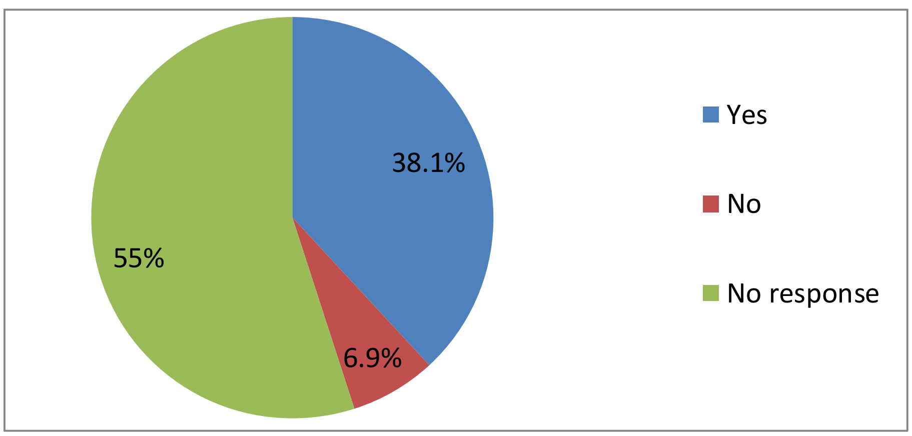

Figure 4.20: Percentage Distribution by Respondents' Satisfaction with Family Planning Services/Method
Source: Field Survey, 2010

of 55% did not respond at all. This indicates low number of respondents who are satisfied with FP services/methods offered at health centre, which means that more has to be done by government medical personnel to provide clients with adequate services.

4.3: Socio-economic Variables and Family Planning

4.3.1 Introduction

Socio-economic variables are important because they have great influence on knowledge and use of FP methods and decision making. Thus, it will be interesting to know which of these variables influence respondents' attitude towards FP in the study area. In this chapter, Chi square analysis is used to ascertain the relationship between age, religion, ethnicity, marital status, educational attainment, type of occupation and income and family planning.

4.3.2 Socio-economic Variables and Knowledge of Family Planning

4.3.2.1 Age and Knowledge of Family Planning

Table 4.20 shows that knowledge of FP is highest (100.0%) among respondents 15-19, 30-34 and 35-39 years and lowest (75.0%) for age group 50+. This shows that knowledge decreases as age increases. According to Oyediran *et al* (2006), age and education were identified as

Table 4.20: Age and Knowledge of Family Planning

Age group	Have heard	Have not heard	Row Total
15-19	42(100.0)	0(0.0)	**42(100.0)**
20-24	44(95.7)	2(4.3)	**46(100.0)**
25-29	67(97.1)	2(2.9)	**69(100.0)**
30-34	75(100.0)	0(0.0)	**75(100.0)**
35-39	45(100.0)	0(0.0)	**45(100.0)**
40-44	42(97.7)	1(2.3)	**43(100.0)**
45-49	25(96.2)	1(3.8)	**26(100.0)**
50+	6(75.0)	2(25.0)	**8(100.0)**
Column Total	**346(97.7)**	**8(2.3)**	**354(100.0)**
Calculated X^2=5.408	**df=7**	**P value=0.610**	**Remark=Not significant**

Source: Field Survey, 2010

key factors determining FP knowledge and use among married men. The high knowledge of FP in the study area might be as a result of government's effort to publicize and create awareness of FP programmes in rural and urban areas especially through the mass media. The statistical analysis of X^2=5.408, df=7, P=0.610, does not show a significant relationship between age and knowledge of FP (Table 4.20).

4.3.2.2 Religion and Knowledge of Family Planning

Some 98.0% of Muslims and 97.0% of Christians have heard of FP. The statistical analysis of X^2=0.317, df=1, P=0.573, does not show a significant relationship between religion and

Table 4.21: Religion and Knowledge of Family Planning

Religious group	Have Heard	Have Not Heard	Row Total
Muslims	286(97.9)	6(2.1)	**292(100.0)**
Christians	60(96.8)	2(3.2)	**62(100.0)**
Column Total	**346(97.7)**	**8(2.3)**	**354(100.0)**
Calculated X^2=0.317	**df=1**	**P value=0.573**	**Remark=Not significant**

Source: Field Survey, 2010

knowledge of FP (Table 4.21). This means that religion has no positive influence on respondents' level of awareness of FP. This is due to intensified effort by the Nigerian government to provide its population with the required FP information.

4.3.2.3 Ethnicity and Knowledge of Family Planning

Awareness of FP is highest (100.0%) among Igbo, Northern and Southern minority, followed by 97.4% of Hausa/Fulani. The statistical analysis of X^2=1.450, df=4, P=0.835, does not

Table 4.22: Ethnicity and Knowledge of Family Planning

Ethnicity	Have Heard	Have Not Heard	Row Total
Hausa/Fulani	266(97.4)	7(2.6)	**273(100.0)**
Igbo	16(100.0)	0(0.0)	**16(100.0)**
Yoruba	29(96.7)	1(3.3)	**30(100.0)**
Northern minority	30(100.0)	0(0.0)	**30(100.0)**
Southern minority	5(100.0)	0(0.0)	**5(100.0)**
Column Total	**346(97.7)**	**8(2.3)**	**354(100.0)**
Calculated X^2=1.450	**df=4**	**P value=0.835**	**Remark=Not significant**

Source: Field Survey, 2010

show a significant relationship between ethnicity and knowledge of FP (Table 4.22). This means that ethnicity has no positive influence on awareness of FP.

4.3.2.4 Marital Status and Knowledge of Family Planning

Table 4.23 shows that awareness of FP is highest (100.0%) among respondents who are single, divorced and widowed. The statistical analysis of X^2=21.277, df=4, P=0.000 in the table shows a significant relationship between marital status and knowledge of FP. This

Table 4.23: Marital Status and Knowledge of Family Planning

Marital Status	Have Heard	Have Not Heard	Row Total
Single	21(100.0)	0(0.0)	**21(100.0)**
Married	318(97.8)	7(2.2)	**325(100.0)**
Divorced	4(100.0)	0(0.0)	**4(100.0)**
Separated	1(50.0)	1(50.0)	**2(100.0)**
Widowed	2(100.0)	0(0.0)	**2(100.0)**
Column Total	**364(97.7)**	**8(2.3)**	**354(100.0)**
Calculated X^2= 21.277	**df=4**	**P value=0.000**	**Remark=Significant**

Source: Field Survey, 2010

indicates that knowledge is higher among currently unmarried respondents compared to those in marital union. It also shows that marital status positively influences knowledge of FP.

4.3.2.5 Educational Attainment and Knowledge of Family Planning

Table 4.24 shows that awareness of FP is 100.0% and 50% among respondents with tertiary adult literacy education respectively. Thus, knowledge is improving with enhancement in educational qualification. Education exposes people to innovations and new ideas, thereby helping to spread information very fast. Education relates positively to levels of acceptability of FP as it offers better understanding among the people (Olawepo and Okedare, 2003). Therefore, with improved level of education there is an increase in awareness of family planning. The statistical analysis of X^2=18.155, df=5, P=0.003 in the table shows a significant relationship between educational attainment and knowledge of FP.

Table 4.24: Educational Attainment and Knowledge of Family Planning

Educational Attainment	Have heard	Have not heard	Row Total
None	4(80.0)	1(20.0)	**5 (100.0)**
Quranic	56(93.3)	4(6.7)	**60(100.0)**
Primary	18(94.7)	1(5.3)	**19(100.0)**
Adult literacy	1(50.0)	1(50.0)	**2(100.0)**
Secondary	63(96.9)	1(3.1)	**64(100.0)**
Tertiary	204(100.0)	0(0.0)	**204(100.0)**
Column Total	**346(97.7)**	**8(2.3)**	**354(100.0)**
Calculated X^2=18.155	**df=5**	**P value=0.003**	**Remark=Significant**

Source: Field Survey, 2010

4.3.2.6 Occupation and Knowledge of Family Planning

Table 4.25 shows that awareness of FP is 99.4% and 98.1% among respondents working in the civil service and doing business and respectively. Although level of FP awareness is high

Table 4.25: Occupation and Knowledge of Family Planning

Occupation	Have Heard	Have Not Heard	Row Total
Farming	25(96.2)	1(3.8)	**26(100.0)**
Civil/Public service	158(99.4)	1(0.6)	**159(100.0)**
Trading	20(95.2)	1(4.8)	**21(100.0)**
Business	53(98.1)	1(1.9)	**54(100.0)**
Others	22(95.7)	1(4.3)	**23(100.0)**
Student	32(97.0)	1(3.0)	**33(100.0)**
Housewife	18(94.7)	1(5.3)	**19(100.0)**
Unemployed	18(94.7)	1(5.3)	**19(100.0)**
Column Total	**346(97.7)**	**8(2.3)**	**354(100.0)**
Calculated X^2=5.036	**df=7**	**P value=0.656**	**Remark=Not significant**

Source: Field Survey, 2010

across all types of occupation; the statistical analysis of X^2=5.036, df=7, P=0.656 in the table does not show a significant relationship between occupation and knowledge of FP.

4.3.2.7 Income and Knowledge of Family Planning

Table 4.26 shows that knowledge of FP is 100.0% among respondents earning 26,000- 35,999, 36,000- 45,999 and 46,000 Naira and above. The relationship between income and knowledge of FP in the table of X^2=7.919, df=6, P=0.161 is not statistically significant. Knowledge of FP is high across all income groups because public enlightenment

Table 4.26: Income and Knowledge of Family Planning

Income in Naira	Have Heard	Have Not Heard	Row Total
Did not disclose their income	93(95.9)	4(4.1)	**97(100.0)**
N< 6,000	16(94.1)	1(5.9)	**17(100.0)**
N6,000 - 15,999	35(94.6)	2(5.4)	**37(100.0)**
N16,000 - 25,999	59(98.3)	1(1.7)	**60(100.0)**
N26,000-35,999	46(100.0)	0(0.0)	**46(100.0)**
N36,000-45,999	29(100.0)	0(0.0)	**29(100.0)**
N46,000 and above	68(100.0)	0(0.0)	**68(100.0)**
Column Total	**346(97.7)**	**(2.3)**	**354(100.0)**
Calculated X^2=7.919	**df=6**	**P value=0.161**	**Remark=Not significant**

Source: Field Survey, 2010

campaign through the media or medical personnel by government does not attract any cost. Men are not only aware of FP methods but are starting to accept and encourage the use of various methods to their families (Agbese, 2011).

4.3.3 Socio-economic Variables and Use of Family Planning

4.3.3.1 Age and Current Use of Family Planning

It is only natural that couples begin to plan their family after having a first or second child. However, it is important to know that FP methods are not only used to limit family size but for child spacing. Current practice of FP is 47.5% among age group 20-24 years closely followed by 39.1% for age group 35–39 years. However, it is lowest (14.3%) for age 50+ years (Table 4.27). This implies that the use of FP methods is more prevalent among the middle age group; with the older group declining to practice FP. This could be due to the

Table 4.27: Age and Current Use of Family Planning

Age group	Using	Not Using	Row Total
15-19	10(26.3)	28(73.7)	**38(100.0)**
20-24	19(47.5)	21(52.5)	**40(100.0)**
25-29	24(35.8)	43(64.2)	**67(100.0)**
30-34	26(38.8)	41(61.2)	**67(100.0)**
35-39	18(39.1)	28(60.9)	**46(100.0)**
40-44	14(34.1)	27(65.9)	**41(100.0)**
45-49	9(37.5)	15(62.5)	**24(100.0)**
50+	1(14.3)	6(85.7)	**7(100.0)**
Column Total	**121(36.7)**	**209(63.3)**	**330(100.0)**
Calculated X^2=31.172 df=7		**P value=0.000**	**Remark=Significant**

Source: Field Survey, 2010

fact that older women who have reached menopause have no need for FP or declining sexual activity among older men. The relationship between age and current use of FP methods of X^2 =31.172, df=7, P= 0.000 is statistically significant (Table 4.27). The finding does not correspond with that of Solomon *et al* (2010), where age groups 35-39, 30-34 and 40-44 years had the highest proportion of current use of FP with 10%, 5.6% and 5.0% respectively. This could be because their study concentrated on contraceptive use among women in three different communities in northern Nigeria.

4.3.3.2 Religion and Current Use of Family Planning

Table 4.28 reveals that 29.7% and 74.5% of Muslims and Christians are currently practicing FP respectively. This is an indication that Christians practice FP more than Muslims in the study area. This is due to the fact that it is only the Roman Catholics among Christians, who strongly object FP compared to Muslims who view FP as birth control used to limit fertility. The Chi square test of X^2 = 33.837, df = 1, P=0.000 shows a significant relationship between religion and current practice of FP (Table 4.28). This is reaffirmed by Ekpo's (2011) finding where 40.2% and 29.1% of Christians and Muslims were practicing FP. No doubt, religion

Table 4.28: Religion and Current Use of Family Planning

Religious group	Using	Not Using	Row Total
Muslims	83(29.7)	196(70.3)	**279(100.0)**
Christians	38(74.5)	13(25.5)	**51(100.0)**
Column Total	**121(36.7)**	**209(63.3)**	**330(100.0)**
Calculated X^2=33.837	**df=1**	**P value=0.000**	**Remark=Significant**

Source: Field Survey, 2010

plays an essential role in the lives of people and has great impact on the acceptance or rejection of family planning in any society, especially in Nigeria where people are deeply rooted in their religious beliefs.

4.3.3.3 Ethnicity and Current Use of Family Planning

Igbo have the highest percentage of usage with 83.3%, followed by Yoruba (64.0%). Only 31.0% of Hausa/Fulani are currently using a FP method. The statistical analysis of X^2=20.377, df=4, P=0.000 therefore shows a significant relationship between ethnicity and current practice of FP (Table 4.29). This is not surprising in a society where Islam and the

Table 4.29: Ethnicity and Current Use of Family Planning

Ethnicity	Using	Not Using	Row Total
Hausa/Fulani	81(31.0)	180(69.0)	**261(100.0)**
Igbo	10(83.3)	2(16.7)	**12(100.0)**
Yoruba	16(64.0)	9(36.0)	**25(100.0)**
Northern minority	12(42.9)	16(57.1)	**28(100.0)**
Southern minority	2(50.0)	2(50.0)	**4(100.0)**
Column Total	**121(36.7)**	**209(63.3)**	**330(100.0)**
Calculated X^2=20.377	**df=4**	**P value=0.000**	**Remark=Significant**

Source: Field Survey, 2010

Hausa/Fulani cultures object FP and encourage having large family sizes. This corroborates the finding of Duze and Muhammad (2006), where they found that Muslim Yoruba in the south west have a positive attitude towards FP when compared to the Hausas of northern Nigeria.

4.3.3.4 Marital Status and Current Use of Family Planning

Table 4.30 reveals that 50.0% each of singles and divorced respondents are currently practicing FP, followed by 36.8% of those married. However, none of the respondents who are separated and widowed are currently practicing FP because even if they are, unmarried

Table 4.30: Marital Status and Current Use of Family Planning

Marital Status	Using	Not Using	Row Total
Single	2(50.0)	2(50.0)	**4(100.0**
Married	117(36.8)	201(63.2)	**318(100.0)**
Divorced	2(50.0)	2(50.0)	**4(100.0)**
Separated	0(0.0)	2(100.0)	**2(100.0)**
Widowed	0(0.0	2(100.0)	**2(100.0)**
Column Total	**121(36.7)**	**209(63.3)**	**330(100.0)**
Calculated X^2=2.930	**df=4**	**P value=0.570**	**Remark=Not significant**

Source: Field Survey, 2010

people would not want to be regarded in the society as being sexually promiscuous. The statistical analysis of X^2=2.930, df=4, P=0.570 in the table does not show a significant relationship between marital status and current practice FP; which is an indication that marital status does not have a positive influence on the practice of family planning.

4.3.3.5 Educational Attainment and Current Use of Family Planning

About 43.3% of respondents with tertiary education are practicing family planning, followed by 37.3% of those with secondary school education. FP use is increasing with improvement in educational qualification. The statistical analysis of X^2=18.015, df=5, P=0.003 shows a significant relationship between education and current practice FP (Table 4.31). This clearly means that a minimum of secondary school education, as the critical level of educational attainment is required for effective utilization of FP. Education is a strong influential factor on FP use because it exposes people to information, provides knowledge and better

Table 4.31: Educational Attainment and Current Use of Family Planning

Educational Attainment	Using	Not Using	Row Total
None	1(20.0)	4(80.0)	**5(100.0)**
Quranic	12(20.7)	46(79.3)	**58(100.0)**
Adult literacy	1(50.0)	1(50.0)	**2(100.0)**
Primary	4(21.1)	15(78.9)	**19(100.0)**
Secondary	22(37.3)	37(62.7)	**59(100.0)**
Tertiary	81(43.3)	106(56.7)	**187(100.0)**
Column Total	**121(36.7)**	**209(63.3)**	**330(100.0)**
Calculated X^2 =18.015	**df=5**	**P value=0.003**	**Remark=Significant**

Source: Field Survey, 2010

understanding of the desire to use FP methods. The tremendous effect of educational improvement on the use of FP is also related to its role of empowering individuals to make rational decisions and understand that it is possible to control fertility using FP methods (Duze and Muhammad, 2006). This further supports the notion that the greatest obstacle to rapid change in unfavourable attitudes towards FP is illiteracy that has lead to misconceptions about the aim of FP programmes. Solomon *et al* (2010) in their study in northern Nigeria also found that women with higher levels of education exhibited greater awareness and utilization of family planning.

4.3.3.6 Occupation Current Use of Family Planning

Table 4.32 shows that 40.0% of traders are currently using FP methods, followed by 39.5%. Farmers have the lowest percentage of FP usage with (19.2%), which might be due to their low level of education or the desire to have more children who would help on the farm. Farmers see children as productive agents; the practice of subsistence agriculture with heavy reliance on family labour contributes to high fertility (Duze and Mustapha, 2006). The statistical analysis of X^2=4.569, df=7, P= 0.712 does not show a significant relationship between occupation and current practice of FP (Table 4.32).

Table 4.32: Occupation Current Use of Family Planning

Occupation	Using	Not Using	Row Total
Farming	5(19.2)	21(80.8)	**26(100.0)**
Civil/Public service	60(39.5)	92(60.5)	**152(100.0)**
Trading	8(40.0)	12(60.0)	**20(100.0)**
Business	20(39.2)	31(60.7)	**51(100.0)**
Others	8(36.4)	14(63.6)	**22(100.0)**
Student	8(30.8)	18(69.2)	**26(100.0)**
Unemployed	5(35.7)	9(64.3)	**14(100.0)**
Housewife	7(36.8)	12(63.2)	**19(100.0)**
Column Total	**121(36.7)**	**209(63.3)**	**330(100.0)**
Calculated X^2=4.569	**df=7**	**P value=0.712**	**Remark=Not significant**

Source: Field Survey, 2010

4.3.3.7 Income and Current Use of Family Planning

Table 4.33 shows that 32.1% of respondents who did not disclose their income are using FP. However, 53% of respondents earning 46,000 Naira and only 25% of respondents earning N6,000 - 15,999 use FP methods. The middle and high income earners are leading in FP

Table 4.33: Income and Current Use of Family Planning

Income	Using	Not Using	Row Total
Did not disclose their income	27(32.1)	57(67.9)	**84(100.0)**
N< 6,000	4(26.7)	11(73.3)	**15(100.0)**
N6,000 - 15,999	9(25.0)	27(75.0)	**36(100.0)**
N16,000 - 25,999	22(38.6)	35(61.4)	**57(100.0)**
N26,000-35,999	13(28.9)	32(71.1)	**45(100.0)**
N36,000-45,999	11(40.7)	16(59.3)	**27(100.0)**
N46,000 and above	35(53.0)	31(46.9)	**66(100.0)**
Column Total	**121(36.7)**	**209(63.3)**	**330(100.0)**
Calculated X^2=12.238	**df=6**	**P value=0.032**	**Remark=Significant**

Source: Field Survey, 2010

usage. High income motivates people to desire good standards of living, which could be achieved by having smaller family sizes. The statistical analysis of X^2 =12.238, df=6, P= 0.032 shows a significant relationship between income and current practice of FP.

4.3.4 Socio-economic Variables and Family Planning Methods Currently Using

4.3.4.1 Age and Family Planning Methods Currently Using

Table 4.34 shows that 9.5% of respondents between the age group of 15-19 years are using injectables, 15.2% of age 20-24 years are using condoms and 12.5% of age group 50 years and above are using LAM. Injectables, pills and condoms are the most used methods due to their accessibility, convenience, effectiveness and confidentiality. The statistical analysis of in Table 4.34 X^2=85.036, df=63, P=0.034 shows a statistically significant relationship between age and types of FP methods currently used. This indicates that age positively influences the types of FP methods respondents are using. This corroborates (2011) Ekpo's finding where age had a statistically significant relationship with FP methods used.

4.3.4.2 Religion and Family Planning Methods Currently Using

Table 4.35 shows that 26.5% and 24.1% of Muslims are using pills and injectables respectively; 39.4% and 23.7% of Christians are using injectables and condoms respectively. While Christians have a high preference for using injectables and condoms, Muslims use pills and natural FP methods more. This could be due to the fact that Christians use more of modern FP methods, compared to Muslims who use natural FP methods which do not have side effects or are believed to be as effective as modern FP methods. The statistical analysis in Table Table 4.35 of X^2=16.002 df=9, P=0.067 does not show a significant relationship between religion and types of FP methods used. This suggests that religion has a negative influence on the types of FP methods used.

Table 4.34: Age and Family Planning Methods Currently Using

Age group	Abstinence	Withdrawal	Condom	Pills	Injectables	IUCD	Diaphragm	Tubectomy	Herbs	LAM	**Row Total**
15-19	0(0.0)	2(4.8)	1(2.4)	1(2.4)	4(9.5)	0(0.0)	1(2.4)	1(2.4)	0(0.0)	0(0.0)	**10(100.0)**
20-24	2(4.3)	0(0.0)	7(15.2)	3(6.5)	4(8.7)	2(4.3)	0(0.0)	0(0.0)	0(0.0)	1(2.3)	**19(100.0)**
25-29	1(1.4)	0(0.0)	7(9.9)	4(5.6)	8(11.3)	2(2.8)	0(0.0)	0(0.0)	1(1.4)	1(1.4)	**24(100.0)**
30-34	0(0.0)	3(4.3)	3(4.3)	8(11.4)	9(12.8)	2(2.9)	0(0.0)	0(0.0)	1(1.4)	0(0.0)	**26(100.0)**
35-39	2(4.2)	1(2.0)	2(4.2)	6(12.5)	6(12.5)	1(2.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	**18(100.0)**
40-44	2(4.7)	2(4.7)	1(2.3)	1(2.3)	3(7.0)	2(4.7)	0(0.0)	0(0.0)	1(2.3)	2(4.7)	**14(100.0)**
45-49	2(7.7)	0(0.0)	4(15.4)	1(3.8)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	1(3.8)	**9(100.0)**
50 +	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	1(12.5)	**1(100.0)**
Column Total	**8(2.3)**	**10(2.8)**	**21(5.9)**	**27(7.6)**	**35(9.9)**	**9(2.5)**	**1(0.3)**	**1(0.3)**	**3(0.8)**	**6(1.7)**	**121(100.0)**

Calculated X^2=85.036 **df=63** **P value=0.034** **Remark=Significant**

Source: Field Survey, 2010

Table 4.35: Religion and Family Planning Methods Currently Using

Religious group	Abstinence	Withdrawal	Condom	Pills	Injectables	IUCD	Diaphragm	Tubectomy	Herbs	LAM	**Total**
Muslims	7(8.4)	9(10.8)	12(14.4)	22(26.5)	20(24.1)	5(6.0)	0(0.0)	0(0.0)	3(3.6)	5(6.0)	**83(100.0)**
Christians	1(2.6)	1(2.6)	9(23.7)	5(13.2)	15(39.4)	4(10.5)	1(2.6)	1(2.6)	0(0.0)	1(2.6)	**38(100.0)**
Total	**8(2.3)**	**10(2.8)**	**21(5.9)**	**27(7.6)**	**35(9.9)**	**9(2.5)**	**1(0.3)**	**1(0.3)**	**3(0.8)**	**6(1.7)**	**121(100.0)**

Calculated X^2=16.002 **df=9** **P value=0.067** **Remark=Not significant**

Source: Field Survey, 2010

4.3.4.3 Ethnicity and Family Planning Methods Currently Using

Table 4.36 reveals that 30.9% and 22.2% of Hausa/Fulani are using injectables and pills, 30.0% each of Igbo are using condoms and pills and 25.0% each of Yoruba are using injectables, condoms and pills. While 6.2% of Hausa/Fulani use LAM because breastfeeding for at least two years is highly encouraged in Islam, Igbo and Southern minority use pills and condoms more than any ethnic group, which suggests that men from these ethnic groups embrace male modern FP methods more. However, the statistical analysis in Table 4.36 of X^2=40.273, df=36, P=0.287 does not show a significant difference between ethnicity and types of FP method used; which means that ethnicity does not positively influence the types of FP methods respondents use.

4.3.4.4 Marital Status and Family Planning Methods Currently Using

Table 4.37 reveals that 50.0% each of respondents who are single use injectables and condoms and 29.0% and 23.1% of those married are using injectables and pills. The non use of FP methods among divorced and separated respondents could also mean that the unmarried may not have been sexually active and therefore may not require practicing FP. The statistical analysis in Table 4.37 of X^2=10.417, df=36, P=0.917 does not show a significant relationship between marital status and types of FP methods used; which means that marital status has no positive influence on the types of FP methods respond.

Table 4.36: Ethnicity and Family Planning Methods Currently Using

	Family Planning Methods Currently Using										
Ethnicity	Abstinence	Withdrawal	Condom	Pills	Injectables	IUCD	Diaphragm	Tubectomy	Herbs	LAM	**Row Total**
Hausa/Fulani	7(8.6)	10(12.3)	9(11.1)	18(22.2)	25(30.9)	4(4.9)	0(0.0)	0(0.0)	3(3.7)	5(6.2)	**81(100.0)**
Igbo	0(0.0)	0(0.0)	3(30.0)	3(30.0)	2(20.0)	1(10.0)	1(10.0)	0(0.0)	0(0.0)	0(0.0)	**10(100.0)**
Yoruba	0(0.0)	0(0.0)	4(25.0)	4(25.0)	4(25.0)	2(12.5)	0(0.0)	1(6.2)	0(0.0)	1(6.2)	**16(100.0)**
Northern minority	1(8.3)	0(0.0)	4(33.3)	1(8.3)	4(33.3)	2(16.7)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	**12(100.0)**
Southern minority	0(0.0)	0(0.0)	1(50.0)	1(50.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	**2(100.0)**
Column Total	**8(2.3)**	**10(2.8)**	**21(5.9)**	**27(7.6)**	**35(9.9)**	**9(2.5)**	**1(0.3)**	**1(0.3)**	**3(0.8)**	**6(1.7)**	**121(100.0)**
Calculated X^2=40.273		**df=36**			**P value=0.287**			**Remark=Not significant**			

Source: Field Survey, 2010

Table 4.37: Marital Status and Family Planning Methods Currently Using

	Family Planning Methods Currently Using										
Marital Status	Abstinence	Withdrawal	Condom	Pills	Injectables	IUCD	Diaphragm	Tubectomy	Herbs	LAM	**Row Total**
Single	0(0.0)	0(0.0)	1(50.0)	0(0.0)	1(50.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	**2(100.0)**
Married	8(6.8)	10(8.5)	19(16.2)	27(23.1)	34(29.0)	8(6.8)	1(0.9)	1(0.9)	3(2.6)	6(5.1)	**117(100.0)**
Divorced	0(0.0)	0(0.0)	1(50.0)	0(0.0)	0(0.0)	1(50.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	**2(100.0)**
Separated	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	**0(0.0)**
Widowed	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	**0(0.0)**
Column Total	**8(2.3)**	**10(2.8)**	**21(5.9)**	**27(7.6)**	**35(9.9)**	**9(2.5)**	**1(0.3)**	**1(0.3)**	**3(0.8)**	**6(1.7)**	**121(100.0)**
Calculated X^2=10.417			**df=36**			**P value=0.917**			**Remark=Not significant**		

Source: Field Survey, 2010

4.3.4.5 Educational Attainment and Family Planning Methods Currently Using

Table 4.38 shows that 32.1%, 21.0% and 19.8% of respondents with tertiary education are using injectables, condoms and pills; 22.7% and 18.2% each of those with secondary education are using injectables, condoms and pills respectively. Respondents with secondary and tertiary education use injectables, condoms and pills more compared to other levels of educational attainment, which suggests that people with higher levels of education use modern FP methods more. This also reveals that highly educated men are more enlightened on the use of condom as a modern FP method for men. The statistical analysis in Table 4.38 of X^2=54.307, df=45, P=0.161 does not show a significant relationship between educationand and types of FP methods used. This suggests that educational level has no positive influence on the methods of FP used by respondents, thus men's educational attainment does not determine the FP methods they use. This finding does not correspond to Ekpo's finding (2011), where educational attainment had a statistically significant relationship with FP methods used by women.

Table 4.38: Educational Attainment and Family Planning Methods Currently Using

	Family Planning Methods Currently Using										
Educational Attainment	Abstinence	Withdrawal	Condom	Pills	Injectables	IUCD	Diaphragm	Tubectomy	Herbs	LAM	**Row Total**
None	0(0.0)	0(0.0)	0(0.0)	1(100.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	**1(100.0)**
Quranic	1(8.3)	3(25.0)	1(8.3)	2(16.7)	3(25.0)	1(8.3)	0(0.0)	0(0.0)	1(8.3)	0(0.0)	**12(100.0)**
Adult literacy	0(0.0)	0(0.0)	0(0.0)	1(100.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	**1(100.0)**
Primary	0(0.0)	0(0.0)	0(0.0)	2(50.0)	1(25.0)	0(0.0)	1(25.0)	0(0.0)	0(0.0)	0(0.0)	**4(100.0)**
Secondary	2(9.1)	2(9.1)	4(18.2)	4(18.2)	5(22.7)	1(4.5)	0(0.0)	0(0.0)	1(4.5)	3(13.6)	**22(100.0)**
Tertiary	5(6.2)	5(6.2)	17(21.0)	16(19.8)	26(32.1)	7(8.6)	0(0.0)	1(1.2)	1(1.2)	3(3.7)	**81(100.0)**
Column Total	**8(2.3)**	**10(2.8)**	**21(5.9)**	**27(7.6)**	**35(9.9)**	**9(2.5)**	**1(0.3)**	**1(0.3)**	**3(0.8)**	**6(1.7)**	**121(100.0)**
Calculated X^2=54.307			**df=45**		**P value=0.161**			**Remarks=Not significant**			

Source: Field Survey, 2010

4.3.4.6 Occupation and Family Planning Methods Currently Using

Table 4.39 reveals that 35.0% and 26.7% of civil/public servants use injectables and pills and 40.0% of farmers use withdrawal because it is a natural means of preventing pregnancy. About 71.4% of full time housewives use injectables which could be due to its convenience and confidentiality, with only a visit to a health facility every 2 or 3 months. The statistical analysis in Table 4.39 of X^2=68.618, df=63, P=0.293 does not show a significant relationship between occupation and types of FP methods used.

Table 4.39: Occupation and Family Planning Methods Currently Using

Occupation	Family Planning Methods Currently Using										
	Abstinence	Withdrawal	Condom	Pills	Injectables	IUCD	Diaphragm	Tubectomy	Herbs	LAM	**Row Total**
Farming	0(0.0)	2(40.0)	1(20.0)	0(0.0)	1(20.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	1(20.0)	**5(100.0)**
Civil service	5(8.3)	5(8.3)	6(10.0)	16(26.7)	21(35.0)	5(8.3)	0(0.0)	1(1.7)	0(0.6)	1(1.7)	**60(100.0)**
Trading	0(0.0)	2(25.0)	2(25.0)	0(0.0)	2(25.0)	1(12.5)	0(0.0)	0(0.0)	1(12.5)	0(0.0)	**8(100.0)**
Business	2(10.0)	0(0.0)	5(25.0)	6(30.0)	2(3.7)	0(0.0)	1(5.0)	0(0.0)	2(10.0)	2(10.0)	**20(100.0)**
Others	1(12.5)	0(0.0)	2(25.0)	3(37.5)	0(0.0)	1(12.5)	0(0.0)	0(0.0)	0(0.0)	1(12.5)	**8(100.0)**
Student	0(0.0)	0(0.0)	3(37.5)	2(25.0)	1(12.5)	1(12.5)	0(0.0)	0(0.0)	0(0.0)	1(12.5)	**8(100.0)**
Unemployed	0(0.0)	1(20.0)	1(20.0)	0(0.0)	3(60.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	**5(100.0)**
Housewife	0(0.0)	0(0.0)	1(14.3)	0(0.0)	5(71.4)	1(14.3)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	**7(100.0)**
Column Total	**8(2.3)**	**10(2.8)**	**21(5.9)**	**27(7.6)**	**35(9.9)**	**9(2.5)**	**1(0.3)**	**1(0.3)**	**3(0.8)**	**6(1.7)**	**121(100.0)**
Calculated X^2=68.618			**df=63**			**P value=0.293**			**Remarks=Not significant**		

Source: Field Survey, 2010

4.3.4.7 Income and Family Planning Methods Currently Using

Table 4.40 reveals that 37.0% and 22.2% of respondents who did not disclose their income use injectables and condoms, 30.7% and 23.1% of those earning 26,000-35,999 use injectables and pills and 37.1% and 22.8% of respondents earning 46,000 and above use injectables and pills. The statistical analysis in Table 4.40 of X^2=21.594, df=54, P=0.992 does not show a significant relationship between income and types of FP methods used, which means that income level does not have a positive influence on FP methods used. This is because men are economically empowered than women, thus they can afford to pay for any modern FP method. This does not correspond with Ekpo's result where the relationship between income and FP methods used by women was statistically significant.

Table 4.40: Income and Family Planning Methods Currently Using

Income	Abstinence	Withdrawal	Condom	Pills	Injectables	IUCD	Diaphragm	Tubectomy	Herbs	LAM	**Row Total**
Did not disclose their income	1(3.7)	1(3.7)	6(22.2)	5(18.5)	10(37.0)	3(11.1)	0(0.0)	0(0.0)	0(0.0)	1(3.7)	**27(100.0)**
N< 6,000	0(0.0)	1(25.0)	1(25.0)	1(25.0)	1(25.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	**4(100.0)**
N6,000-15,999	1(11.1)	0(0.0)	2(22.2)	1(11.1)	1(11.1)	1(11.1)	1(11.1)	0(0.0)	0(0.0)	2(22.2)	**9(100.0)**
N16,000-25,999	2(9.1)	3(13.6)	4(18.2)	6(27.3)	4(18.2)	1(4.5)	0(0.0)	0(0.0)	1(4.5)	1(4.5)	**22(100.0)**
N26,000-35,999	1(7.7)	1(7.7)	2(15.4)	3(23.1)	4(30.7)	2(15.4)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	**13(100.0)**
N36,000-45,999	0(0.0)	1(9.1)	2(18.1)	3(27.3)	2(18.1)	1(9.1)	0(0.0)	0(0.0)	1(9.1)	1(9.1)	**11(100.0)**
N46,000 and above	3(8.5)	3(8.5)	4(11.4)	8(22.8)	13(37.1)	1(2.9)	0(0.0)	1(2.9)	1(2.9)	1(2.9)	**35(100.0)**
Column Total	**8(2.3)**	**10(2.8)**	**21(5.9)**	**27(7.6)**	**35(9.9)**	**9(2.5)**	**1(0.3)**	**1(0.3)**	**3(0.8)**	**6(1.7)**	**121(100.0)**

Calculated X^2=21.594 **df=54** **P value= 0.992** **Remark= Not significant**

Source: Field Survey, 2010

4.3.5 Socio-economic Variables Family Planning Decision Making

4.3.5.1 Age and Family Planning Decision Making

Couples' joint decision is highest among respondents age 45-49 and 40-44 years with 77.8% and 71.4% respectively. Joint decision making is high and suggests that couples are involved

Table 4.41: Age and Family Planning Decision Making

Age group	Husband only	Wife only	Joint	Others	Total
15-19	3(30.0)	0(0.0)	7(70.0)	0(0.0)	**10(100.0)**
20-24	4(21.1)	3(15.8)	10(52.6)	2(10.5)	**19(100.0)**
25-29	6(25.0)	0(0.0)	17(70.8)	1(4.2)	**24(100.0)**
30-34	7(26.9)	7(26.9)	11(42.3)	1(3.8)	**26(100.0)**
35-39	4(22.2)	3(16.7)	11(61.1)	0(0.0)	**18(100.0)**
40-44	1(7.1)	3(21.4)	10(71.4)	0(0.0)	**14(100.0)**
45-49	2(22.2)	0(0.0)	7(77.8)	0(0.0)	**9(100.0)**
50 +	0(0.0)	0(0.0)	1(100.0)	0(0.0)	**1(100.0)**
Column Total	**27(22.3)**	**16(13.2)**	**74(61.2)**	**4(3.3)**	**121(100.0)**
Calculated X^2=21.279		**df=21**	**P value=0.442**	**Remark=Not significant**	

Source: Field Survey, 2010

in discussing FP matters together. The statistical analysis of X^2= 21.279, df=21, P=0.442 does not show a significant relationship between age and who makes the decision to practice FP (Table 4.41).

4.3.5.2 Religion and Family Planning Decision Making

Table 4.42 reveals that 65.1% and 64.5% of Muslims and Christians make FP decisions jointly and about 25.3% of Muslims and 29.0% of Christians indicate that decision is made by husband and wife only respectively. While Islam confers on the husband sole authority on

Table 4.42: Religion and Family Planning Decision Making

Religious group	Husband only	Wife only	Joint	Others	Total
Muslims	21(25.3)	7(8.4)	54(65.1)	1(1.2)	**83(100.0)**
Christians	6(19.4)	9(29.0)	20(64.5)	3(9.7)	**31(100.0)**
Column Total	**27(22.3)**	**16(13.2)**	**74(61.2)**	**4(3.3)**	**121(100.0)**
Calculated X^2=9.298	**df=3**		**P value=0.020**	**Remark=Significant**	

Source: Field Survey, 2010

decision making among the Muslims, the wife has the major say when deciding on FP among the Christians, thus Christian women are allowed to take such decisions on their own compared to Muslim women. This confirms the high position of men in Islam and that religion plays an important role in making FP decision. Family planning use remains a deeply sensitive issue that often involves religious or philosophical convictions (Solomon *et al*, 2010). The statistical analysis in the table of X^2 =9.298, df=3, P=0.020 indicates a significant relationship between religion and who makes the decision to use FP.

4.3.5.3 Ethnicity and Family Planning Decision Making

Table 4.43 shows that joint decision making is high across all ethnic groups with 64.2% of Hausa/Fulani reporting joint FP decision making, decision making by husband only is 26.0% among the Hausa/Fulani. Decision making by wife only is lowest (8.3% and 8.6%) among the Northern minority and Hausa/Fulani ethnic groups; which is not surprising as religion and

Table 4.43: Ethnicity and Family Planning Decision Making

Ethnicity	Husband only	Wife only	Joint	Others	Total
Hausa/Fulani	21(25.9)	7(8.6)	52(64.2)	1(1.2)	**81(100.0)**
Igbo	1(10.0)	4(40.0)	5(50.0)	0(0.0)	**10(100.0)**
Yoruba	3(18.7)	3(18.7)	9(56.3)	1(6.3)	**16(100.0)**
Northern minority	2(16.7)	1(8.3)	7(58.3)	2(16.7)	**12(100.0)**
Southern minority	0(0.0)	1(50.0)	1(50.0)	0(0.0)	**2(100.0)**
Total	**27(22.3)**	**16(13.2)**	**74(61.2)**	**4(3.3)**	**121(100.0)**
Calculated X^2=47.086	**df=12**	**P value=0.000**	**Remark= Not Significant**		

Source: Field Survey, 2010

culture in the study area give men more authority on decision making in marital and family life. However, the Southern minority ethnic group and Igbo allow their wives to take such decision on their own unlike the Hausa/Fulani and Northern minority ethnic groups. Generally, most Nigerians, irrespective of ethnic groups, recognize the significance and dominance of men in family life and the society as well (Isiugo-Abanihe, 2003). The statistical analysis in the table further shows a statistically significant relationship between ethnicity and who makes the decision to practice FP (X^2=47.086, df=12, P=0.000), which implies that ethnicity has positive influence on decision making to practice FP. This finding corroborates Duze and Muhammad's (2006) result where 78% of spouses among Hausa and Kanuri agreed that the wife has no say on family size, compared to only 6.7% of Igbo, Ijaw (10.5%) and Yoruba (10.5%). This further confirms the significant role men play in fertility decision making among Hausa people.

4.3.5.4 Marital Status and Family Planning Decision Making

Table 4.44 shows that the ability of couples to take decisions jointly to practice FP by married respondents is 63.2% and decision by husband only is 22.2%. For singles, the ability of husband or self and others (medical personnel) to make decision is 50.0% each. This implies that FP is mainly practiced by the married; the unmarried may not reveal their use of FP method for fear discrimination within the society. Decision making by husband only is

Table 4.44: Marital Status and Family Planning Decision Making

Marital Status	Husband only	Wife only	Joint	Others	Total
Single	1(50.0)	0(0.0)	0(0.0)	1(50.0)	**2(100.0**
Married	26(22.2)	14(11.9)	74(63.2)	3(2.6)	**117(100.0)**
Divorced	0(0.0)	2(100.0)	0(0.0)	0(0.0)	**2(100.0)**
Separated	0(0.0)	0(0.0)	0(0.0)	0(0.0)	**0(100.0)**
Widowed	0(0.0)	0(0.0)	0(0.0)	0(0.0)	**0(100.0)**
Total	**27(22.3)**	**16(13.2)**	**74(61.2)**	**4(3.3)**	**121(100.0)**
Calculated X^2 =28.909	**df=12**	**P value=0.000**		**Remark= Significant**	

Source: Field Survey, 2010

also higher for married respondents compared to the divorced where women alone or self make FP decision. This reaffirms the patriarchal system in Nigeria with men being major decision makers even in issues that affect women directly. It also reflects women's complete dependence on their husbands due to the lack of right to decide on the use of FP. About 18% of Nigerian women rely on their husbands' decision to practice FP compared to 1.7% who could make such decision alone (NDHS, 2008). The Chi square test in the table of X^2 =28.909, df=12 and P value=0.000 indicates that the relationship between marital status and who makes the decision to practice FP is statistically significant. This means that marital status positively influences the decision to use FP methods.

4.3.5.5 Educational Attainment and Family Planning Decision Making

Table 4.45 shows that 66.7% and 65.4% of respondents with Quranic and tertiary education decide jointly to practice FP respectively. Decision making by husband only is 50.0% for respondents with primary education. The Chi square test in the table showing the calculated

Table 4.45: Educational Attainment and Family Planning Decision Making

Educational Attainment	Husband only	Wife only	Joint	Others	Total
None	0(0.0)	1(100.0)	0(0.0)	0(0.0)	**1(100.0)**
Quranic	3(25.0)	1(8.3)	8(66.7)	0(0.0)	**12(100.0)**
Adult literacy	0(0.0)	0(0.0)	1(100.0)	0(0.0)	**1(100.0)**
Primary	2(50.0)	1(25.0)	1(25.0)	0(0.0)	**4(100.0)**
Secondary	8(36.4)	3(13.6)	11(50.0)	0(0.0)	**22(100.0)**
Tertiary	14(17.3)	10(12.3)	53(65.4)	4(4.9)	**81(100.0)**
Total	**27(22.3)**	**16(13.2)**	**74(61.2)**	**4(3.3)**	**121(100.0)**
Calculated X^2 =15.675	**df=15**		**P value=0.404**	**Remark=Not significant**	

Source: Field Survey, 2010

X^2 of 15.675 with degree of freedom of 15 and P value of 0.404 indicates that the relationship between educational qualification and who makes the decision to practice FP is not statistically significant. This implies that education has no positive influence on who makes the decision to use FP methods. This is not surprising in a society where a woman's educational level gives her little room to make such decisions alone. Due to socio-cultural limitations, women are obliged to respect the wishes of their husbands, in view of the essential position that men enjoy in Nigerian societies.

4.3.5.6 Occupation and Family Planning Decision Making

Table 4.46 reveals that joint decision making to use FP methods is 65.0% and 63.3% among respondents doing business and civil servants respectively. Decision making by husband only is 57.1% for housewives. The calculated X^2 of 23.655 with degree of freedom of 21 and P

Table 4.46: Occupation and Family Planning Decision Making

Occupation	Husband only	Wife only	Joint	Others	Total
Farming	0(0.0)	0(0.0)	5(100.0)	0(0.0)	**5(100.0)**
Civil/public service	13(21.7)	7(11.7)	38(63.3)	2(3.3)	**60(100.0)**
Trading	3(37.5)	1(12.5)	4(50.0)	0(0.0)	**8(100.0)**
Business	4(20.0)	3(15.0)	13(65.0)	0(0.0)	**20(100.0)**
Others	1(12.5)	2(25.0)	5(62.5)	0(0.0)	**8(100.0)**
Student	2(25.0)	0(0.0)	5(62.5)	1(12.5)	**8(100.0)**
Unemployed	0(0.0)	2(40.0)	2(40.0)	1(20.0)	**5(100.0)**
Housewife	4(57.1)	1(14.3)	2(28.6)	0(0.0)	**7(100.0)**
Total	**27(22.3)**	**16(13.2)**	**74(61.2)**	**4(3.3)**	**121(100.0)**
Calculated X^2 =23.655	**df=21**	**P value=0.310**	**Remark=Not significant**		

Source: Filed Survey, 2010

value of 0.310 in Table 4.46 indicates that the relationship between occupation and who makes the decision to practice FP is not statistically significant; which means men's type of occupation has no positive influence on who makes the decision to practice FP.

4.3.5.7 Income and Family Planning Decision Making

Table 4.47 shows that the ability of couples to make joint decision on family planning is 89.0% for respondents earning 6,000-15,999 Naira respectively. About 27.3% and 75.0% of those earning 16,000-25,999 and less than 6,000 Naira said it is husband only and wife alone, in that order. Decision making by wife alone is higher for respondents with the lowest

Table 4.47: Income and Family Planning Decision Making

Income	Husband only	Wife only	Joint	Others	Total Row
Did not disclose their income	8(29.6)	3(11.1)	14(51.9)	2(7.4)	**27(100.0)**
N< 6,000	1(25.0)	3(75.0)	0(0.0)	0(0.0)	**4(100.0)**
N6,000 - 15,999	0(0.0)	0(0.0)	8(88.9)	1(11.1)	**9(100.0)**)
N16,000 - 25,999	6(27.3)	4(18.2)	12(54.5)	0(0.0)	**22(100.0)**
N26,000-35,999	3(23.1)	2(15.4)	7(53.8)	1(7.7)	**13(100.0)**
N36,000-45,999	1(9.1)	1(9.1)	9(81.8)	0(0.0)	**11(100.0)**
N46,000 and above	8(22.8)	3(8.6)	24(68.6)	0(0.0)	**35(100.0)**
Total Column	**27(22.3)**	**16(13.2)**	**74(61.2)**	**4(3.3)**	**121(100.0)**
Calculated X^2=27.981	**df=18**	**P value=0.022**		**Remark=Significant**	

Source: Field Survey, 2010

income level and decreases with an increase in income. This means that improvement in respondents' income could empower women to make FP decision on their own. The statistical analysis in the table of X^2 =27.981, df= 18, P= 0.022 shows a significant relationship between income and who makes decision to practice FP, which means that higher income gives room to women to participate in FP decision making.

4.3.6 Discussion

Chi square analysis was used to ascertain the relationship between socio-economic variables and knowledge, current use of FP, who makes family planning decision and FP methods used. The Chi square test shows that marital status and educational attainment have significant relationship with knowledge of FP. Age, religion, ethnicity, educational level and income have significant influence on current use of FP. This means that the null hypothesis is rejected. Religion, ethnicity, marital status and income also have positive influence on who makes the decision to use FP methods, thus the alternative hypothesis is accepted. The analysis reveals that these socio-economic variables encourage joint decision making to practice family planning. The results also reaffirm the position of men as major decision makers on FP matters. With men having absolute power over so many family issues, the perceived wishes and decision of the husband may influence the behaviour of the wife. Thus, unequal decision making power between partners in a patrilineal system established in this study could be the cause of high fertility in the northern region and Nigeria at large. Women who mainly carry the burden of childbearing 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 continue to remain constant or even rise beyond the present level (Odimegu and Adedini, 2000).

CHAPTERFIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Summary

The study assessed the role of men and their attitudes toward FP with emphasis on men's knowledge, decision making and use of FP methods. Findings from the study reveal that family planning facilities are accessible with hospitals and clinics as the major sources of family planning services/methods. The desire for large family size is deeply rooted in the fundamental belief that children are gifts from God, thus it is not within human capacity to determine the number of children couples should have. Respondents' main motives for having children are to provide them with financial support and the need to keep on the family name.

The study revealed that men play an important role in decisions pertaining to reproductive health matters in Zaria LGA. The decision to practice FP is made jointly and by husbands only. Religion, ethnicity, marital status and income are the socioeconomic that positively influence men's role in the decision to use FP methods. The findings also reveal that respondents discuss and approve of family planning; however, the practice of FP is low.

5.2 Conclusion

The apparent benefits respondents derive from having children does not support FP. The desire for additional children and the attitude of men towards FP is greatly influenced by people's social values attached to family life, marriage and procreation. The small proportion of respondents currently using FP typifies it. It is imperative to change people's attitude towards large family size and the desire for such through intensive media campaign and individual contact by government and FP providers.

The Chi square tests show that marital status and educational attainment with P values of 0.000 and 0.003 respectively, have significant relationship with knowledge of FP. Age, religion and ethnicity with P values of 0.000 each; education and income with P values of 0.003 and 0.032 respectively also have significantly positive influence on FP practice. Ethnicity and marital status with P values of 0.000 each; religion and income with P values of 0.020 and 0.022 respectively, have statistically significant association with who makes the decision to practice FP. The analysis also reveals that these socio-economic variables encourage joint decision making as well as decision by husband alone to practice family planning.

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. Most decisions that affect family life as well as political life are made by men. They hold positions of leadership and influence from the family unit right through the national level. Male role in FP means more than the number of men who encourage and support their partners to use FP methods. It also means government policy has to be more conducive by developing male-related programmes which include increasing the number of men using condoms and having vasectomies. 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 accelerate the understanding and practice of family planning in general.

Population is a subject that evokes strong emotions, conscious and subconscious. So, it is not surprising that it is an area where political debate tends to be rather passionate. However, there is a need for persistent drive against those social customs, beliefs, and traditions which belittle the importance of family planning in the society.

5.3 Recommendations

Many sub-Saharan African countries are still decades away from attaining lower fertility levels. It is not possible to legalize abortion for everyone in a country like Nigeria where FP stirs a lot of controversies. However, women are losing their lives to illegal and unskilled abortion due to unwanted pregnancies. This is a huge problem, but FP offers hope because it prevents women from having unplanned pregnancies. However, if FP programmes are to accelerate the process in Nigeria and Africa at large, then they would require the following:

i. Greater political will from our national leaders, which includes more commitment in supporting FP programmes, is needed and not just population policies on paper.
ii. Government should encourage western education particularly the girl-child education in Muslim dominated areas like Zaria LGA. This will empower women to make rational decision and enhance the effective utilization of FP.
iii. Government should provide jobs and increase the income levels of Nigerians, which could improve their standards of living and make people desire smaller family sizes.
iv. Men should be encouraged to be interested and involved in family planning, since they are the main decision makers on FP.
v. Men should be encouraged to ginger spousal communication especially on FP matters, where both can come up with reasonable mutual decision on reproductive health issues. This will help facilitate transition to lower fertility.
vi. Husbands can support their wives by giving them permission to visit FP clinics as well as organizing transportation to the clinic, paying for family planning methods and services, and taking care of children during clinic visits.
vii. Couples should be motivated to space their children beyond two years. This will reduce frequent childbirth and large family sizes that expose women to health problems which can contribute to high maternal mortality.
viii. Government and non-governmental organizations should provide a holistic knowledge (appropriate method of choice, correct use, side effects and the benefits of use) of FP methods among Nigerian men considering the country’s varied cultural context.

REFERENCES

Abdulazeez, B. (1990). *Knowledge, Attitude and Practice of Family Planning in Zaria*. An Unpublished B.Sc. Project. Department of Community Medicine, Ahmadu Bello University, Zaria.

Adamchak, D.J. and Adebayo, A. (1985). "Male Fertility Attitudes: A Neglected Dimension of Nigerian Fertility Research". *Social Biology,* Vol. 34, No 1-2. Pp 55-67.

Adewuyi, A. and Ogunjuyigbe, P. (2003). The Role of Men in Family Planning: An Examination of Men's Knowledge and Attitude to Contraceptive Use among the Yorubas. *Journal of African Population Studies,* Vol. 18, No. 1, Pp 35-49.

Agadjanian,V. (2002). Men's Talk about Women's Matters: Gender, Communication and Contraception in Urban Mozambique.

Agbese, A.C. (2011). Child Spacing Panacea for Safe Motherhood. **Daily Trust,** May 2011, Pp 55.

Akinwunmi, A. (2002). *Knowledge and Practice of Family Planning in Iyara, Kogi state.* An Unpublished B.Sc. Project. Department of Geography, Ahmadu Bello University, Zaria.

Alan Guttmacher Institute. (2003). In Their Own Right: Addressing the Sexual and Reproductive Health of Men Worldwide. New York: AGI.

Alan Guttmacher Institute (2003). In Their Own Right: Addressing the Sexual and Reproductive Health of Men Worldwide. New York: AGI.

Ameh, N. and Sule S.T. (2007). "Contraceptive Choices among Women in Zaria." *Nigerian Journal of Clinical Practices,* Vol. 10, No.3. Pp 205-207.

Ampofo, A. A. (2001). "When Men Speak Women Listen: Gender Socialization and Young Adolescents' Attitudes to Sexual and Reproductive Issues". *African Journal of Reproductive Health*, Vol. 5, No.3. Pp 196-212.

Auta, Z.S. (1998). *The Determinants of Women's Participation in Decision Making about Family Planning in Kaduna Metropolis.* An Unpublished B.Sc. Project. Department, Ahmadu Bello University, Zaria.

Bandarage, A. (1997). Women, Population and Global Crisis: A Political-EconomicAnalysis. London: Zed Books.

Bankole, A. (1995). "Desired Fertility and Fertility Behaviour amog the Yoruba of Nigeria: A Study of Couples' Preferences and Subsequent Fertility". *Population Studies* Vol. 49, Pp 317-328.

Bauman, K., Viadro, C., and Tsui, A. (1994) Use of True Experimental Designs for Family Planning Programme Evaluation: Merits, Problems and Solutions. *International Family Planning Perspectives*. Vol. 20, No 3, Pp 108-113.

Biddlecom, A.K., Anne, E., Bolaji, M.F. (1997). Covert Contraceptive Use: Prevalence, Motivations and Consequences. *Studies in Family Planning*. Vol.29, No. 4, Pp 360-372.

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

Caldwell J.C. and Caldwell P. (2002). Africa: The New Family Planning Frontier: Family Planning Programs in the 21st Century. *Studies in Family Planning*, Vol. 33.

Caldwell J.C., Orubuloye, I.O.and Caldwell P. (1992). Fertility Decline in Africa: A New Type of Transition. *Population Development Review*. Vol. 18, Pp 211-242.

Danforth N. (1999). Men and Family Planning: “Meeting Unmet Needs”. New Strategy Services. Vol.43, No. 1, Pp 10-15.

Danforth N. and Jezowski, T. (1999). “Men and Family Planning: What We Know” Paper Presented at National Council for International Health, Washington, D.C.

Donovan, P. (1995). “In Nigeria, Traditions of Male Dominance Favor Large Families, but Some Men Report Having Fewer Children”. *International Family Planning Perspectives*, Vol. 21, No.1, Pp 39-40.

Drennan, M.(1998). Reproductive Health: New Perspectives on Men’s Participation. *Population Reports, Series J.,* No.46.Baltimore: John Hopkins University School of Public Health, Population Information program.

Duze, C.M. and Muhammad, Z.I. (2006). Male Knowledge, Attitude and Family Planning in Northern Nigeria. *African Journal of Reproductive Health*, Vol.10, No. 3: Pp 53-65, Accessed from www.jstor.org on 18, March, 2009. Women's Health and Action Research Centre.

Eades (1980). Customary Law Practices and Violence against Women.

Ekpo, R. (2011). *Women’s Role and Attitude towards Family Planning in Makarfi and Jaba Local Government Areas*, Kaduna State. An Unpublished M.Sc. Project. Department of Geography, Ahmadu Bello University, Zaria.

Ezeh, A.C. (1992). Contraceptive Practice in Ghana: Does Partners Attitude Matter? Paper Presented at the Annual Conference of the Population Association of America. Denver, Colorado, 29th April – 2nd May.

Ezeh, A.C., Seroussi, M., and Raggers, H.(1996). Men's Fertility, Contraceptive Use, and Reproductive Preferences. *Demographic and Health Surveys Comparative Studies, No. 18, Pp 52.* Calverton, Maryland: Macro International.

Fapohunda, E. R. and Todaro, M. P. (1988). “Family Structure, Implicit Contacts, and the Demand for Children in Southern Nigeria”. *Population and Development Review*, Vol. 14, No. 4: Pp 571-594.

Fatusi, A.O., Onwuka, S.I., Chizea, A.C. and Afieghe, C.A. (1998). “Strengthening Family Planning Services in Rural Areas: A Nigerian experience”. Paper presented at the International Union for Scientific Study of Population, Seminar Presented on Reproductive Change in sub-Saharan Africa, Nairobi, Kenya.

Federal Government of Nigeria (1988). *National Population Policy on Development, Unity, Progress and Self-reliance.* Ikoyi, Lagos, Nigeria: Federal Ministry of Health.

Fikree, F., Khan, A., Masood, K.M., Sajan, F., and Rahbar, H (2001). What Influences Contraceptive Use among Young Women in Urban Squatter Settlements of Karachi, Pakistan? *International Family Planning Perspectives,Vol.* 27, No. 3, Pp 130-136.

Gallen, M.E., Liskin, L. and Kak, N. (1986). Men – New Focus for Family Planning. *Population Reports, Series J, No. 33.* Baltimore: The Johns Hopkins University of Population Information Programme.

Hatcher, R.A., Ward R., Blackburn, R. and Geller, J.S.(1997). *The Essentials of Contraceptive Technology*. Baltimore: Population Information Programme.

Hore, P.N. (1970), “Weather and Climate” In Mortimore, M.J. (Ed.) *Zaria and Its Region: A Nigerian Savannah City and Its Environs*. Occasional Paper No. 4, Department of Geography, Ahamdu Bello University, Zaria.

International Planned Parenthood Federation. (1984). *Male Involvement in Family Planning*. London:IPPF.

International Institute for Population Sciences and Macro International (2007). National Family Health Survey (NFHS-3), International Institute for Population Sciences (2005-06) Mumbai: India.

Isakoto, S.A. (2002). *The Effects of Family Planning on Reproductive Behaviors in Urban Zaria*. An Unpublished B.Sc. Project. Department of Geography, Ahmadu Bello University, Zaria.

Isiugo-Abanihe, U.C. (1994). Reproductive Motivation and Family Size Preferences among Nigerian Men. *Studies in Family Planning,* Vol 25, No. 3Pp 149-161.

Isiugo-Abanihe, U.C. (2003). *Male Role and Responsibility in Fertility and Reproductive Health*: Ibadan Ababa Press Limited.

Izugbara C.O. and Ezeh A.C. (2010). Women and High Fertility in Islamic Northern Nigeria. *Studies in Family Planning,* Vol. 41, No. 3, Pp 193-204.

Jackson, G. (1970), "Vegetation" In Mortimore, M.J. (Ed.) *Zaria and Its Region: A Nigerian Savannah City and Its Environs*. Occasional Paper No. 4, Department of Geography, Ahamdu Bello University, Zaria.

Joshua, S. (2010). *Traditional Medicine in Sabon Gari Local Government Area, Zaria*. An Unpublished M.Sc. Project. Department of Geography, Ahmadu Bello University, Zaria.

Johns Hopkins University and Population Information Program. (1994). Population Reports, Centre for Communication Programs. Baltimore:Johns Hopkins School of Public Health. Vol. 22, No. 1.

Kaduna State Government (2007). Kaduna State Ministry of Health. Department of Reproductive Health, Kaduna.

Karen H., Zheming X., Baochang G., (2004). Family Planning and Women's Lives in Rural China. *International Family Planning perspectives.* Vol. 1, No. 2, Pp 68- 76.

Khalifa, M. A. (1988). Attitudes of Urban Sudanese Men towards Family Planning. *Studies in Family Planning,* Vol. 19, No. 14, Pp 236-243.

Kim, Y.M. Marangwanda, C., and Kols, A. (1996). Involving Men in Family Planning: The Zimbabwe Male Motivation and Family Planning Method Expansion Project, 1993–1994. Baltimore: Johns Hopkins School of Public Health, Centre for Communication Programs.

King L. C. (1948): 'A theory of bonhardts' .Geogrl. J. Vol 112, Pp 83-87.

Klinkenberg, K. "Soils" In Mortimore, M.J. (Ed.) *Zaria and Its Region: A Nigerian Savannah City and Its Environs*. Occasional Paper No. 4, Department of Geography, Ahamdu Bello University, Zaria.

Lamptey, P., Nicholas, D. D., Offosu-Amaah, S. and Lourie, M. (1978). An Evaluation of Male Contraceptive Acceptance in Rural Ghana. *Studies in Family Planning,* Vol. 9, No. 8, Pp 22-27.

Laurie, F.D., Doodoo, F.N-A., Ezeh, A.C. and Owuor, T.O. (2004). Does Discussion of Family Planning Improve Knowledge of Partners Attitude toward Contraceptives? *International Family Planning Perspective.* Vol. 23, No. 1, Pp 87-93. Published by Guttmacher Institute.

Lasee, A. and Becker, S. (1997). Husband-Wife Communication about Family Planning Communication and Contraceptive Use in Kenya. *International Family Planning Perspective.* Vol. 30, No. 2.

Mamman, M. (1992). An Analysis of Fertility Differentials in Kaduna Metropolis, Kaduna State. An Unpublished Ph.d Thesis. Department of Geography, Ahmadu Bello University, Zaria.

Mamman, M. (2008). An Unpublished Lecture Notes on Demographic Analysis.

Mao T. T. (1967). Quotations from Chairman MaoTse-Tsung. Beijing: Foreign Language Press

Mbizvo, M.T. and Adamchak, D.J. (1991). “Family Planning Knowledge, Attitude and Practice among Males in Zimbabwe”. *Studies in Family Planning,* Vol. 22, No. 1, Pp 31-38.

Mbizvo, M.T. and Basset, M.T. (1996). “Reproductive Health and AIDS Prevention in sub-Saharan Africa: The Case for Increased Male Participation In” *Health Policy Planning.*

Ministry of Health (1998). *Family Welfare Programme in India, Year Book 1996-1997*. Department of Family Welfare. Ministry of Health and Family Welfare, New Delhi, India.

Ministry of Health and Family Welfare (2000). *Family Welfare Programme in India*. Department of Family Welfare. Ministry of Health and Family Welfare, New Delhi, India.

Morgan, S.P. and Niraula, B. (1995). How Gender Roles Influence Sexual and Reproductive Health among South African Adolescent. *Studies in Family Planning,* Vol. 34, No. 3, Pp 160-172.

Mortimore, M.J. (1970). Zaria and Its Region: A Nigerian Savannah City and Its Environs. Occasional Paper No. 4, Department of Geography, Ahmadu Bello University, Zaria.

National Population Commission (1998). *1991 Population Census of the Federal Republic of Nigeria:An Analytical Report at the National Level*. Abuja: NPC.

National Population Commission (2004). *National Policy on Population for Sustainable Development.* Federal Republic of Nigeria.

National Population Commission (2009). *Priority Tables of the 2006 Population and Housing Census of the Federal Republic of Nigeria*. Abuja: NPC.

National Population Commission and ORC [Nigeria] Macro (2009). *Nigerian Demographic Health Survey, 2008.* Calverton. Maryland, USA: NPC AND ORC Macro.

National Population Commission and ORC [Nigeria] Macro (2004). *Nigerian Demographic Health Survey, 2003.* Calverton. Maryland, USA: NPC AND ORC Macro.

Odimegwu, C.O. (1999). Family Planning Attitudes and Use in Nigeria: Factor Analysis. International Family Planning Perspective. Vol. 25, No 2, Pp 86-91.

Odimegu C., Adedini S., (2000). Gender Equality and Fertility Transition in Africa. University of Witwatersrand, South Africa. European Population Conference 2012, Stockholm University, Stockholm, Sweden 13th-16th June.

Olawepo, R.A. and Okedare, E.A. (2003). Men's attitude towards Family Planning in a Traditional Urban Centre: An Example from Ilorin, Nigeria. *International Journal of Gender and Health studies*. Vol 1, No. 1.

Omotolani, N. (2002). *People's Perceptions of Family Planning Methods in Zaria*. An Unpublished B.Sc. Project. Department of Geography, Ahmadu Bello University, Zaria.

Oni G.A. and MacCarthy, J. (1991). "Family Planning Knowledge, Attitude and Practice among Males in Ilorin, Nigeria. *"International Family Planning Perspective,* Vol. 17, No. 2. Pp 54.

Orubuloye, I.O. (1993). "Women's Control over their Sexuality". Paper Presented at JUSSP Seminar on Women and Demographic Change in sub- Saharan Africa Dakar Senegal 3rd-6th March.

Ottenberg, S. (1995). "Male Fertility through Survey". *Demographic and Health Survey Experience*. Cambridge University Press.

Oyediran, K.A., Ishola G.P., Feyisetan B.J. (2006). Factors Affecting Ever Married Men's Contraceptive Knowledge and Use in Nigeria. *Journal of Biosocial Science.* Vol. 34, No Pp 497-510.

Oyeniyi, J.A. (2000). *Knowledge, Attitude and Practice of Family Planning among Married Women in Offa, Kwara State.* An Unpublished B.Sc. Project Department of Geography, Ahmadu Bello University, Zaria.

Petro-Nustas, W. (1999). Men's Knowledge of and Attitudes toward Birth Spacing and Contraceptive use in Jordan. *International Family Planning Perspective,* Vol.25, No. 4. Published by Guttmacher Institute.

Piotrow, P.T., Kincaid, D.L., Hindin, M.J., Lettenmaier, C.L., Kuseka, I., Silberman, T., Zinanga, A. Chikara, F., Adamchak, D.J., Mbizvo, M.T., Lynn,W., Kumah, O.M and Kim, Y.(1992). Changing Men's Attitude and Behaviour: The Zimbabwe Male Motivation Project. *Studies in Family Planning,* Vol. 23, No. 6, Pp 365 – 375. Published by Population Council.

Population Reference Bureau {PRB} (2009). World Population Data Sheet. Washington D.C.: United States Agency for International Development

Population Reports (1994).

Poston D. and Gu B. (1987). "Socioeconomic Development, Family Planning, Fertillity in China". Demography. Vol. 24, No. 4, Pp 531– 552.

Ringheim, K. (2002). When the client is male: client–provider interaction from a gender perspective *International Family Planning Perspectives.* Vol 28, No. 3: Pp 170-175.

Salway, S.(1994). How Attitudes towards Family Planning and Discussion between Wives and Husbands Affect Contraceptive Use in Ghana. *International Family Planning Perspectives*, Vol. 20, No. 2, Pp 44-47.

Sathar, Z. & Casterline, J. B. (1998). The Onset of Fertility Transition in Pakistan. *Population and Development Review*, Vol. 24, No.4, Pp 773-796.

Solomon, A., Larai A., Ado Z. M., Sunday A., Oladapo, S., Ejembi C.(2010). Fertility Intentions, Contraceptive Awareness and Contraceptive Use Among Women in Three Communities in Northern Nigeria. African Journal of Reproductive Health. Vol 14, No 3, Pp 67.

Soto, J. (2008). "Family Planning in Rwanda: How a Taboo Topic Became Priority Number One," Intra Health accessed on line at www.health.org on 24 July 2010.

Stokes, B. (1980). Men and Family Planning. World watch Paper 41.Worldwatch Institute, Washington D.C.

Tober, D.M., M. Taghdisi, and M. Jalali. (2002). "Fewer Children, Better Life' or 'As Many as God Wants'? Family Planning among Low-Income Iranian and Afghan Refugee Families in Isfahan, Iran."*Medical Anthropology Quarterly.* Vol. 20, No. 150–71.

Tyoden, C.L. (2010). *Gender Roles and Responsibilities in Zaria.* An Unpublished M.Sc. Project. Department of Geography, Ahmadu Bello University, Zaria.

Umoh A.V., Abah G.M., Ekanem U.S. (2012). A Study of Fertility Intentions of Women in Uyo, Nigeria. *Journal Public Health and Epidemiology*. Vol. 4, No. 1, Pp 14-18.

Upadhyay, U.D. and Robey B. (1999)"Why Family Planning Matters". *Population Reports Series* J 49.

United Nations (1994). *International Conference on Population and Development.* Draft Programme of Action of the conference, Cairo, Egypt, 5th-13th September.

United Nations (1995). Report of the Fourth World Conference on Women, Beijing, China. UN, 17 October 1995.

United Nations Agency for International Development {UNAID} (1999). *Gender and HIV/AIDS. Taking Stock of Research and Programming*. Washington D.C.: UNAIDS Best Practices Series 9916E.

Urquhart, A.W. "Morphology of Zaria" In Mortimore, M.J. (Ed.) *Zaria and Its Region: A Nigerian Savannah City and Its Environs*. Occasional Paper No. 4, Department of Geography, Ahamdu Bello University, Zaria.

Van De Walle, E. and Knodel, J.(1980). Europe's Fertility Transition: New Evidence and Lessons for Today's Developing World. *Population Bulletin,* Vol. 34, No. 6. Washington D.C.: Population Reference Bureau.

Varga, C.A. (2001). The Forgotten Fifty Percent: Review of Sexual and Reproductive Health Research and Programmes focused on Boys and Young men in sub-Saharan Africa. *African Journal of Reproductive Health.*Vol 3, No 1: Pp 174-195.

World Health Organization (2006). India and Family Welfare Planning: An Overview, South East Asia Regional Office.

APPENDIX A

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

Dear respondent,

The purpose of this questionnaire is to obtain socio-economic information that influence the role of men and their attitudes towards family planning in Zaria Local Government Area. Your answers will be confidential and strictly for academic use. I sincerely request your cooperation in completing this questionnaire. Please tick the appropriate option.

SECTION A
DEMOGRAPHIC AND SOCIO-ECONOMIC INFORMATION

1. What is your age?

a. 15-19 years	[ ]	e. 35-39 years	[ ]
b. 20-24 years	[ ]	f. 40-44 years	[ ]
c. 25-29 years	[ ]	g. 45-49 years	[ ]
d. 30-34 years	[ ]	h. 50-54 years	[ ]

2. What is your gender? a. Male [ ] b. Female [ ]

3. What is your religion?

a. Islam [ ] b. Christianity [ ] c. Traditional [ ] d. Pagan [ ]
e. Others (specify) …………………………………......................

4. What is your ethnic group?

a. Hausa/Fulani [ ] b. Igbo [ ] c. Yoruba [ ] d. Northern minority [ ]
e. Southern minority [ ] f. Others (specify) ………………………………........

5. What is your marital status?

a. Single [ ] b. Married [ ] c. Divorce [ ] d. Separated [ ]
e. Widow [ ] f. others (specify) ……………………………….

6. Type of marital union

a. monogamy [ ] b. polygamy [ ] c. others (specify)………………………….

7. If polygamous union, how many wives has your husband/do you have?

a. 2 [ ] b. 3 [ ] c. 4 [ ] d. 5 and above [ ]

8. What is your highest educational qualification?

a. Qur'anic [ ] b. Adult literacy [ ] c. Tertiary [ ] d. Secondary [ ]
e. Primary [ ] f. none [ ]

9. Do you have a gainful employment? a. yes [ ] b. no [ ]

10. Type of occupation.

a. Farming	[ ]	g. Artisan	[ ]
b. Civil service	[ ]	h. Unskilled labourer	[ ]
c. Public service	[ ]	i. Student	[ ]
d. Trading	[ ]	j. Unemployed	[ ]
e. Business	[ ]		
f. Petty trading	[ ]	h. Others (specify) …………………….	

11. How much income do you receive monthly?

a. 5,999 and below	[ ]	d. 26,000-35,999	[ ]
b. 6,000- 15,999	[ ]	e. 36,000-45,999	[ ]
c. 16,000- 25,999	[ ]	f. 46,000 and above	[ ]

12. How many living children do you have now? a. none [ ] b. 1-3 [ ]

c. 4-6 [ ] d. 7-9 [ ] e. 10-12 [ ] f. 13 and above [ ]

13. How many children would you prefer to have? a. none [ ] b. 1-3 [ ]

c. 4-6 [ ] d. 7-9 [ ] e. 10-12 [ ] f. 13 and above [ ] g. up to God [ ]

14. Do you want to have more children than you now have?

a. yes [ ] b. no [ ] c. no response [ ] d. up to God [ ]
f. others (specify)………………………………......

15. What are your reasons for having children?

a. Continuation of family name [ ] e. To provide labour [ ]
b. Financial support in future [ ] f. To inherit my wealth [ ]
c. Source of joy/comfort [ ]
d. To prove ones masculinity/femineity [ ] g. Others (specify) ………………………….

16. Have you lost any child or children?

a. yes [ ] b. no [ ] c. no response [ ]

17. If yes, how many?

a. 1-2 [ ] b. 3-4 [ ] c. 5-6 [ ] d. 7 and above [ ]

18. What was the cause of death?

a. diarrhea [ ] b. malaria [ ] c. accident [ ] d. pneumonia
e. malnutrition [ ] f. others (specify)…………………………….............................

SECTION B

KNOWLEDGE, ATTITUDE AND USE OF FAMILY PLANNING

19. Have you ever heard of family planning? a. yes [ ] b. no [ ] c. no response [ ]

20. Where did you obtain the information about family planning?

a. medical personnel [ ] d. radio/television [ ]
b. family member [ ] e. school/Institution [ ]
c. friend [ ]
d. magazine/newspaper [ ] f. others (specify) ……………………………….

21. Do you approve of family planning? a. yes [ ] b. no [ ] c. no response [ ]

22. If you, approve, why?

a. Have reached the desired number of children [ ] e. Economic hardship [ ]
b. Complications during pregnancy/ childbirth [ ] f. Spousal approval [ ]
c. To promote the health of wife and children [ ] g. Child spacing [ ]
d. Want to have the number of children we can take care of [ ]

h. Others (specify) ……………………………...

23. If you disapprove, what is the reason?

a. Contradicts religious belief [ ] e. Not interested [ ]
b. Side effects [ ] f. Desire many children [ ]
c. Promotes promiscuity [ ] g. Spousal disapproval [ ]
d. Cultural abomination [ ] h. Others (specify) …………………………

24. Have you or your spouse ever used any family planning method?

a. yes [ ] b. no [ ] c. no response [ ]

25. If yes, which of the following method (s)?

i) Abstinence [ ] viii) Intra Uterine Device/Loop [ ]
ii) Withdrawal [ ] ix) Diaphragm [ ]
iii) Breastfeeding [ ] x) Vasectomy/Male sterilization [ ]
iv) Use of herbs [ ] xi) Tubectomy/Female sterilization [ ]
v) Condom [ ] xii) Douche [ ]
vi) Oral contraceptive pills [ ] xiii) Ring [ ]
vii) Injectables [ ] xiv) Norplant/Implanon [ ]

26. Are you or your spouse currently using any method?

a. yes [ ]   b. no [ ]   c. no response [ ]

27. If yes, indicate the method (s).

i) Abstinence	[ ]	viii) Intra Uterine Device/Loop	[ ]
ii) Withdrawal	[ ]	ix) Diaphragm	[ ]
iii) Breastfeeding	[ ]	x) Vasectomy/Male sterilization	[ ]
iv) Use of herbs	[ ]	xi) Tubectomy/Female sterilization	[ ]
v) Male condom	[ ]	xii) Douche	[ ]
vi) Oral contraceptive pills	[ ]	xiii) Ring	[ ]
vii) Injectables	[ ]	xiv) Norplant/Implanon	[ ]

28. Who makes the decision to practice family planning?

a. husband [ ]   b. wife [ ]   c. both [ ]   d. medical practitioner [ ]

29. What determines the adoption of any family planning method?

a. availability	[ ]	d. spousal approval	[ ]
b. effectiveness	[ ]	e. convenience	[ ]
c. cost	[ ]	f. others (specify)……………………………........	

30. Who obtains or buys the family planning device?

a. husband	[ ]	d. no response	[ ]
b. wife	[ ]		
c. both	[ ]	e. others (specify)…………………………	

31. If no to 26, do you intend using any family planning method in the future?

a. yes [ ]   b. no [ ]   c. no response [ ]

32. If yes, why?

a. old age	[ ]	c. have reached the desired number	[ ]
b. economic hardship	[ ]	d. if child bearing poses health risks to spouse	[ ]

e. (others specify) ……………………………..

33. Do you know that men should be fully involved in family planning by visiting the hospital and using family planning methods just like women?

a. yes [ ]   b. no [ ]   c. no response [ ]

SECTION C

SPOUSAL COMMUNICATION AND DECISION MAKING PROCESS

34. Do you and your spouse discuss family planning together?

a. yes [ ]   b. no [ ]   c. no response [ ]

35. If no, why?

a. cultural taboo [ ]   d. spousal disapproval [ ]
b. contrary to religious belief [ ]   f. competition among wives [ ]
c. not of mutual interest [ ]   h. others (specify) …………………….

36. Have both of you discussed the number of children you desire?

a. yes [ ]   b. no [ ]   c. no response [ ]

37. If no, why?

a. Do not know how many will survive [ ]   f. Cultural taboo [ ]
b. Children are gifts/blessings from God [ ]   g. Religious objection [ ]
c. Every child is born with his wealth [ ]   h. Spousal disapproval [ ]
d. Want as many children as my parent [ ]   i. Competition among co-wives [ ]
e. Lack of spousal communication [ ]   j. Others (specify) ……………..

38. Who makes the decision on number of children desired?

a. husband [ ]   b. wife [ ]   c. both [ ]   d. others …………………………

39. Do you practice child spacing?

a. yes [ ]   b. no [ ]   c. no response [ ]

40. Who makes decision on the duration of child spacing?

a. husband [ ]   b. wife [ ]   c. both [ ]   d. others …………………………

41. How long do you space your children?

a. <1 year [ ]   b. 1-2 years [ ]   c. 2-4 years [ ]   d. others (specify)………………

SECTION C

AVAILABILITY AND SOURCES OF FAMILYPLANNING SERVICES/METHODS

42. Are family planning services available in your locality? a. yes [ ] b. no [ ]

43. What are the sources of family planning services/methods?

a. hospital [ ] b. clinic [ ] c. pharmacy [ ]
d. herbalist [ ] e. others (specify)…………………………

44. Are you satisfied with the existing family planning methods/services offered at source/ supply centre ?

a. yes [ ] b. no [ ] c. no response [ ]

45. What are your views on the role of men in family planning, do they have an important part to play?

………………………………...
……………………………………………………………………………………………..

APPENDIX B

FOCUS GROUP DISUSSION GUIDE

Introduction: I am a student from Geography department, A.B.U. Zaria undertaking a research to assess the role of men and their attitudes towards family planning. 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 will provide is strictly for academic purpose and is confidential. Please you will tell us your name and your educational qualification before you respond. Thank you for your participation.

Questions	Probe for
General questions Why is Family Planning frowned at in this society?	Explain the reasons.
Family size desire With regards 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 desired number of children?	Explain the reasons.
What are the reasons why men want a large family size?	Explain the reasons.
Family life decision making Who do you think should have the final say about whether or not to have more children?	Husband or wife, explain the reasons.
One would think that women as the child bearers should be the ones to decide the number to have and when to have children. What is your view on this?	Explain the reasons.
Some women practice FP without their husband's approval. What is your view on this?	Explain the reasons.
Do you think the husband and wife need to discuss the number of children they want to have?	Yes or no, give reasons.