DETERMINANT OF MALE INVOLVEMENT IN THE CHOICE OF CONTRACEPTIVE METHOD IN SOUTH WEST

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CERTIFICATION

This is to certify that this research work titled the determinant of male involvement in the choice of contraceptive method in South West was carried out by **AJAYI BOLUWATIFE OLUWAFEMI** with Matriculation number **DSS/13/1478** of the Department of Demography and Social Statistics, Faculty of social science, Federal University Oye-Ekiti.

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DEDICATION

I dedicate this work to almighty God, my parent Mr. and Mrs Ajayi and my brother Ajayi Oluwaseun and to my husband Isaac Kareem and handsome son Kareem Abraham for the unrelented support and attention during the course of this programme. I sincerely want to thank you for your financial support, unflagging faith, prayers and understanding.

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ABSTRACT

Male involvement in reproductive health has two major sides, as men give sufficient support in need, choice and rights to their partners in reproductive health and fertility control, on the other hand, men's owns reproductive health related to knowledge, contraceptive use and safe sexual behaviors (UNFA,1995).The study examines the determinants of male involvement in the choice of contraception method in South-West, Nigeria. This study was undertaken to provide insight into the determinant of male involvement in the choice of contraception among male in south-west.

Three basic conceptual theoretical components namely choice, process and context are amalgamated and provide an explanatory framework while aiming to understand the mechanism involved in the behavior of people a specific socio-cultural environment.

Male data from the Nigeria Demographic and Health Survey from 2013 was used.

The univariate, bivariate and multivariate were employed for the study. The chi-square test was used for the study. The analysis of the data showed that male in the urban area are more likely to use any method of contraceptives with $X^2(1)= 36.36$,P=0.0003, Christian and Yoruba's in particular with $X^2(2)= 4.76$, P=0.2230 and $X^2(3)= 32.61$,P=0.0003 respectively.

The study concludes that the educational attainment of men, their employment status, number of children ever born, age and place of residence are vital to the determining factors of men involvement in the choice of contraceptive method.

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CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

The high fertility rate leading to the rapid growth of country's population is a major hindrance towards the development of a nation (NDHS 2013) high maternal mortality again is another major hindrance which leads to loss of life and more expenditure on health care. Women of reproductive age die due to lack of proper health care practice, which include, family planning and provision of health care.

According to Nigerian population census 2006, there were 44,152,637 women of reproductive age in Nigeria. Nigerian demographic and health survey (NDHS 2013) reported that only 15.1%married women of reproductive age were using contraception, 10% of currently married women reported using a modern method and 5% use other methods of contraception. In addition there is a significant unmet need for family planning in Nigeria where 16% of married women have an unmet need for family planning (NDHS, 2013).

Reproductive health program and services are commonly targeted to women's reproductive health and offered their services exclusively to women, especially conduct with family planning, prevention of unwanted pregnancy, maternal care during the pregnancy period, risky abortion and the improvement of safe motherhood .But the role of men in reproductive health and family planning has been always ignored by the family planning programs and most contraceptive methods are designed for women only (Dewi, 2009). Reproductive health of couples largely depends on the attitude of men; i.e. Husband, towards family planning program and their knowledge on

reproductive health. The family planning program in Nigeria could not be utilized properly because of all kinds of activities and policies are being focused mainly for women (Clark et al, 2008).Most of the family planning field service delivery system is female based and field workers are also females. They only cover their area mainly targeting the women because of convenience. So there is a little opportunity for male to receive service from family planning providers (Hossain, 2003).Moreover, this is traditional practice that men always want to avoid to take the equal responsibility in their conjugal life on fertility related issues, especially on contraceptive usage, though they support to their wife on contraception (Mosiur et al., 2008). Most men have little knowledge on reproductive health, they have no proper knowledge of symptoms, transmutations and prevention of reproductive tract infection (RTIs) and sexually transmitted diseases (Hossain, 2004). So there are huge numbers of male suffering from reproductive health problem (Dunnet al, 2006).Recently, there is increasing evidence that male plays fundamental role to avoid risky sexual behaviors and influences the couple's contraceptive decision-making process (Hossain.2004) Men can keep important roles by giving support during the pregnancy period of women (Dewi,2009). The declaration of the International Conference on Population and Development (ICPD), can be considered as a major step to raise the male's responsibility about reproductive health and family planning. The ICPD held in Cairo 1994 emphasis on men's involvement in this area "Special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behavior, including family planning; prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV; prevention of unwanted and high-risk

pregnancies; shared control and contribution to family income, children's education, health and nutrition; and recognition and promotion of the equal value of children of both sexes.

Reproductive health includes reproductive processes, functions and system at all stages of life (UNFA,1995).This organization considers the all aspects of reproductive life such as "people are able to have a responsible, satisfying and safe sexual life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so"(UNFA,1995:6).

They emphasis on that men and women have equal right to get information about reproductive health and access to safe and satisfactory methods of fertility control and the ability to access to appropriate health care services (UNFA,1995).

It is clear that male's involvement in family planning and reproductive health may improve equality in gender relation, promoting better relationship between men and women through which they can take decision regarding family planning jointly and equal responsibility of sexual behavior (Hossain, 2003).

Male involvement in family planning and reproductive health is an umbrella term which includes three aspects such as reproductive health problems and programmes, reproductive rights and reproductive behavior (UNFA, 1995).

Male involvement in reproductive health has two major sides, as men give sufficient support in

needs, choices and rights to their partners in reproductive health and fertility control, on the other hand, men's owns reproductive health related to knowledge, contraceptive use and safe sexual behaviors (UNFA,1995).

So, Male involvement in family planning and reproductive health regards men's knowledge of reproductive health and family planning, attitudes about the use of contraception, communication with partners about family planning, choices about appropriate contraceptive methods, gives emotional and behavioral support to their partners' contraceptive use (Clark et al.,2008).

Some previous studies tried to explore a few of reasons of non-participation of male spontaneously in family planning actions as well as unwillingness to use contraception especially ones which are related to males' initiative. Those studies provided a little attention to investigate the factors or determinants that influence male involvement in family planning and reproductive health systems. So this study is designed to identify the factors influencing male involvement in reproductive health and family planning procedures in South-West. The involvement of men not only improves the health of both male and female but also pick up their health and nutritional status and in such a way it affects positively women's reproductive health along with the esurient of sound psychological capital.

1.2 Statement of Research Problem

In many cases, women's inferior role, low status, and restricted access to birth control are manifested in their high fertility. High fertility, however, affects the health of the mothers. The health of mothers, in turn, could result in low birth weight and, eventually, infant and maternal mortality. As of 2008, infant mortality was as high as 100 per every thousand born, female life expectancy is 47 years and child malnutrition or underweight was 39% (Population Reference Bureau, 2008). Thus, Robert *et'al* (1996), argues that; n early 100 million married women would prefer to avoid pregnancy in the whole world,

but are not using any method of family planning, which means that they have an unmet need for family planning.

In Nigeria for example, a report of the world population Reference Bureau in 2001 shows that; the country presented a frightening picture of a population crisis with serious consequences on the socio-economic development of the country. This goes in line with the Nigeria Demographic Health Survey (NDHS 2008) report, which stated that; the level of fertility rate in Nigeria is quite high reaching up to 5.7 in 2008.

This problem attracted the attention of scholars, thereby inspiring the conduct of various research woks like that of Olawepo and Okedare (2006) on men's attitudes towards family planning in a traditional urban center: Ilorin, Nigeria. The researchers concluded that; majority of the respondents are fully aware of the phenomena, but three variables of religion, family size and literacy level of people plays vital role in determining the acceptability and utilization of the services. Coming down to Kano state, a study carried out by Nura, (2011) on the acceptance of family planning among rural dwellers in Kano, a case study of Sumaila local government. With a scope restricted to the level of acceptance of the services in rural areas only, and the level of acceptance by the rural dwellers is very minimal in the study area.

Although, the above studies have succeeded in bringing out the attitudes and level of awareness of men with regards to family planning, as well as the rate of acceptability of the planning among rural dwellers. However, the first study focused on male attitudes only while the second dwelled on assessing the acceptability of the contraceptives only there by ignoring the level of accessibility and utilization of the services, thereby leaving a gap for further researches.

Hence, there is the need to fill the above gap examining the determinant of men's involvement in choice of contraceptive in South-West. The research aims at investigating the determinants of male involvement in the choice of contraceptive method in South-West.

1.3 Research Questions

This research will be carried out to answer the following research questions:

- ✓ What is the male's current status on participation in family planning and reproductive health in south-west, Nigeria?
- ✓ What are the factors that influences to male participation in family planning and reproductive health.

1.4 Objectives

- ✓ To determine the factors that influence to male participation in family planning and reproductive health.

CHAPTER TWO

LITERATURE REVIEW

2.0 INTRODUCTION

The Concept of Contraceptives

Contraceptive is any device used to prevent conception or pregnancy; it is used by males and females, although there are different types of contraceptives based on the method chosen. This can either be mechanical or chemical barrier. The Longman Dictionary (1978) defines contraceptive as 'any drug or object or material used inside or outside the sex organ as a means of preventing an act of sex from resulting in the birth of a child.' Contraceptives have long been in existence as history reveals that people either make use of contraceptive unconsciously or consciously. In the olden days a lot of things have been used as device to prevent unwanted pregnancy and space births among couples. In traditional African society these include the use of rings (oruka), substances from locally available herbs, salt, potash etc. Traditional methods of contraceptive have been used throughout history and are still in use today despite the availability of modern contraceptive. One of the earliest methods of barrier dated back to 1550BC in the ancient Egyptian society. The mild acidity of the Arabic gum was believed to be a barrier to the spermicide. The substance such as oil of cedar recommended by Aristotle might have been partly successful. In Rome, women sometimes wiped the semen with soft wool and oil in order to stop conception. Each of these methods varied from place to place. The 19th century witnessed further development of modern contraceptives and this was marked with by invention of condom.

This study discusses contraceptives that are deemed appropriate for couples. This is because certain contraceptive methods are not suitable for couples in Nigeria e.g. sterilization. Types of contraceptives for the purpose of this study are:

i. **Condoms:** They are thin latex sheaths that are placed on the male organ as a means of containing semen after ejaculation.

ii. **Intra Uterine Device (I.U.D):** It is a plastic object that gynecologists insert into the uterine cavity. I.U.D comes in various sizes, manufactured to fit various sized uterine cavities.

iii. **Douche:** It is a clearing of the vaginal canal by using syringe and stream of water. The belief is that semen can be removed from the vaginal by clearing it. The disadvantage of this method is that it is not a reliable method of contraceptive.

iv. **Contraceptive Jellies, Forms, Tablets and Suppositions:** Are commercial products that are highly effective in destroying sperm within the vagina.

v. **Vaginal diaphragm:** It is a circular device that fits tightly in the vaginal and completely covers the cervix.

Other methods include:

i. **Oral contraceptive (pills)** – These are pills which are taken orally. They are an ovulatory in the sense that they inhibit ovulation or egg formation.

ii. **Rhythm method** – It is a partial form of abstinence using the supposition that there is a certain time in each month when the woman is likely to become pregnant. During this period a man and woman refrain from sexual intercourse (sexual abstinence).

iii. **Coitus interruption (Withdrawal method)** – This is deliberate removal of male reproductive organs before ejaculation. It is not also a reliable method of contraception because semen may escape into the vaginal before the male organ is removed.

With all these methods listed, the rate at which people use of all forms of contraceptives in Nigeria is just 16 percent (NDHS, 2013) and contraceptives are used more by married couples than single people in Nigeria (PRB, 2013). Previous research has tended to ignore women's ability to use contraceptives based on existing power relations at the household level in Nigeria, where persistent seclusion, religious norms, patriarchal family structure challenge women in acquiring power. Social obligations further compounded women's decision making autonomy, by the perception of husbands who may see their wives use of contraceptives as undermining their roles as household heads or as likely to encourage promiscuity (Oni and McCarthy, 1991). In that respect, contraceptives decisions exclude the wife who not only succumbs to marital expectations, but also to communal ideas of valuation of child birth.

2.1 Natural Family Planning

The natural family planning training committee of the World Health Organization (W.H.O.) (1986), defines Natural Family Planning as: Methods for planning and preventing pregnancies by observation of the naturally occurring signs and symptoms of the fertile and infertile phases of the menstrual cycle. It is implicit in the definition of natural family planning when used to avoid conception, that (a) drugs, devices and surgical procedures are not used; (b) there is abstinence from sexual intercourse during the fertile phase of the menstrual cycle, and (c) the act of sexual intercourse, when

occurring, is complete. Furthermore, the W.H.O. definition implies that the woman is able to define the days of the cycle when she is potentially fertile (fertility awareness), and that the couple agrees to adjust their sexual behavior according to their family planning intention.

2.2 Factors Influencing the Choice of Family Planning

According to Olaitan (2009) a myriad of different factors affect a person's personal decisions about what types of family planning method he should use:

2.2.1 Effectiveness: People who are not in a financial or emotional situation to have children might opt for the most effective type of family planning in order to avoid pregnancy. A couple or woman with a casual approach towards parenthood, such as not actively pursuing it, but not unwilling to take it on, might choose a less certain form of contraception, such as natural family planning.

2.2.2 Religion: Some religions, such as Catholicism, have restrictions on contraception based on the belief that it is God's will to bring children into the world. According to Dixon-Muller (1999), religious believers or observers might choose to avoid certain methods of family planning, such as birth control pill, in an effort to live their lives according to the teachings of their religion.

2.2.3 Cost: Some forms of contraception, such as minor surgery (like vasectomy), carry a fairly significant amount of one's time and is very cost as compared to other options, such as condom or the calendar cycle methods which are less expensive; hence, couples engage in them.

2.2.4 Health risk: For people with multiple sexual partners, the choice to use family planning devices helps them to keep healthy. For example, using condoms can reduce the chance of contracting sexually transmitted diseases.

2.2.5 Permanence: Some contraception choices, such as vasectomy, are usually permanent. So couples who do not want to have children at present, but would like to have one in the future, might want to choose a less – permanent option such as condoms or birth control pills.

2.2.6 Partner involvement: One has to consider the preferences of his or her partner when choosing a birth control option. For example, some men do not like to have sex using a condom. In that case, birth control pills might be a better choice for preventing an unwanted pregnancy, according to the National Institute of Health

2.2.7 Socio-economic factors: There are some contraceptive methods of family planning that are expensive, and some couples cannot afford to use or purchase them due to their financial situations in the society. For instance, people in rural areas cannot afford to use the expensive contraceptive methods of family planning such as vasectomy, Intra-uterine devices (IUD) (which are small, flexible, plastic frame inserted in the vagina of women) and female sterilization method.

2.2.8 Cultural norms factors: This is the most important factor influencing the choice of family planning among couples. This includes: community norms, religious belief and gender role.

2.2.9 Community norms: Community norms also prescribe how much autonomy an individual has in making family planning decisions. The larger the differences in reproductive intentions within a community, the more likely the community norms

support individual choices. Household and community influence can be so powerful that they can obscure the line between individual desires and community norms. For instance, in some culture, many women reject contraception because bearing and raising children is the path to respect and dignity in the society. People are often unaware that such community norms influence their choices. In other cases, they are particularly aware. For example, young people often decide not to seek for family planning because they do not want their parents or other adults to know that they are sexually active. Some couples in the community feel that bearing children is the major aim of their marriage, as tradition, customs and beliefs. In some northern part of Nigeria, especially the Islamic religion, they believe that bearing more children will indicate how wealthy they are, in which they tend to withdraw themselves from the use of family planning.

2.2.10 Religious factors: Family planning choice depends on the religion of the couple. It may be Islam or Christianity that calls for raising and bearing of more children in the society. Some religions, such as Catholicism, have restriction on contraception based on the belief that it is "God's will to bring children" into the world.

2.2.11 Gender role: Some couples want to have a male child; and in cases when the child born to them is female, the family is unhappy. Therefore, the couple may wish to have another child in order to have a male child.

Olaitan (2009) also identified the following as Types of Family Planning

2.2.12 Abstinence: Abstinence is the act of avoiding sex, whether sexual contact altogether or just intercourse. This method of family planning is the only one that is 100 percent effective in preventing pregnancy and protecting against sexually transmitted diseases (STDs). Abstinence can be difficult to maintain and allows for little spontaneity.

2.2.13 Birth Control Pills: Many types of birth control pills are on the market. Pills keep a woman's ovaries from releasing eggs, thus preventing fertilization. Birth control pills are 95 percent effective with standard use.

The mini pill contains only progestin, while the combination pill contains both progestin and estrogen. Women who take these forms of the pill must be sure to take it at the same time each day or risk getting pregnant.

Another type of birth control pill is taken continuously for 3 months.

2.2.14 Birth Control Ring: The small, flexible birth control ring is placed in the vagina, where it releases a steady supply of progestin and estrogen hormones. The ring stays in the vagina for 3 weeks, after which it is discarded. The ring is over 99 percent effective when used as prescribed. The ring may cause unwanted side effects such as nausea and weight gain.

2.2.15 Condoms: Condoms are thin latex coverings that form a barrier between sperm and the vagina. When used as indicated, condoms are 95 to 97 percent effective in preventing pregnancy and have the added bonus of protecting against STDs. Female and male varieties are available, and they come in a wide range of colors and styles.

2.2.16 Fertility Awareness: Also known as natural family planning, fertility awareness is the act of abstaining from intercourse on a woman's fertile days, when she is most likely to become pregnant. To follow this method, women need to accurately and precisely chart their fertility, either through basal body temperature changes or changes in cervical mucus, or by following the calendar.

2.2.17 IUDs: An intrauterine device (IUD) is a small copper or plastic device inserted into the uterus that creates a hostile environment for sperm. Some IUDs release small

amounts of hormones. IUDs last from 5 to 12 years and are an effective method of birth control but should only be used by women in monogamous relationships who have already given birth.

2.2.18 Spermicide: Spermicides are creams, jellies or suppositories that stop sperm from moving. Spermicides can be conveniently purchased from drugstores and are easy to use, but they are not effective when used alone. Spermicides are most effective when used with another method of family planning, such as condoms.

2.2.19 Surgery: Women and men can be sterilized. In women, tubal ligation is performed to cut off the fallopian tubes so eggs cannot be released into the uterus for fertilization. Men have a vasectomy, where the tubes that carry sperm are blocked. Sterilization is nearly 100 percent effective, but should be considered a permanent decision.

In Global context, family planning is one of the most cost-effective ways to prevent maternal mortality, infant and child mortality, it can reduce maternal mortality by reducing the number of un-intended pregnancies, The number of abortions and the proportion of births at high risk. It has been estimated that meeting women's need for modern contraceptive, would prevent about one-quarter to one-third of all maternal deaths, saving 140,000 to 150,000 lives per year. Family planning offers a host of additional health, social and economic development and protects the environment. Among women of reproductive age in developing countries 867million 57% are in need of contraceptive because they are sexually active but do not want a child in the next two years, of theses about 222million 26% do not have access to modern methods of contraceptive resulting in significant unmet need.

2.3 Family Planning In Nigeria

Nigeria is the most populous country in sub-Saharan Africa, with more than 120 million people. The annual of population growth stands at 3.5% and the total fertility rate is 6.0 lifetime births per woman (Ottong, 2010). This has posed a major health and economic challenges to the nation. Households with many children are more likely, over time, to become poor and less likely to recover from poverty than families with only a few children (Ajakaiye and Adeyeye, 2001; Orbeta, 2005). Furthermore, children from large families are usually less well nourished and less well educated than those from smaller families. In was in view of this that Nigeria adopted its first population policy in 1988, titled "National Policy on Population for Development, Unity, Progress and Self-Reliance". Compatible with the nation's economic and social goals, an important goal of this policy is to make Family Planning Information (FPI) accessible to every household in the nation as a way of controlling population explosion and fostering equitable distribution of resources. (Goliberet al 2009; Chinweike, 2010). In fact, access to FPI have been identified as a reproductive health right (Asghar, et al 2010). However, very little progress has been achieved ever since. The reasons, why the policy targets are not being met include poor diffusion of information, weak programming, inadequate resources, weak institutional framework and a lack of strategic planning.

According to the report of Premium time, the National Bureau of Statistics (NBS, 2012) says that family planning has remained low due to lack of contraception materials and effective campaigns for child-spacing in urban and rural areas. This is contained in the 2012 Millennium Development Goals Performance Tracking Survey Report," issued in Abuja. The report tracks the progress and challenges towards the achievement of the

Millennium Development Goals (MDGs). However, "Only about 17.3 per cent of women between 15 years and 49 years used any method of child-spacing in 2012. "'The unmet need for family planning equally rose marginally like in the previous years, 2004 and 2008. Only about 21.5 per cent of contraception need was not met," the report said that family planning, antenatal care visits and coverage were not encouraging in the poorest households. "Only about 3.3 per cent of women in the poorest households used any method of child-spacing. In contrast, about 25.8 per cent of those in the wealthiest households used contraception". The report further said the number of births by women in the poorest household attended to by skilled health workers was 14.5 per cent, compared to 84.3 per cent for those in the richest households. "About 19.9 per cent of skilled health workers provided antenatal care services; while antenatal care visits of those in the richest households was 84.1 per cent with about 90.8 per cent of skilled health workers providing antenatal services,"

Furthermore, research conducted in the Aminu Kano Teaching Hospital in Kano by A.O Ohons et al (2010) reveals that different measures were use for family planning including; Inject able contraceptives is the most commonly used having 40.63%, followed by the intrauterine contraceptive device (IUCD) (34.53%). Most women of low parity used the injectable contraceptive method (36.2%) and oral contraceptive pills (30.7%), while those in the early reproductive age group (37.1%) used oral contraceptive pills and injectable contraceptive method (32.5%) than any other method. Women of high parity (47.1%) and those in the late reproductive age group (51.2%) used injectable contraceptives more, followed by IUCD (43.0% and 46.1% respectively). There was very low acceptance of Implants (0.54%) and voluntary surgical contraception (0.36%).

2.4 Theoretical Framework

The process-context approach developed by de Willekens (1990) and de Bruijn (1999) has provided the general theoretical perspective for this research. The three basic conceptual theoretical components namely choice, process and context are amalgamated and provide an explanatory framework while aiming to understand the mechanisms involved in people's behavior in a specific sociocultural environment. The concept of choice (de Buijn 2004) does not restrict people's behavior to objectified rationality thereby rendering such behavior incomprehensible to the outsider. Rather, it provides a tool for identifying the decision frame for peoples' actions like motivation, representations and self-efficacy that are situation and time-bound process-centric (de Bruijn 1999). Contextually, an individual decision-maker is influenced by social institutions, biolsogical and psychological givens, administrative and political structures and other structural constraints (Giddens 1984, Langlois 1986, Schotter 1981).This approach allows for subjectivity, imperfections and constraints affecting people's decisions and performance. Hence, effective ways can be identified to influence adverse behavior outcomes at individual and societal levels (de Bruijn 1999). This approach has been used in areas of legislation, family planning and gender systems (McNicoll 1994, McNicoll and Cain 1990).

The second dimension of the approach, rooted in time, is that people are in a continuous process of development involving varying dynamics and that the stages of development are influenced both by social institutions and cumulative life experiences resulting in an enhanced understanding of behavior (Levinson et al. 1978, Mayer and Tuma 1990, Sugarman 1986, Säävälä 2001, Willekens 1991).

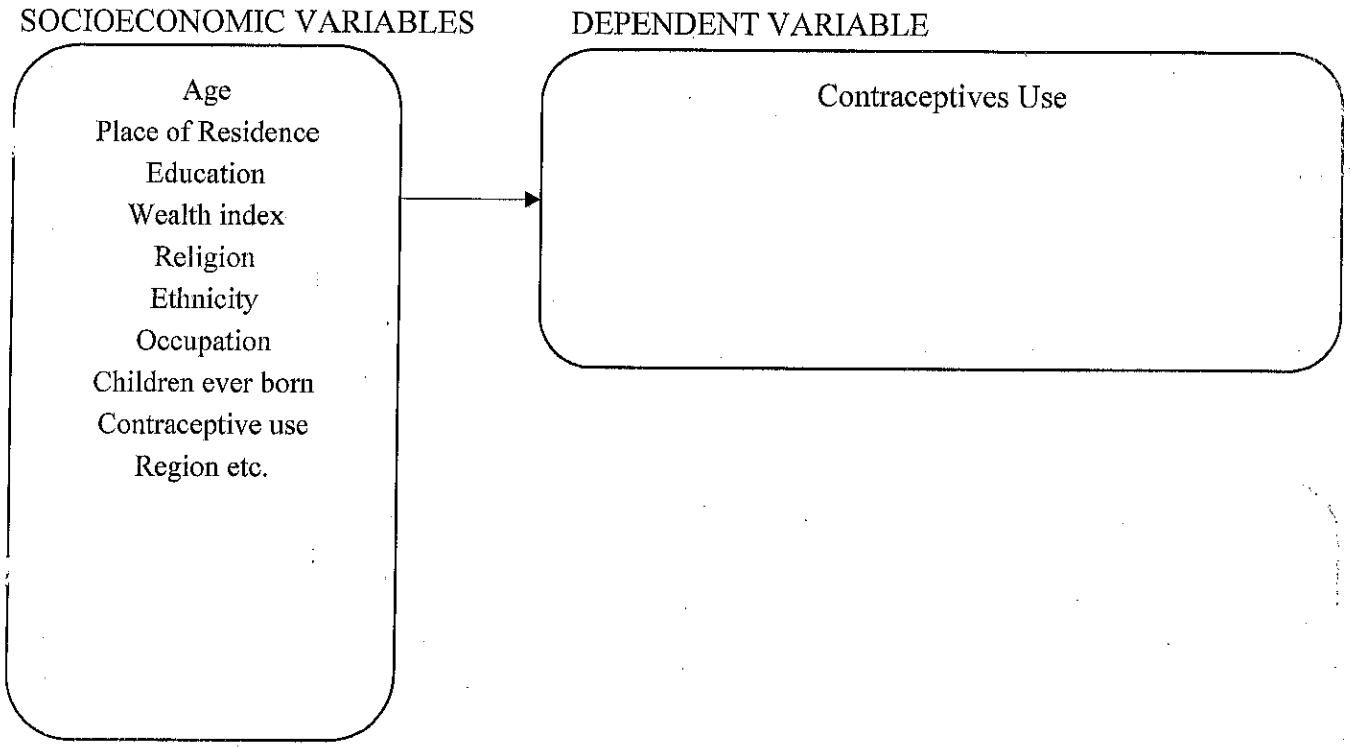
The impact of the social environment on individual considerations, behavior and health outcomes, can be substantiated by a combination of quantitative and qualitative research methods (Bruijn 1999, Greenhalgh 1995, Obermeyer 1997), which is one of the key characteristics of the current research. Although de Bruijn's process-context approach incorporates the social dimension to decision-making and choices, it is an individual-centric model. Progressing further from de-Bruijn's proposition, this study starts from de Bruijn's approach but stresses even further the importance of the institutional and social context of an individual actor.

The ICPD Programme of Action (1994) is similar to de Bruijn (1999) model and both are based on the enhanced need of individual autonomy in reproductive decision-making. However, in the Indian context, pre-dominant individual autonomy is never the case (Jeffery et al. 1994). Also, a good life is to be lived when one is maximally related: dependent and most of all, having others who depend on oneself. To have dependants is not to be 'free', because responsibility means obligations that limit the choices one has (Säävälä 2001). This means that male involvement in reproductive health in India has to be examined in a context where the usual take for- granted, universal ideas of the individual actor in reproductive health research are questioned. The goal in the field of reproductive health for the rural people is not individual decision-making autonomy but to create an environment in which people can act as a part of the social whole along with their dependencies.

The current research focused on some specific aspects of the process-context model.

2.5 Conceptual Framework

Family planning can simply be define as the method or way of families to having desired number of children at desired time of family, on the other hand family planning is eradicating the undesired birth arranging the two periods between two pregnancies, choosing the right age for pregnancy and the right number of children for a family. The most important reason of these works is to provide to the children and mother higher health. (Qasim, 2013).



CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter seeks to explain the plan and approach for executing the research work. It covers the description of the study area, target population, source of data, sampling design and sample size, method of data collection, measurement of variables, method of data analysis and limitations of the study.

3.1 Description of the Study Area

Nigeria is a West African country located between latitudes 4°16' and 13°53' north and longitudes 2°40' and 14°41' east. It is extends from Gulf of Guinea in the south to the fringes of the Sahara Desert in the north. The country is bordered by Niger Republic and Chad in the north, Cameroon on the east, and the Republic of Benin on the west. With a population of 140,431,790 (NPC, 2006), Nigeria is the most populous country in Africa and the 14th largest in land mass (World Bank, 2012). Nigeria has great geographical diversity, with its topography characterized by two main land forms: lowlands and highlands. The uplands stretch from 600 to 1,300 meters in the North Central and the east highlands, with lowlands of less than 20 meters in the coastal areas. The lowlands extend from the Sokoto plains to the Borno plains in the North, the coastal lowlands of western Nigeria, and the Cross River basin in the east. The highland areas include the Jos Plateau and the Adamawa Highlands in the north, extending to the Obudu Plateau and the Oban Hills in the southeast. Other topographic features include the Niger-Benue Trough and the Chad Basin.

Nigeria has a tropical climate with wet and dry seasons. Its climate is influenced by the rain-bearing southwesterly winds and the cold, dry, and dusty northeasterly winds, commonly referred to as the Harmattan. The dry season occurs from October to March with a spell of cool, dry, and dusty Harmattan wind felt mostly in the north in December and January. The wet season occurs from April to September. Nigeria marked its centenary in 2014, having begun its existence as a nation-state in 1914 through the amalgamation of the northern and southern protectorates. Before this time, there were various cultural, ethnic, and linguistic groups, such as the Oyo, Benin, Nupe, Jukun, Kanem-Bornu, and Hausa-Fulani empires. These groups lived in kingdoms and emirates with sophisticated systems of government. There were also other strong ethnic groups such as the Igbos, Ibibios, Ijaws, and Tivs. The establishment and expansion of British influence in both northern and southern Nigeria and the imposition of British rule resulted in the amalgamation of the protectorates of southern and northern Nigeria in 1914.

3.2 Target Population

The category of people considered as eligible respondents in this study are male in the South-West region of Nigeria and were used as a criterion for the study.

3.3 Sources of Data

3.3.1 Quantitative Data Source

This study analyses data from the NDHS 2013.

3.4. Sample Design for the 2013 NDHS

The 2013 NDHS was nationally representative. The survey used as a sampling frame the list of enumeration areas (EAs) prepared for the 2006 Population Census of the Federal Republic of Nigeria, provided by the National Population Commission.

3.5.0. Dependent variable: Contraceptives Use

This study use the NDHS concepts of contraceptives use, there are about 13 different types of contraceptives as explained by the NHDS, these are pills, condoms, injectable, IUD, diaphragm, Female sterilization, periodic abstinence, withdrawal, Female condom, implants, Lactational Amenorrhea Method (LAM), other modern methods and standard days methods. Those couples who are not using any form of contraceptives are coded No = 0, and those who are currently using are coded Yes = 1.

3.5.1 Independent variables

Socioeconomic characteristics

Age of Men: The age of men was measured from the NDHS using the grouped age of respondents as thus 15-24, 25-34 and 35+.

Place of Residence of Couples: One of the two divisions of the NDHS Place of residence will be used (Urban).

Level of Education: This is a categorical variable that is divided into four categories. These are No Education, Primary, Secondary and Higher Education. The levels of education of the couples were combined together as uneducated, where both of the respondents have no education, and were coded as 0. If both of them have Primary education and above, it was coded as 1 = both uneducated and where one of the respondents have no education, it was coded as 2 =either one of them is educated.

Religion: The religion of the respondents were measured in three categories; the first groups were Christians, which was the combination of Catholics and other Christians and was coded as 0 = Christian, the second group was Islam, was coded as 1 = Islam, the last group are the traditionalists, which was coded as 2 = Traditional.

Wealth Index: The wealth index is a categorical variable, which was divided into three categories; Poor, Moderate, Rich.

Contraceptive Use: it was revealed through either using or not using some types of contraceptives representing choice.

Ethnicity: It was divided into the major three types which is Yoruba, Hausa, Igbo then others as the case may be.

3.6 Data Processing and Analysis

The NDHS dataset from 2013 was pooled, processed and analyzed using STATA application package (STATA 12.0). The data processing was necessary before the proper analysis in order to measure the variables in this study accurately as well as to make the analysis well presentable and easily interpretable. The tools for data manipulation were employed on the STATA application package to achieve this task.

Univariate analysis was carried out using tables of frequency distribution to describe the background characteristics of the respondents and the bivariate analysis was done using the chi-square (χ^2) and Cramer's V test to show the association between use of contraceptives and the various socio economic and demographic characteristics that are categorical variables in the datasets. Furthermore, binary logistic regression is used in

the multivariate analysis to identify the strength of association and examine predictors of contraceptives use in the study area.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS OF RESEARCH FINDINGS

4.0. INTRODUCTION

This chapter concentrates on the presentation of results and data analysis of research work on Determinant of Men's Involvement in the Choice of Contraceptive Method in South-west Nigeria. The analysis of the study was done in line with the research questions raised for this project work. The background characteristics of the husbands as well as the common contraceptive methods in the contemporary Nigeria society was identified, while chi-square and logistics regression were used to identify the relationship between choice of contraceptive methods and influencing factors.

TABLE 1: THE FREQUENCY DISTRIBUTION OF SAMPLE SOCIO-DEMOGRAPHIC CHARACTERISTICS

VARIABLES/CATEGORIES	FREQUENCY	PERCENTAGE
CURRENT AGE OF MEN		
15-24	1005	35.33
25-34	830	29.17
35+	1009	35.50
Place of Resident		
Urban	2205	77.53
Rural	639	22.47
Religion		
Christian	1740	61.37
Islam	1062	37.44
Traditional	34	1.19
Ethnicity		

Yoruba	1989	69.95
Hausa	102	3.57
Igbo	279	9.80
Others	474	16.68
Education		
No education	151	5.31
Primary	434	15.27
Secondary	1702	59.85
Higher	557	19.57
Occupation		
Not working	590	20.83
Working	2241	79.17
Wealth		
Poor	196	6.90
Moderate	305	10.73
Rich	2342	82.37
Children Ever Born		
No Child	1415	49.75
1-2	521	18.33
3+	908	31.93
Contraceptive Use		
Not Using	1872	65.82
Using	972	34.18

Source: Author Field, 2017.

The table above reveals the frequency and the percentage distribution of men Involvement in the choice of contraceptive method in South- West, Nigeria. The study revealed that 65.8% of men are not using contraceptive while 34.2% are using contraceptive. This implies that majority of men in south-west Nigeria are not using any contraceptive methods. It was also shown that 35.5% of the respondents are above age 35

years followed by age 15-24 that is 35.3%. In the studied area 77.5% of men live in urban areas while 22.5% live in rural areas. This implies that most of the men in southwest lived in urban area, most of the respondents are Christian (61.4%) while 37.4% are Muslims. Furthermore, ethnicity shows that 70% are Yoruba's, others are 9.8%, Hausa's and 3.6% are Igbo's. It was depict from respondent level of education that 59.9% had secondary education, while 19.6% with higher education, while 5.3% had no education. The table also shows that 79.2% of men are working while 20.8% do not engaged in any economic activities. In evaluating respondent wealth status 82.4% are rich, 10.7% are moderate while 6.9% are poor. Moreover, 49.8% of men had no child, 31.9% had three or more children.

TABLE 2:Socio-demographic variables of either of the couple using contraceptives.

BACKGROUND CHARACTERISTICS	USING ANY METHODS OF CONTRACEPTIVES	NOT USING ANY METHODS OF CONTRCEPTIVES	Statistics
South-West	34.2	65.8	2844
Age of Men			
15-24	22.1	42.2	$X^2(2) = 110.8$
25-34	37.5	24.9	Pr =0.0000
35+	40.5	32.9	
Place of Resident			
Urban	84.3	74.0	$X^2(1) = 36.36$
Rural	15.7	26.0	Pr =0.0003
Religion			
Christian	63.3	60.4	
Islam	36.1	38.2	$X^2(2) = 4.76$
Traditional	0.7	01.5	Pr =0.2230

Ethnicity			
Yoruba	74.0	67.9	
Hausa	1.4	4.7	$X^2(3)$ =32.61
Igbo	11.1	9.1	Pr =0.0003
Others	13.6	18.3	
Education			
No education	1.6	7.3	
Primary	12.0	17.0	$X^2(3)$ =97.48
Secondary	5.8	60.7	Pr =0.0000
Higher	2.8	15.1	
Occupation			
Not working	11.7	25.6	$X^2(1)$ =69.13
Working	88.3	74.4	Pr =0.0000
Wealth			
Poor	2.7	9.1	$X^2(2)$ =47.93
Moderate	8.7	11.8	Pr =0.0001
Rich	88.7	79.1	
Children Ever Born			
No Child	43.7	52.9	$X^2(2)$ =24.51
1-2	18.5	18.2	Pr =0.0007
3+	37.7	28.9	

The table above revealed that there is a negative association between age 15years above and the choice of contraceptive method in the study. It was also found that involvement in contraceptive usage increases as age increases as more than two-third of men who uses contraceptive were in urban centre which was confirmed as Pearson Chi-square ($X^2(1)$ =36.36, Pr =0.0003) significant relationship between place of resident and the choice of contraceptive method. The study confirms men engaged in economic activities that boost their income thereby able to afford use of contraception. Moreover, it has revealed in the study ($X^2(3)$ =32.61, Pr =0.0003) revealed that there is significant relationship between

ethnicity and choice of contraceptive method. Furthermore, other determinant factors that influence the choice of contraceptive method among respondent, occupation, wealth index and children ever born.

This is an eye opener to scholars and policy makers that educational attainment of men, their employment status, children ever born, age and place of residence are key determinant factors to men involvement in choice of contraceptive method.

Logistic Regression on Factors Influencing the Use of Contraceptive by Men in the South-West

Contraceptive Use	ODD. RATIO	CONF.INTERV LOWER LIMIT	CONF.INTERV UPPER LIMIT
Age of Men			
15-24 (RC)	1.00		
25-34	2.12***	1.62	2.77
35+	1.59*	1.12	2.27
Religion			
Christian (RC)	1.00		
Islam	0.93	0.77	1.13
Traditional	0.67	0.24	1.88
Place of Resident			
Urban (RC)	1.00		
Rural	0.79*	0.61	1.00
Ethnicity			
Yoruba (RC)	1.00		
Hausa	0.51*	0.26	1.02
Igbo	0.90	0.65	1.23
Others	0.83	0.64	1.08
Education			
No education (RC)	1.00		

Primary	1.61	0.84	3.10
Secondary	2.41**	1.28	4.57
Higher	4.03***	2.08	7.78
Occupation			
Not working (RC)	1.00		
Working	2.01***	1.53	2.64
Wealth			
Poor (RC)	1.00		
Moderate	1.98*	1.15	3.39
Rich	2.19**	1.28	3.72
Children Ever			
Born	1.00		
No Child (RC)	0.62**	0.47	0.83
1-2	1.11	0.81	1.53
3+			

*P<0.05 **p<0.01 ***p<0.001

The table shows the multivariate analysis , region revealed that men age 25-34 and 35years plus are 2.12 and 1.59 times more likely to involve in the choice of contraceptive method compared with 15-24 (RC). Also 0.77 percent of men in the rural area are involved in the choice of contraceptive compared with the men in urban centers. Moreover, it was shown that Hausa men are 0.51 times less likely to involved in the choice of contraceptive method compared with the reference category of Yoruba. Those with secondary education are 2.44 times more likely to participate in the choice of contraceptive method compared with no education. Also those with higher education are 4.03 times more likely to involve in the choice of contraceptive method compared with no education. However, it was also shown that those that are working are 2 times more likely to be involved in the choice of contraceptive method compare to those that are not working. Furthermore, those with average and rich wealth index are more likely to participate in the choice of contraceptive method compared with those who are poor. In

conclusion educational attainment of men, their employment status, children ever born, age and place of residence are key determinant factors in evaluating men involvement in choice of contraceptive methods.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECCOMENDATIONS

5.0 INTRODUCTION

This chapter is keen to the presentation of the summary of findings, conclusion and recommendations drawn from the analysis of the research study on determinant of men's involvement in the choice of contraceptive method in south-west Nigeria.

5.1 SUMMARY OF FINDINGS

More importantly this study found that there is association between the age of men 15years above and the choice of Contraceptive method among men in South-West: it was found that involvement in contraceptive usage increases as age increases as men were involved in contraceptive use in age 15-24 were 22.0%, it increases to 37.5% among ages 25-34 and 40.5 among ages 35years and above. Under the studied area 77.5% of men live in urban areas and 22.5% live in rural areas. This implies that most of the men in South-West lived in urban area and mostly practice Christian religion. As it was found that 61.4% of men are Christian, 37.4% of them are Muslim and 1.2% are practicing other traditional religion. Furthermore, from the ethnicity of men it was show that 70% are Yoruba's, 9.8% are Hausa's and 3.6% are Igbo's. It was depict from respondent level of education that 59.9% had secondary education, 19.6% with higher education, follow by primary and men with no education are 15.3% and 5.3% respectively.

Showing Pearson Chi-square ($X^2(2)$ =110.8, Pr =0.0000) for age of men and choice of contraceptive method, it was revealed that there is association between the age of men

15years above and the choice of Contraceptive method among men in South-West: it was found that involvement in contraceptive usage increases as age increases as men were involved in contraceptive use in age 15-24 were 22.0%, it increases to 37.5% among ages 25-34 and 40.5 among ages 35years and above. Also, more than two-third of men who uses contraceptive were in urban centre which was confirmed as Pearson Chi-square ($X^2(1)$ =36.36, pr =0.0003) shows that there is significant relationship between place of resident and the choice of Contraceptive method among men which implies that as most men move to urban area they were able to engaged in economic activities that boost their income thereby able to afford use of contraception.

Other determinant factors that influence the choice of contraceptive method among men in South West are education, occupation, wealth index and children ever born with respective chi-square: ($X^2(3)$ =97.48, Pr =0.0000), ($X^2(1)$ =69.13, Pr =0.0000), ($X^2(2)$ =47.93, Pr =0.0001), and ($X^2(2)$ =24.51, Pr =0.0007).

Thus this give us an eye opener to scholars and policy makers that educational attainment of men, their employment status, children ever born, age and place of residence are key determinant factors to men involvement in choice of contraceptive method.

Thus involvement of men in the choice of contraceptive method in the region revealed that men age 25-34 and 35years plus are 2.12 and 1.59 times more likely to involve in the choice of contraceptive method than age 15-24 (RC). Also men in the rural area are 0.77 times less likely to participate in the choice of contraceptive method compare to men in the urban area. Moreover, it was shown that Hausa men are 0.51 times less likely to

involve in the choice of contraceptive method in relations to Yoruba's ethnic group where as other ethnic group were not different from Yoruba's.

Those with secondary level of education are 2.44 times more likely to participate in the choice of contraceptive method than those with no education, also those with higher education are 4.03 times more likely to involve in the choice of contraceptive method than those with no education. However, it was also shown that those that are working are 2 times more likely to engage in the choice of contraceptive method compare to those that are not working.

5.2 CONCLUSION s

In conclusion educational attainment of men, their employment status, children ever born, age and place of residence are key determinant factors in evaluating men involvement in choice of contraceptive methods.

A reason for the mismatch in men's involvement in the choice of contraceptive methods for themselves may be due to the influence of the fertility intention of their partners. This study has confirmed that women who want the same number of children as their spouse were 1.4 times as likely as to use contraceptive than their husband who desire more children while women whose husband want fewer children were 1.8 time more likely to use contraceptive methods than those who do not (Amoo, 2016).

5.3 RECOMMENDATION

This study suggested that efforts should be intensified to help men get really involve in choice of contraceptives to avert the growing maternal mortality risking their spouse due

to unmet needs of contraceptive in the South-West Nigeria. The other recommendations for this study are stated below.

- Policy makers should up geared up programme towards improving contraceptive decision making and use in households will need to consider men factor in this part,
- More research should provide a basis for the development of policies for male involvement or choice of contraceptive method.
- Support should be provided for operations research at county level to test relevant intervention programmes on the method of contraceptive.
- More research is needed on the socioeconomic impact of contraceptive method in particular in young male.
- Society should mobilize support to put as much pressure on men research should identify the constraints on mobilizing male involvement in the choice of contraceptive.

Nura, M(2011). Acceptance of Family Planning Among Rural Dwellers in Kano State, Nigeria. A Publication of Society for Youth Awareness and Health Development (SYAHD), Kano, Nigeria.

Odewale B.J; Oladosun M.;Amoo E.O. (2016) Fertility Desire and Contraceptive use among women in Nigeria. 3rd International Conference of African Development Issues (CU-ICADI 2016), ISSN:2449-075X.

Olaitan OL (2009). Sexual Behavior of University Students in South West Nigeria. Egypt. Acad. J. Biol. Sci. (Zool.), 1(1): 85-93. Www.eajbs.eg.net

Olawepo, R. A and Okedare, E.A (2006). Men's Attitudes Towards Family Planning in a Traditional Urban Centre: Ilorin, Nigeria. A Research Thesis Presented to the Department of Geography, University of Ilorin, Nigeria. The Philippines. Discussion Paper Series No. 2005-22.

Qasim M, (2013): Middle – East Journal of Scientific Research 17 (12):1626, 2013, ISSN 1990-9233 (c) IDOSI Publications, 2013; DOI: 10.5829/IDOSI. 2013.17.12.7676

Sweta et al (2010): Knowledge and Pattern of Family Planning Adoption In Kashi shweta& M.B Singh

Ohons, *A*.O and, *Attah*, A. R (2010), A Review of Family Planning Methods Used in Kano, Nigeria, Aminu Kano Teaching Hospital, Kano.

Institute of Social and Economic Research, Nigeria, pp: 1-20.

Asghar,et al (2010). K., A.A. Maann, M.I. Zafar and T. Ali, 2010. Practicing of women

Reproductive health rights: A road map for HIV prevention. Pak. J. Nutr., 9: 250-254.

Bankole, A., R. Hussain, G. Sedgh, S. Singh, D. Wulf and Alan GuttmacherInstitute, 2009. Abortion Worldwide: A Decade of Uneven Progress. Alan Guttmacher Institute, New York.

Klaus, H ; Natural Family Planning : A Review 2nd Edition. July 1995, page 13;

Orbeta, A.C., 2005. Poverty, fertility preferences and family planning practice in the Philippines. Discussion Paper Series No. 2005-22. Http://www.eaber.org/node/22668.

Ottong, J.G., 2010. Population of Nigeria.

NFP Center of Washington, D.C. Inc. , 8514 Bradmoor Drive, Bethesda, MD 20817-3810

Nwachukwu I. And Obasi O.O (2008). Use of Modern Birth control Methods Biol. Sci. (Microbiol.), 1(1): 1-5 www.eajbs.eg.net. Reproductive Health 12(1): 101-108

Measures among university students in South West Nigeria. Egypt. Acad. J. Among rural communities in Imo state, Nigeria. African journal of (http://www.premiumtimesng.com/news/150960-family-planning-low-nigeria-report.html).

Bongaarts, J (1996)., B. Casterline, Zeba A. Sathar, and MinhajulHaque. 1996. Obstacles to contraceptive use in Pakistan: A study in Punjab.

Caster line, B (1997)., E. Perez, and E. Biddlecon. 1997. Factors underlying unmet need for family planning in the Philippines. Studies in Family Planning, 28(3): 173-191.

Central Statistical Authority (CSA) [Ethiopia] and ORC Macro. 2001. Ethiopia Demographic and Health Survey 2000. Addis Ababa, Ethiopia, and Calverton, Maryland,USA: Central Statistical Authority and ORC Macro.

Dixon-M (1992); Ruth and Adrienne Germain. 1992. Commentary. Stalking the elusive unmet need for family planning. Studies in Family Planning 23(5):330-335.

Drennan, M. (1998); Reproductive health: New perspectives on men's participation. Population Reports, Series J, Number 46. Baltimore, Maryland USA: Johns Hopkins University School of Public Health, Population Information Program

Clark ,J,.Yount , K. M & Roger, R. (2008). Men's involvement in family planning in rural Bangladesh. *Journal of Biosocial .Sciences 2008(40), 815–840.*

Dewi, V. (2009). Factors that influence male participation in family planning and reproductive health in Indonesia (master's thesis). The Flinders University of South Australia.

Hossain, K. J. (2003). Male involvement in family planning in Bangladesh: factors constraining low use and the potential for augmenting the . Centre for Policy Dialogue CPR. Paper27.

Hossain,S .M.I; Rob. U; Khan, M.E & Sabir,A. A. (2004). Integration of male and female reproductive health services in Bangladesh with an emphasis on increasing male participation and Awareness. Population Review, 43 (2), 88-100.