

**FACTORS INFLUENCING CONTRACEPTIVE USE AMONG URBAN
MEN IN NIGERIA.**

NAME: Samson Ayodeji OGUNMODEDE

MATRIC NO.: DSS/14/1834

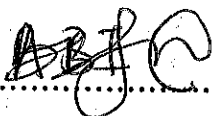
**A RESEARCH PROJECT SUBMITTED TO THE DEPARTMENT OF
DEMOGRAPHY AND SOCIAL STATISTICS, FACULTY OF SOCIAL
SCIENCES, FEDERAL UNIVERSITY, OYE-EKITI, NIGERIA**

**IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE
AWARD OF BACHELOR OF SCIENCE (B.Sc) HONS IN DEMOGRAPHY
AND SOCIAL STATISTICS**

DECEMBER 2018

CERTIFICATION

This is to certify that (OGUNMODEDE SAMSON AYODEJI) of the Department of Demography and Social Statistics, Faculty of Social Sciences, carried out a Research on the Topic "FACTORS INFLUENCING CONTRACEPTIVE USE AMONG URBAN MEN IN NIGERIA. in partial fulfillment of the award of Bachelor of Science (B.Sc) in Federal University Oye-Ekiti, Nigeria under my Supervision



.....
MR BABALOLA
PROJECT SUPERVISOR

19/03/19

.....
DATE



.....
DR. NTOIMO LORRETTA FAVOUR C.
HEAD OF DEPARTMENT

19/3/19

.....
DATE

.....
EXTERNAL EXAMINER

.....
DATE

DEDICATION

The project is dedicated to the ALMIGHTY GOD, the one who was, who is and who is to come, for his goodness and mercy, and also to my family most importantly my parent and friends for their immense support throughout my undergraduate study in the university.

This project is also dedicated to Cristiano Ronaldo. I have been motivated and inspired by his success, endurance, hard work and passion and this has really helped me. God bless you Cr7

ACKNOWLEDGEMENT

First and foremost, I would like to thank God Almighty for giving me the strength, knowledge, ability and opportunity to undertake this research study and to preserve and complete satisfactorily. Without his blessings, this achievement would not have been possible.

I have a great pleasure in acknowledging my gratitude to all my lecturers at the Department of Demography and Social Statistics Federal University Oye Ekiti from whom I have learned much throughout my trainings in the field of Demography and Social Statistics. I would also like to express my gratitude to my colleagues with whom we shared lectures and experience. Their supports, encouragement and credible ideas have been great contributors in the completion of the thesis

I take pride in acknowledging the insightful guidance of **Mr. Blessing Babalola** my project supervisor for sparing his valuable time whenever I approached him and showing me the way ahead.

This journey would not have been possible without the support of my parent Mr&Mrs E.O OGUNMODEDE. Thank you for encouraging me in all of my pursuit and inspiring me to follow my dreams. Both of you supported and invested on me emotionally and financially. I always knew you believed in me and wanted

the best for me. Thank you for teaching me that my job in life was to learn, to be happy and know how to understand myself and others, Also how to use my ideas to influence the world positively.

Thank you my darling mother, **Mrs Ogunmodede** for guiding me as a person.

Thank you for being my biggest fan. You are really my biggest supporter in my life and it means the world to me. Thank you for being a wonderful role model and setting a wonderful example for me to follow throughout the years, and I am forever grateful for you.

I would like to like to express my sincere gratitude to my siblings Gbemisola, Olaoluwa, Fisayo for their support, cares and prayers. Also to my cousin Temitope Gbemiga your type is rare. Thanks for your support and care.

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ABSTRACT

This study concludes that based on the facts from the result that some factors such as age, region, level of education, wealth index, ethnicity on non-use of contraceptive among urban men in Nigeria where p-value less than five percent level of significant. The result from the univariate analysis showed that urban men age 15-19 years was highly reported, followed by age 20-24 years, age 25-29 years, age 30-34 years and 35-39 years, the least reported were age 40-44 years and 45-49 years. Urban men reported mostly from northern region than those reported from southern region. Urban men attained secondary education more, followed no formal education, primary education and highest education. Also, urban men were mostly hausa, followed by Yoruba and Igbo ethnic group. Muslim men was mostly reported, followed by Christian and traditional religion. Men reported more to be rich, followed by poor and middle wealth status. Urban men was employed than those that are not employed. Urban men reported no number of living children more, followed by 1-4 children and those reported to have living children above 4 children. Ideal number of children was reported mostly above 6 children above, followed by 4 children, 5 children, those reported to have 3 children and 2 children ideal number and less than 2 children was least reported. Urban men reported more to know modern contraceptive method, followed by knows no method, knows traditional and folkloric methods. Source of contraceptive was reported from private sector, followed by other sources and public sector.

The result from the bivariate analysis showed significant association between age, region, level of education, ethnicity, religion, wealth index, occupation, number of living children, ideal number of children, knowledge of contraceptive method and contraceptives use ($X^2 = 1270.70$, $P = 0.0000$, $X^2 = 1070.21$, $P = 0.0000$, $X^2 = 985.95$, $P = 0.0000$, $X^2 = 952.94$, $P = 0.0000$, $X^2 = 717.57$, $P = 0.0000$, $X^2 = 852.85$, $P = 0.0000$, $X^2 = 672.4$, $P = 0.0000$, $X^2 = 2176.58$, $P = 0.0000$, $X^2 = 1241.79$, $P = 0.0000$, $X^2 = 78.35$, $P = 0.0004$).

Result revealed that urban men age 40-44 years were 57% less likely to use contraceptives to urban men age 15-19 years (RC). Urban men age 45-49 years were 59% less likely to use contraceptives to urban men age 15-19 years (RC). Urban men from north-east were 0.40 times less likely to use contraceptives to urban men from north-central (RC). Urban men from north-west were 0.29 times less likely to use contraceptives to urban men from north-central (RC). Urban men from south-west were 0.66 times less likely to use contraceptives to

CHAPTER ONE

INTRODUCTION

1.0 BACKGROUND TO THE STUDY

Contraceptives usage and Reproductive health program and services are usually directed towards women's reproductive health and offered their services exclusively to women, especially issues with family planning, maternal care all through the pregnancy period, prevention of unwanted pregnancy, risky abortion and the improvement of safe motherhood (this occur most especially in sub-Sahara Africa) .However, not knowing the role of men in fertility and family planning in sub-Saharan Africa is becoming increasingly important in the context of raising contraceptive prevalence and reducing level of fertility. Men's involvement could assume an essentially prominent role in the individual couple's family planning effort. It is assumed in the "African" context that women do not have control over their own reproductive behavior. Most studies carried out in Nigeria and other African countries (Lasee and Becker, 1997; Donovan, 1995; Isiugo-Abanihe, 1994; Roudi and Asford, 1994; Mbizvo and Adamchalk, 1991; Oni and MacCarthy, 1991) have all asserted the domineering position of men on reproductive health matters. According to the results of these studies, men are dominant decision makers within the family. They also gain socially and economically from having large numbers of children, and that men reproductive preferences and motivation influence their wives reproductive outcome. These assertions are also corroborated by Fapohunda and Todaro (1988) when they concluded in their study that men's negative attitude towards contraceptives use is a major reason why their wives fail to practice family planning, even when the latter are motivated to do so.

Reproductive health of couples, raising of contraceptive prevalence and reducing level of fertility largely depends on the attitude of men; i.e. husband action towards family planning program and their level of knowledge on contraceptive methods. The family planning program in sub-Saharan Africa could not be used properly because of all kinds of activities and policies are being concentrated mainly for women (Clark, 2008). Most of the family planning field service delivery system is female based (i.e it is based on women) and field workers are also females. They only cover their area mainly aiming the women because of ease. So there is a little chance for male to receive service from family planning providers (Hossain, 2003). However, the part of men in reproductive health and family planning has been always disregarded by the family planning programs and most contraceptive methods are designed for women only (Dewi, 2009).

Nigerian men are often the final decision-makers on key household issues, including those related to household purchases, health of family members, timing of pregnancies, family size, and education of children. The attitudes of men toward family planning can affect their partner's Contraceptive attitudes, even when spousal communication about reproductive health is not the norm. Programmatic and policy efforts to promote contraceptive use have often focused on women. Nevertheless, women-only programs or those that involve men in a limited way are not sufficient to bring about the magnitude of change in contraceptive use that is required for fertility decline at a national level . This situation has prompted a shift toward increased involvement of men and a realization that social construction of masculinity and femininity should inform effective strategies for promoting contraceptive uptake and reducing unplanned pregnancies.

The evidence suggests that engaging men in reproductive health decisions as partners can lead to increased spousal communication about family planning, which in turn fosters contraceptive use.

Men should be considered not only as women's partners, but also as individuals with distinct reproductive histories and desires of their own. This study sought to understand the determinants of modern contraceptive use among sexually active men, by exploring factors that are associated with modern contraceptive use in urban centres. Relative strength of these associations is explored in bivariate and multivariate models. Findings indicate that region of residence, place of residence, marital status, religion, wealth, interaction with a health care provider, fertility preference, number of sexual partners and having access to media were all significantly associated with modern contraceptive use among sexually active men. Provider-client interaction as well as dissemination of information through mass media has the potential to increase knowledge and uptake of modern contraceptives.

The persistence of high fertility in sub-Saharan Africa, and Nigeria in particular has been the subject of considerable investigation during the past decade (Isiugo-Abanihe, 1994). Social forces sustaining high fertility and impeding family planning programs are well understood. For instance, Ezeh (1992) observed that women's fertility preferences and behaviour are strongly influenced by their husband's reproductive motivation. Also, in most developing countries, women carry the burden of responsibility on contraceptive use often with little or no support and sometimes with great resistance from their male partners (Lasce and Beeker, 1997; Salway, 1994, Oni and MacCarthy, 1991) In spite of all these realizations, however, there is a paucity of demographic data on male knowledge, attitude and practice of contraception in Nigeria. In other words, there is a need to know the reproductive intentions and expectations of Nigerian men more than ever before. Ignoring men in fertility research and programmers undermines efforts both to change their attitudes on population matters and to motivate them, and through them, their wives, toward family planning. This study is, therefore, significant because, for any

population control activity to be effective, there is a 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. Here, issues such as the knowledge and practice of family planning, men's approval of family planning and other fertility issues deserve serious consideration. Again, there is a dire need to investigate the gender power relations in reproductive health decision-making processes. For instance, who decides when or when not to have additional children? Who decides when to adopt family planning and which family planning methods to use? All these questions are important for major channeling and direction of action programed.

Research has proven it that there is growing evidence that male plays fundamental role to avoid risky sexual behaviors and influences the couple's contraceptive decision making process (Hossain M. B., 2004). Men can keep important roles by giving support during the pregnancy period of women (Dewi V. , 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. Male responsibilities in family life must be included in the education of children from the earliest ages" (United Nations Population Fund, 1994:5).

It is now vividly shown 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).

Some previous studies tried to explore & explain few of reasons of non-participation of male spontaneously in family planning actions as well as unwillingness to use contraception especially 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 contraceptive use among urban men in Nigeria.). Contraceptive use reduces the pregnancy rate, the number of unintended pregnancies and associated induced abortions and the proportion of high-risk. Pregnancies, therefore causing a reduction in maternal mortality and an improvement in maternal and child health. The issue of contraceptive use all over the World has attracted attentions due to its importance in decision making about population growth and development issues. In which Demographers have become increasingly alarmed by the precipitous rise and its effects on population growth, not only in Nigeria or the United States of America, but throughout the World (Okedare, 2000).

Fertility decline which comes in form of family planning is a means of achieving demographic dividend, with the consequent potential of reducing poverty, boosting economic growth and contributing to the overall well-being of families and societies. Family planning means a well-planned family with limited members whose maintenance is possible with available resources and tools and thus builds a healthy and well to do unit. A well planned family is the base for

planned development and richness of the society and of the country. It can also be stated that the family planning is the key point for a planned development.

Family planning is also the ability of individuals and couples to attain their desired number and spacing of their children through contraceptive use- is one of the most cost-effective public health interventions and is pivotal to reducing the country's fertility. Nigeria's family planning program began in 1964 with the National Family Planning Council of Nigeria. Before the 1980's, however, family planning programs were not a priority for the government of Nigeria and consequently were driven by development partners and non-governmental organizations. Following analysis of the consequences of unregulated population growth on health and development in Nigeria, starting in the late 1980's the country began formulating various policies aimed at improving reproductive health outcomes and reducing fertility levels through family planning. Currently, family planning services are provided by both the public and private sectors, with the commodities provided free in public sectors facilities. In spite of the various investments in family planning programs in the country, it is saddening to know that contraceptives prevalence has not shown any sign of increasing. According to this, while knowledge of contraceptives is generally high, uptake is low; only 15% of married women of reproductive age are using any contraceptives method, only 10% are using modern family planning method, while unmet need for contraception is 16%. Therefore, the promotion of family planning in countries with high birth rates has the potential to reduce poverty and hunger and avert 32% of all maternal deaths and nearly 10% of childhood deaths.. "Family planning was accepted as the best way to control the rapidly and massively growing population by Individuals and couples, in order to promote the health and welfare of the family group and thus contribute

effectively to the social development of a country. Contraceptive use takes a value of one if a male partner reported use and zero if otherwise.

The World Health Organization (1971) defined Family Planning as the practice that helps individuals or couples to attain certain objectives such as avoiding unwanted pregnancies, bringing out unwanted babies at the right time, regulating the interval between pregnancies, controlling the time at which birth occurs in relation to the ages of the parents and determining the number of children in the family. An earlier report by WHO (World Health Organization) expert committee (1970), has stated that family planning includes: The proper spacing and limitation of births, advice on sterility, education for parenthood, sex education, screening for pathological conditions related to the reproductive system, genetic counseling premarital consultation and examination, carrying out pregnancy test, marriage counseling, the preparation of couples for the arrival of their first child, providing services for unmarried mothers, teaching home economics and nutrition, providing adoption services.

Family planning as the provision of birth prevention information services and appliances. According to him, it also involves teaching men and women about their bodies and teaching them how to prevent births usually with contraceptives but sometimes also with abortion or sterilization. (Onokerhoraye, 1997).

Nigeria, the seventh most populous nation in the world, has a current estimated population of 183 million, which is projected to reach 285 million by 2050 (United Nations 2013). There are an estimated 35 million women of reproductive age in the country, with an annual number of births of approximately 7 million and annual population growth of 3.2% per annum. The country's rapid population growth is attributable to a high total fertility rate (TFR) of 5.5 children per woman (National Population Commission and ICF International and 2014).

Additionally, the country has relatively high levels of infant mortality (74.09 infant deaths per 1,000 live births, 2014 est.) and maternal mortality (630 maternal deaths per 100,000 live births, 2010est, CIA World Fact book-August 23, 2014). Family planning—the ability of individuals and couples to attain their desired number and spacing of their children through contraceptive use—is one of the most cost-effective public health interventions and is pivotal to reducing the country's fertility (Graff, 2014). In response to these and other serious demographic and health issues, the Nigerian government put into effect a national population policy in 1989 that called for a reduction in the birth rate through voluntary fertility regulation methods compatible with the nation's economic and social goals. During 1992–1993, an information, education and communications campaign was launched to change Nigerians' attitudes toward family planning, and to thereby increase their contraceptive use. The campaign was based on evidence that family planning messages relayed through the mass media can influence contraceptive behavior.

Studies have shown that family planning adoption is likely to be more effective for women when men are actively engaged by the programmes, through education or other targeted activities. Although many researchers advocate for including men in family planning programs, data on men's knowledge and use of contraception remains scarce

1.1 STATEMENT OF PROBLEM

Despite that men are major determinant in the home, yet most studies concentrate on the women on contraceptives behavior. In addition most research on fertility and family planning issues in developing countries involved only women.

One of the major components of the National Population Policy is to reduce the total fertility rate to four by the year 2000. The government is now convinced that high fertility and rapid population growth are barriers to economic development and its efforts to improve the standard

of living of its citizens. One important means of achieving this (i.e. reducing high fertility and rapid population growth) is by widespread and effective contraceptive use.

The low contraceptive prevalence rate is a problem or disaster common to both urban and rural areas of the country (Nigeria Demographic profile 2014); All socioeconomic groups whether high or low have almost equal low rates of contraceptive use, yet the conditions under which Nigerian men will accept family planning and reduce their desire for large number of children have not been fully determined. Only few studies have been done in the past and these have not been conclusive. Although the National family planning program is relative new, it may not be strong enough to motivate new acceptors. It is therefore very timely to conduct studies into factors influencing contraceptive use in Nigeria as the full and proper understanding of these factors will be very crucial to the successful implementation of the national family planning programs which aim at improving contraceptive use.

While these factors are not fully known, the low contraceptive prevalence rate has been blamed partly on the strong desire for large family size largely due to cultural demand (Federal Office of Statistics, 1992). It has also been suggested that strong, standard and well-managed family planning programs are highly effective and could achieve smaller family size in a wide variety of socio-cultural and economic setting (Sadiq, 1991).

The problem of high fertility and rapid population growth

Problem of unintended pregnancy and induced abortion

The problem of HIV/AIDS

1.2 GENERAL OBJECTIVE OF THE STUDY

The general objective of the study is to examine the socio-demographic factors influencing the use of contraceptive methods among urban men in Nigeria.

1.2.1 SPECIFIC OBJECTIVES

The Specific objectives of the study are:

- To understand the level of knowledge of contraceptive methods among urban men in Nigeria.
- To ascertain the level of usage of contraceptive methods among urban men in Nigeria.
- To determine the socio-demographic factors influencing the use of contraceptive methods among urban men in Nigeria.

1.3 RESEARCH QUESTIONS

- What is the level of knowledge of contraceptive methods among urban men in Nigeria?
- What is the level of contraceptive usage among urban men in Nigeria?
- What are the socio-demographic factors influencing the use of contraceptives among urban men in Nigeria?

1.4 HYPOTHESIS

H_0 : Knowledge of contraceptive methods does not influence contraceptive use among urban men in Nigeria.

H_1 : Socio-demographic factors (age, religion, marital status, level of education, employment status, wealth index, ethnicity, number of living children and knowledge of contraceptive methods) do not influence contraceptive use among urban men in Nigeria.

1.5 JUSTIFICATION OF THE STUDY

Nigeria is an example of a nation battling with the prevalence of HIV/AIDS due to low contraceptives rate or use; The disease is highly threatening the Nigerian social and economic development. Researchers documented that HIV was first detected in Nigeria in 1986 (Amanyeiwe, Laurel, Aneesa, Taye, Mehta-Steffen & Valdenebro et al., 2008) and since the discovery, the number of infected young people has increased in threefold; from 1.8% in 1991 to 5.8% in 2001, after which a slight decline was observed (from 5.0% in 2003 to 4.4% in 2005), with prevalence as high as 16% in some parts of the country (Kombe, Galaty & Nwagbara, 2004). Evidently, Nigeria has been known as the second largest HIV infected people in the world (USAID, 2010) and the infection now stands as one of the leading causes of death among people aged 15-49 years across all the geographical regions (Kombe, Galaty & Nwagbara, 2004).

Male's participation at all levels in the reproductive health and family planning programmes is regarded as a vital tool for achieving Nigeria's Vision 2030. This study focused on filling the knowledge gap on the factors that constrain male involvement in family planning in urban Centre. It aimed at bringing up male-sensitive research and development programmes to ensure their participation at all levels in the reproductive health and family planning programmes. It established that family planning programmes are not usually organized to target men thus rendering it hard in achieving a sustainable impact. Lack of regular spousal communication leads men into having a negative attitude towards the use of FP and reproductive health. Knowledge of FP poses a direct influence on male involvement in that, the more knowledgeable a man is on FP, the higher the possibility that he would be involved in the same, and that there is unmet need for FP services targeting men thus the absence of such services hinders their active involvement in family planning. The study was deemed important because the findings could be used by both

the national and county governments as a basis of formulating policies that relate to family planning and reproductive health. Development experts, organizations and institutions especially those concerned with the implementation of vision 2030, Millennium Development Goals (MDGs) and other development blue prints in the sector of family planning and women empowerment would also find the results of the study useful in both review of the existing projects as well as designing, planning, implementing and evaluating future projects. Through the findings of this study, such stakeholders will be concerned with involving men from the designing, planning and implementation phases of FP programmes to ensure they achieve a sustainable impact.

The study will also be of great importance to other researchers and academicians who seek to understand the factors that hinder men's involvement in family planning and how these factors can be mainstreamed into the project cycle in achieving lasting impact. In addition, the community including households and families could also use the findings of the study to challenge themselves in advocating for the importance of male involvement in FP programmes and to adopt practices that can help them in embracing family planning.

Contraceptive prevalence is lower in Nigeria than in most countries in sub-Saharan Africa with a high level of unmet need for contraception in spite of the high rate of sexual activity and contraceptive knowledge, this low contraceptive use has contributed to the high rate of unintended pregnancy in the region. Unintended or unwanted pregnancies are more likely than intended pregnancies to end in negative health outcomes, including low birth weight, infant and child mortality, and maternal morbidity and mortality. Effect of low contraceptive prevalence rate leads to:

- i. The problem of high birth rate and rapid population growth
- ii. The problem of HIV/AIDS
- iii. Problem of unwanted or unintended pregnancy and induced abortion

The purpose of this research study is to investigate the relationship between socio demographic factors influencing contraceptive use among urban men in Nigeria and how it affects their spouse fertility preferences both now and in years to come.

1.6 Significance of the Study

Nigeria has an ambitious target of more than doubling her contraceptive prevalence rate with four years (2014 – 2018), from 15% to 36%. This is against a backdrop of persistently low and stagnating contraceptive use. For effective policy implementation, the need to determine factors responsible for low coverage and the observed wide variations across the country is not only imperative but urgent if better results are to be achieved. In terms of policy and programming implications of the proposed study, we believe that presence of urban-level effects on contraceptive uptake, if identified, will indicate the need for changes in family planning programming that will factor in community and service delivery characteristics (e.g., health campaigns, number and type of services), with positive influences on program and maternal health outcomes for whole communities.

1.7 DEFINITION OF TERMS

Men: A fully developed male from maturity onward who fall within the age group of 15- 49.

Use of any Contraceptive method: The act of currently using any Contraceptive method which include Male condom, Male Sterilization and Withdrawal method.

Male Involvement: The act of engaging men in the reproductive health and family planning services.

Barriers: Challenges/factors that pose complexities thus inhibiting male involvement in family planning.

Culture/Traditions: Beliefs, customs, practices and social behavior embedded in urban Centre Nigeria

WHO: World Health Organization

FP: Family planning

AIDS: Acquired Immunodeficiency Syndrome

CPR: Contraceptive Prevalence Rate

HIV: Human Immunodeficiency Virus

ICPD: International Conference on Population and Development

MDG: Millennium Development Goal

SRH: Sexual Reproductive Health

TFR: Total Fertility Rate

UN: United Nations

UNDP: United Nations Development Programme

CHAPTER TWO

2.0 LITERATURE REVIEW

This chapter presents literature review on the factors that influence male involvement in family planning. The review was carried out with the following subheadings: male participation in family planning, and the cultural, demographic and economic factors that influence male involvement in family planning.

Fertility and family planning research and programs have ignored men's roles in the past, focusing on women's behaviour, and services are traditionally presented within the context of maternal and child health. Most of the family-planning services were offered within maternal and child health (MCH) centers, most research and information campaigns focused on women and this has reinforced the misconception that family planning is largely a woman's business, with the man playing a very peripheral role especially in a society where male supremacy and virility is very important and is marked by Procreation.

Realization of the need to focus on men had resulted at the 1994 International Conference on Population and Development (ICPD) in Cairo as well as at the 1995 World Conference on Women in Beijing. The Program of Action endorsed at the Cairo conference calls for the need to recognize men as equal partners with women in all matters relating to reproductive health and family planning. Taking the cue from the ICPD, the National Population Policy of Nigeria 2000 recognizes men as the under-served population. It sees the exclusion of the men from the family planning programs as a shortfall of the past for in a patriarchal society like India men play the critical role in all matters relating to the family. Therefore it aims at focusing attention on men in the information and education campaigns and to promote the small family norm.

Traditionally most family planning programs had focused only on women. The basic assumption was since women are the ones who bear children it will be enough to concentrate on women only to bring down the fertility levels. However, childbearing is the outcome of a participation of both partners in a conjugal union and men together with women play key roles in reproductive health decision-making including family planning. In fact, men not only take decisions about themselves but also often play the dominant roles in decisions crucial to the reproductive health of women, especially in developing countries. Childbearing has an impact on men's lives too. For in most socio-economic setup they are the ones who provide for the wife and children financially. Emotionally as well men play crucial role by caring for the health of the child and also that of the mother.

The evolved focus on men's participation in family planning stems from valid concerns. Firstly, as already indicated, women of many cultures seek the approval of their husbands to use contraception and do not use if the husband has not agreed to its use. Even educated and motivated women may not use contraception due to opposition from husbands as a survey in Sudan shows (Bankole and Singh, 1998). Involving men in matters related to reproductive health is an indispensable strategy to contain the incidence and spread of RTIs, STDs and HIV/ AIDs which are evidences of men's risky sexual behaviour (Riley, 1997). Involving men actively in reproductive decision- making will also reduce the incidence of unwanted pregnancies.

Encouraging men to use contraception is one of the ways by which men can actively take part in family planning. In such a scenario the low use of contraception by men becomes a matter of serious concern. In this paper we analyze the various social, economic and demographic and behavioral factors that influence contraceptive use by men in India. For the purpose we have selected the states from north and south of India given the north -south dichotomy that exists as

regards to various social, economic and demographic and autonomy aspects (Dyson and Moore, 1983).

The concept of "wealth flows" and the use of the concept to explain both stable high fertility and onset of sustained fertility decline is the main focus of the theory of fertility decline as restated by Caldwell. Its relevance to fertility decline is found in the sense that fertility decline is the result of changes in the family's internal economic structure (Caldwell 1982). He concludes by stating that the onset of fertility decline can only be explained in terms of the nature of the pre-existing stable high fertility regime and the conditions of destabilization and that these explanations are the ones of fundamental economic and social change.

Since, the 1994 International Conference on Population and Development (ICPD), and the 1995 UN World Conference on Women, interest in men's involvement in reproductive health has increased. There has also been a shift in objectives of male participation and concerns, from increasing contraceptive use and achieving demographic goals to achieving gender equality and fulfilling various reproductive responsibilities.

Involving men in FP is another way of obtaining their commitment to the improvement of its methods. This study provides information on the factors that aid or hinder men's participation in FP. For men to be more involved in FP and other reproductive health services, they require adequate information. Men with adequate knowledge of FP are more likely to use contraceptive methods and to encourage their partners to do likewise, thereby combating maternal mortality. The educational level of men also plays a significant role in their involvement in FP. This study revealed that men who had secondary or tertiary level of education were more likely to be more involved in FP than men who were uneducated or had only the primary level of education.

Educated men are more likely to have good knowledge of FP which can enable them to make informed decisions on the benefits and risks of FP methods. Uneducated men, on the other hand, often have misconceptions about FP methods, especially with regards to side effects. These misconceptions are usually the cause of low male involvement in FP services.

Birth spacing was also discovered to be significantly associated with male involvement in FP. Men whose partner's interval between the last two deliveries was 13 months and more demonstrated higher levels of involvement in FP. However, the studies reviewed did not report this association; rather, they reported the current number of living children and the desire for more than five children to be associated with men's participation in FP.

Hence, this is a descriptive study designed to assess the knowledge and attitude of men towards contraceptive use in urban areas in Nigeria.

Studies have shown that in Nigeria the high rate of population growth has been driven by high fertility rates, which have fallen much less rapidly than the crude death rate. The country's total fertility rate has declined only slightly, from 6.3 births per woman in 1981-82 to 5.7 births per woman in 2008. The persistence of high fertility has been the subject of considerable investigation during the past decade. Researchers have suggested various reasons to explain why, despite the high fertility rate, acceptance and utilization of modern family planning methods remain low, currently 11 percent. Factors include poor accessibility of services, the low status of women, high illiteracy rate among the female population, the patriarchal nature of the society, and a general lack of male involvement in family planning.

Many works have been done worldwide on men's participation in family planning, but there is a dearth of researches on similar issues in Nigeria because unfortunately, data on the knowledge and use of modern contraception among men and on male participation in reproductive health are

generally scanty, and the existing studies are rather similar in focus and limited in scope. The family unit in Nigeria is essentially patriarchal and patrilineal, with all the important decisions taken by the male head while the woman's fundamental social role is to bear and raise children and engage in productive tasks within the household. Wives are usually socially and economically dependent on their husbands.

Available studies show that in many developing countries males often dominate in making important decisions in the family, including those concerned with reproduction, family size, and contraceptive use. Men are also recognized to be responsible for the large proportion of ill reproductive health suffered by their female partners. Male involvement helps not only in accepting a contraceptive but also in its effective use and continuation. Improvement in condom use among sexually-active men and women may be effective in reducing the incidence of HIV infection and other STIs in Nigeria, where the source of HIV infection is mainly sexual intercourse (Pepin J, Plummer FA, Brunham RC, Piot P, Cameron DW & Ronald AR. 1989.)

One of the most serious problems developing countries still have to solve is their rapid and uncontrolled increase in population.¹ It is well documented that men's general knowledge and attitudes concerning the ideal family size, gender preference of children, ideal spacing between child births, and contraceptive method use greatly influence women's preferences and opinions. However, fertility and family planning research and programs have ignored men's roles in the past, focusing on women's behaviour,⁴ and services are traditionally presented within the context of maternal and child health.⁵ Since, the 1994 International Conference on Population and Development (ICPD), and the 1995 UN World Conference on Women, interest in men's involvement in reproductive health has increased.^{4,6} There has also been a shift in objectives of

Reproductive health of couples, raising of contraceptive prevalence and reducing level of fertility largely depends on the attitude of men; i.e. husband action towards family planning program and their level of knowledge on contraceptive methods. The family planning program in sub-Saharan Africa could not be used properly because of all kinds of activities and policies are being concentrated mainly for women (Clark, 2008). Most of the family planning field service delivery system is female based (i.e it is based on women) and field workers are also females. They only cover their area mainly aiming the women because of ease. So there is a little chance for male to receive service from family planning providers (Hossain, 2003). However, the part of men in reproductive health and family planning has been always disregarded by the family planning programs and most contraceptive methods are designed for women only (Dewi, 2009).

Nigerian men are often the final decision-makers on key household issues, including those related to household purchases, health of family members, timing of pregnancies, family size, and education of children. The attitudes of men toward family planning can affect their partner's contraceptive attitudes, even when spousal communication about reproductive health is not the norm. Programmatic and policy efforts to promote contraceptive use have often focused on women. Nevertheless, women-only programs or those that involve men in a limited way are not sufficient to bring about the magnitude of change in contraceptive use that is required for fertility decline at a national level . This situation has prompted a shift toward increased involvement of men and a realization that social construction of masculinity and femininity should inform effective strategies for promoting contraceptive uptake and reducing unplanned pregnancies.

The evidence suggests that engaging men in reproductive health decisions as partners can lead to increased spousal communication about family planning, which in turn fosters contraceptive use.

male participation and concerns, from increasing contraceptive use and achieving demographic goals to achieving gender equality and fulfilling various reproductive responsibilities.

Results from a large national sample indicated that 55% of commercial sex workers (CSWs) consistently used a condom during the last five sexual acts (Oladosu M & Ladipo O. 2001). Hence, the use of condoms for prevention of HIV/AIDS has been extensively advocated (Heymann DL & Edstorm K. 1991). Improvement in condom use among sexually-active men and women may be effective in reducing the incidence of HIV infection and other STIs in Nigeria, where the source of HIV infection is mainly sexual intercourse (Pepin J, Plummer FA, Brunham RC, Piot P, Cameron DW & Ronald AR. 1989.)

Although the condom appears to be effective and reliable as a preventive measure for both STIs/HIV/AIDS and pregnancy, there is difficulty in its use. A study involving CSWs in Nairobi, Kenya, found that 71.4% of those who reported not having used condoms became HIV-positive compared to 46.0% of those who reported some use of condoms during a three-year period (Ngugi EN, Plummer FA, Simonsen JN, Cameron DW, Bosire M, Waiyaki P et al. 1988). According to the study, condoms appeared to be effective in reducing HIV transmission among CSWs. Several other studies also revealed that condom use is effective in the prevention of HIV-1 infection (Conant M, Hardy D, Sernatinger J, Spicer D & Levy JA. 1993 & Weller SC. 1993).

The majority of studies all over the world indicate that women prefer having and running smaller families. According to the UNFPA (2011), over 100 million women globally would prefer avoiding pregnancy although they do not use any family planning methods. This indicates that there have been unmet needs for family planning up to date. In Nigeria, for instance, the unmet need for family planning currently stands at 46% thus leading to women undergoing unsafe abortions as a result of unwanted pregnancies (UNFPA, 2011). In the last two decades,

the population of Nigeria has more than doubled, and the APHRC (2013) suggests that Kenya will experience perpetual rapid population growth. Irrespective of the government taking significant initiatives to increase access to family planning services, its use remains to be very low among many couples, those in the rural areas being the majority. This is attributed to the traditional family structure whereby men remain being considered as family heads and the entire decision-making in the family left to them (GoK, 2013). As much as it is the wish of every woman to cease bearing more children, their male counterparts do not allow them to do so while at the same time they are unwilling to use the available male family planning methods.

Several studies examined the non-contraceptive health benefits of family planning methods on women. Oral contraceptive is shown to reduce at least eight serious diseases and other gynecological morbidities (Ory 1982; Jensen and Speroff 2000; Dayal and Barnhart 2001). Contraceptive use is also shown to improve child survival through optimal child spacing, lengthening birth intervals, and reducing sibling competition for scarce family and maternal resources (Potts 1990; Rutstein 2005; DaVanzo, Hale et al. 2007; DaVanzo, Hale et al. 2008; Yeakey, Muntifering et al. 2009).

2.1 Male Involvement in Family Planning Initiatives

Following the Cairo initiative that took place about two decades ago, there have been various efforts and attention put in place to increase male involvement in family planning services. However, there is no accepted understanding of a broad meaning of active male involvement in family planning that exists. According to Toure (1996), male involvement is defined as all activities targeted at increasing the number of men who use contraceptives (Toure, 1996). However, his definition is criticized by Greene (2000) who defines male involvement as all

organizational activities targeted at men with the objective of increasing the number of men that encourage and inspire their wives to use family planning services. Greene (2000) adds that it is influencing the policy environment to make it conducive for male-related programmes and not just increasing the number of men who use contraceptives. Nelson *et al.* (1996) defines male involvement in all activities that promote men's active participation in family planning activities, projects and programme services with the aim of achieving gender equality and empowering women. "Male involvement in FP is very important because it will reduce misunderstanding between couples as when one is aware of his partner use of FP methods, will give freedom to women not to hide those methods as some hide pills so as not to be seen by their spouse.

The main challenge to encourage male involvement in FP is to get them into action, directly involved in service delivery. This requires effective ways to reach out to men, in their homes, in their communities or in their workplace.

2.2 Barriers to Male Involvement in Family Planning

2.2.1 Cultural Factors

Levy (2008) suggests that the ability of a woman to control her fertility level is strongly affected by the social constructs of gender roles and expectations. An assortment of researchers indicates that gender inequality has a tendency of who uses, accesses, and makes decisions of contraceptives. In a patriarchy society, gender inequality would result in verbal and physical abuse to women. Research conducted by the Family Health International Women Studies in Bolivia and Philippines about the relationship between gender and family planning found that the use of contraceptives was a factor in domestic violence. In the Philippines, 25% of the women reported having been physically abused by their husbands. In India, Char (2011) argues that

since the society is male dominated, the acceptance and use of female sterilization is only significant based on the husband's decision.

In Malawi, Paz Soldan (2004) found that men determine family size decision-making and the use of contraceptives. However, the study points out those male partners are always resistant to family planning initiatives. It further reports that fear of spousal retaliation due to disagreements about whether to use contraceptives or not as a major barrier to male involvement. The role of men in the family is quite in a contradictory state thus their decision-making role is detached from reproductive health issues, thereby posing immense challenges for their active involvement in family planning and contributing to low contraceptive prevalence rates in the African context. Religion instigates different beliefs and norms surrounding sexuality issues. It is a powerful tool with the capability of swaying people's opinions as regards family planning. Most religions are against the use of modern contraceptives. The majority of Islamic jurists in Swaziland indicate that the use of family planning is not forbidden. Others, on the other hand, suggest that family planning violates God's primary intention of marriage. FP methods that are permitted are those that do not induce abortion and are reversible. Irreversible sterilization methods are not allowed. This research reported that the majority of married men in Kenya are not aware of modern contraceptives. Thus, it remains a barrier to male involvement since this knowledge is absent to them. As such, there is a great fear of side effects of contraceptive use among men. Ojaka (2008), and Balaiah *et al.* (2005), therefore, suggest that there is a great need to conduct further studies to ascertain the knowledge level on contraceptives in Kenya so as to determine the mean number of contraceptives known to men.

The extent to which cultural factors impede male involvement in family planning differs based on the social and cultural background of married men. According to Oyedokun (2008), males

have a limited choice of contraceptives due to their personal beliefs, dislike, and perception of contraceptive costs and their side effects. Cultural factors contribute to higher extent barriers to male involvement in family planning as a result of several couples autonomy and age of the married couple. According to a study conducted in Nepal, there exists a significant association between male involvement in family planning and gender roles. An assortment of studies shows that a couple that increases their contraceptive use improve their social and cultural changes while at the same time reducing maternal and child mortality. Most studies indicates that culturally, most communities render it hard for a male to be involved in family planning because contraception would lead to sexual unfaithfulness among the taker. However, a study conducted show that partners who were unaware of modern contraceptives and where their male counterparts were also non-knowledgeable, chances of the spread of STIs and HIV could be high. Therefore, WHO (2010) is concerned about the reluctance of male involvement in family planning which may hinder its goal of reducing the AIDS epidemic by 26% by 2020. In Kenya, Okech (2011), Nzioka (2001) and Ngetich (2013) indicate that lack of male involvement may further increase maternal and child mortality rates making it hard for the government to achieve its Millennium Development Goal and Vision 2030 with regard to reproductive health and family planning.

2.2.2 Religious Factors

Religion influences human behavior fundamentally. In order to establish the influence religion has on male involvement in family planning initiatives, the researcher asked the respondents whether their religion accepted the practice of family planning. Most of the respondents reported that their religion accepted the practice of family planning while others indicated that their religion was against the practice of FP.

2.2.3 Economic Factors

Developing nations have high poverty rates. Highly populated countries are no exception as the per capita income is relatively small owing to the large population. The level of a couple's income influences male involvement in family planning. Oluwasanmi *et al.* (2011) further indicate that unemployed men have high levels of not participating in contraceptive use compared to the employed ones. In Sudan and Uganda, the research found that male involvement in family planning declined with the decrease in the level of a household's income (Oluwasanmi *et al.*, 2011).

The unmet need for family planning is associated with education level. Studies conducted by Ferdousi *et al.* (2010), Mehta *et al.* (2002) and Hossain (2003) in India, Pakistan and Bangladesh, respectively, found that the level of education couples have contributed to their use of contraceptives. As such, the higher the level of education, the higher the rate of contraceptive use. The unmet need for family planning decreases with the level of a married couple's educational achievement and employment status. Studies show that the unmet need for family

The educational level of men also plays a significant role in their involvement in FP. This study revealed that men who had secondary or tertiary level of education were more likely to be more involved in FP than men who were uneducated or had only the primary level of education. This result compares with those of other studies conducted in Nigeria, likely to have a more perception towards family planning. Educated men are more likely to have good knowledge of FP which can enable them to make informed decisions on the benefits and risks of FP methods. Uneducated men, on the other hand, often have misconceptions about FP methods, especially with regards to side effects. These misconceptions are usually the cause of low male involvement. Women's level of education was also seen to be a strong factor in their husband's

or partner's involvement in FP. Our findings suggest that women who are educated facilitate their partner's involvement in their health issues and in those of their children. Other studies also found an association between women's educational level and male involvement in FP and other related issues.

Male involvement in sexual and reproductive health services, especially in family planning, is crucial in boosting FP methods among men and their partners. FP programs should, therefore, be designed to strengthen and incorporate the responsibility and role of men in the practice of FP services. Furthermore, community health education sessions should be organized to provide communities with adequate information on FP services. Men may not benefit directly from safe motherhood services, but their partners need their understanding and support to have access to basic reproductive health services. Men's involvement, therefore, remains a major determinant in all FP initiatives. The level of male involvement in this study was high, and was driven, among other factors, by age, level of education, level of FP knowledge, partner's level of education, and birth spacing between their partner's last two deliveries.

Some of the obstacles to male involvement were financial constraints, conception difficulties, inadequate information on FP, desire for large family sizes, tradition, side effects of female methods (unwanted weight gain for example) and unskilled and/or unfriendly health care providers. Men and women have equal responsibility in their reproductive health condition and should make joint decisions in FP methods.

Research by the Guttmacher Institute (2008) in the US reports that developing countries still lavish in poverty owing to their high population rates. According to the World Population (2004), poorer couples have a tendency of having children at a relatively younger age as compared to the wealthy ones. Moreover, this study found that poorer couples have more

children throughout their lives compared to wealthy couples. Conversely, the use of modern contraceptives is only evident among wealthy couples. Thus, poorer couples are left enshrined to the traditional contraceptive use where at most time's males are reluctant to adopt. Therefore, consequences that are associated with lack of male involvement in family planning persist in such households.

2.3 The problem of HIV/AIDS

Almost three decades into the HIV/AIDS pandemic, the virus has become one of the top ten leading death causes worldwide. In low-income countries the disease even is the fifth leading death cause (WHO, 2008a). AIDS is currently recognized as more than a health and biological problem (Hasnain & Levy, 2005); it is presently a major international health concern which is threatening to wipe off the whole human existence if adequate precautions are not taken. The entire world including the Sub-Saharan African countries are exerting all kinds of precautionary efforts –not limited to medical- to curb the detriments of HIV/AIDS in their countries. However, these enormous efforts have been insignificant in quelling the prevalence of HIV/AIDS. In 2007 alone, there were 33million people with HIV/AIDS worldwide. Throughout the year, about 2.7million people became infected with the virus sand two million people died of HIV-related causes (UNAIDSS, 2008). This means that every fifteen seconds, somebody dies of AIDS and every twelve seconds, somebody is infected with AIDS (WHO, 2008b). Therefore, more panaceas are expected to be explored in order to achieve a significant annihilation of HIV/AIDS.

2.4 Problem of unintended pregnancy and induced abortion

In developing countries like Nigeria, unplanned pregnancies abound and this usually results in abortions by untrained persons with resultant cases of diseases and death. In the world nearly 350,000 women die annually while another 50 million suffer from illness and disability from

complications as a result of pregnancy related issues and child birth and Nigeria is among the first six countries that contribute to about 50% of maternal death annually. This is alarming, bearing in mind that Nigeria's contraceptive prevalence rate is still quite low even at 15% though it is an increment of about 2% from 2003 NDHS report. In industrialized countries, virtually all married women resort to contraceptives at sometimes in their reproductive period, little wonder the fertility rates in those nations are very low. In contrast however, the percentage of people reporting such huge use of contraceptives in developing countries is extremely low. As earlier reported, adopting modern contraceptive use is a very complex sociological issue in Nigeria therefore a study of contraceptive usage in Nigeria is one of the ways for providing inquiry into the factors motivating reproductive behavior. At present, it could be argued that examination of the socio-economic cultural characteristics of contraceptive adopters will provide insights into the causes of observed levels and trends in the fertility differentials in the Nigerian Context and that's what this study is set to achieve. In Nigeria, Contraceptive Prevalence Rate (CPR) is low and according to the report released by the International Women's Health Coalition in 2007, the Contraceptive Prevalent Rate among the cohort of married women aged 15-49 years indicated an all-time low of 8% for modern methods and 12% for all methods. In Nigeria, as revealed by, adopting modern contraceptive use is a rather difficult and complex issue that is highly influenced by sociological factors, cultural affiliations and religious convictions.

2.5 The problem of high fertility and rapid population growth

Nigeria has a growing population and what can also be referred to as an increasing population. The 1991 census figure put Nigerian population at about 89 million people with the growth rate of 2.82 and the total fertility rate as revealed by Post Enumeration Survey (PES) at 5.89 percent. The Nigeria Demographic and Health Survey (NDHS), (2003 and 2008) put the

total fertility rate at 5.7 percent as against that of 1999 NDHS which was 5.2 percent. Going by 2006 Nigerian National Population Census, Nigeria had a population of one hundred and forty million, three thousand and five hundred and forty two (140,003,542) (National Bureau of Statistics, 2009). The growth rate was 3.02 percent per annum. The population is capable of doubling itself in less than twenty three years. In addition, the United Nations estimates of 2009 put the Nigerian total population at one hundred and fifty one million, thirty thousand and four hundred (151,030,400). Nigeria is the most populous country in Africa and also the most populous among the black nations of the world. Globally, Nigeria is among the ten top countries with the largest population, in fact, the seventh among the countries with the largest population in the world (United Nations, 2009).

Nigeria population is increasing mostly due to the effect of the first factor, that is, high birth rate. For instance, Crude Birth Rate (CBR) was 39.0 and 44.6 in 1990 and 1991 respectively (NPC, 2000). It was 42.0 in 2003 (NDHS, 2003). All these buttress the fact that there is high CBR in Nigeria. Nigerian population has gathered momentum. It will continue to increase for some time even if there is a change favorable towards family planning and birth control. Increasing population at the expense of socio-economic development is inimical to people's wellbeing and development. An increasing population has consequences and implications most especially for a country like Nigeria.

2.4 THEORETICAL FRAMEWORK

This study is based on the social ecological theory, which suggests that an individual's behavior is associated with at least three spheres of influence: individual characteristics, interpersonal features and environmental factors. Social ecological theory was chosen because of its relevance, inclusivity and comprehensibility.

Socio-ecological models were developed to further the understanding of the dynamic interrelations among various personal and environmental factors. Socio-ecological models were introduced to urban studies by sociologists associated with the Chicago School after the First World War as a reaction to the narrow scope of most research conducted by developmental psychologists. These models bridge the gap between behavioral theories that focus on small settings and anthropological theories that analyze larger settings.

Several demographic studies have identified individual-level traits or social and demographic characteristics that affect contraceptive use, most notably formal education. According to a study from Nepal, a husband's education has a greater influence on contraceptive use than his wife's, especially in relation to male-controlled methods such as male sterilization and condoms (Gubhaju B. 1996–2006). Other individual-level factors associated with contraceptive use include spousal age difference, religion and parity.

Finally, social ecological theory proposes an association between environmental characteristics and contraceptive use. The few studies that have looked at relationships between men's contraceptive use and household and community characteristics have done so without including other characteristics. Most of those have focused on household wealth, used national-level data for developing countries and adjusted for urban-rural differences, and have found that men residing in poorer households are less likely to use contraceptives than richer men. Poor men have the lowest level of contraceptive use, which results in the highest rates of unmet need, unwanted pregnancies and fertility. Few studies have examined men's contraceptive use and community characteristics, such as neighborhood type (e.g., slum or non-slum). Furthermore, few studies have included urban men's characteristics and determined whether the level of

knowledge of contraceptive methods and socio-demographic factors together are associated with men's contraceptive use, within and across urban settings.

As it has been noted above, there is increased literature exploring the effects of men's characteristics on contraceptive use. The objective of this study is to examine associations between relationship-level characteristics and contraceptive use among men living in urban areas in Nigeria.

2.5 CONCEPTUAL FRAMEWORK

Contraceptive use is considered in this conceptual frame work as the dependent variable and the unit of analysis is ever married men. While this model is simple, it is however adequate to explain the contraceptive use in Nigeria.

The general characteristics of the population considered are age, number of living children, desired family size, residence, education, occupation, ethnicity and knowledge of contraceptive methods. Some important factors influencing contraceptive use will be examined. These are demographic, socioeconomic, and program related factors.

Current contraceptive use, the dependent variable will be classified as not using and male condom.

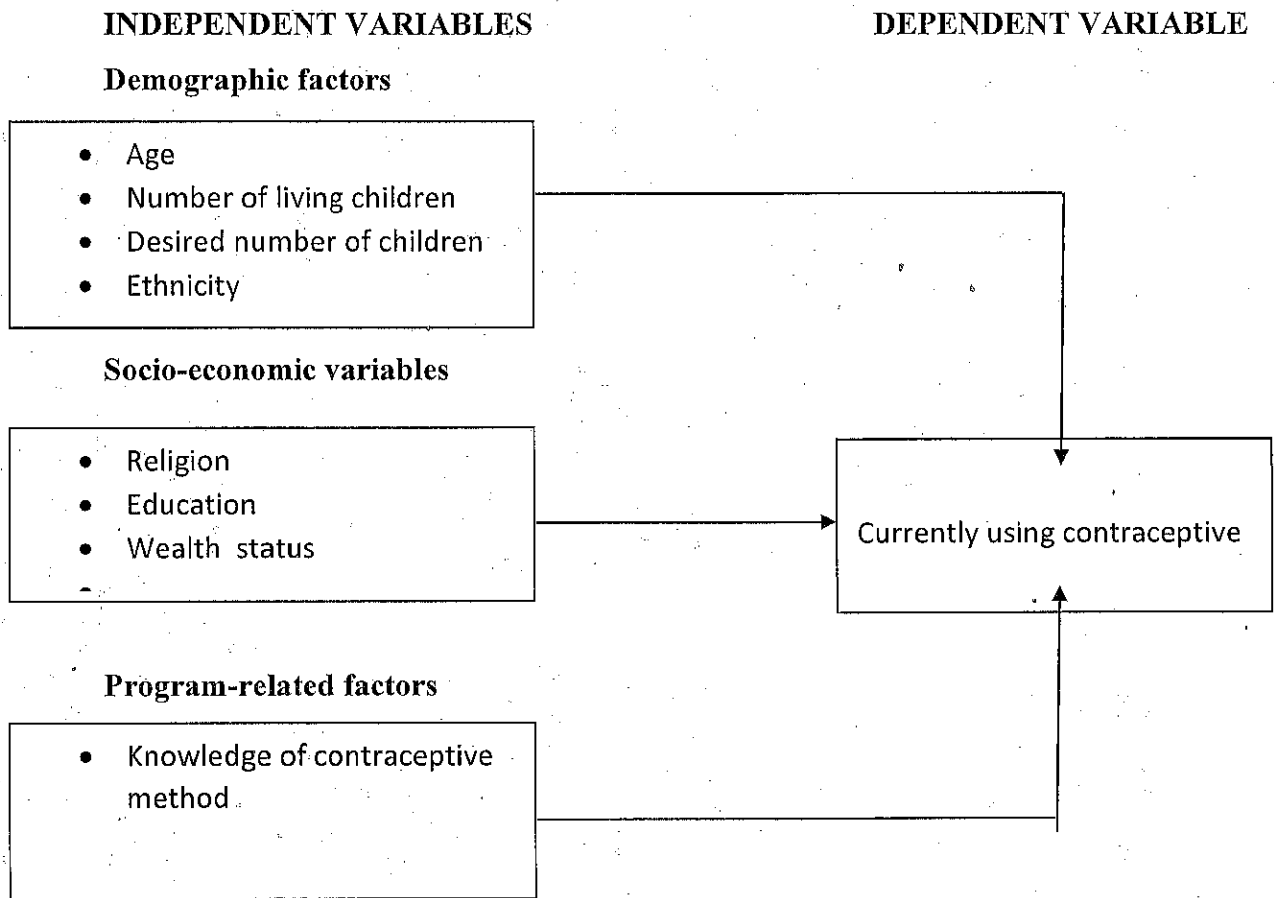
Note: According to the DHS 2013 men's recode Data Sets, male contraceptive methods includes male condom, male sterilization and withdrawal. However, this study focuses on male condom only and this is due to the fact that the percentage of men using male sterilization method is not significant and it is rather difficult to measure the number of men using the withdrawal method.

The independent variables are made up of three groups:

1. Demographic factors which comprise of age, number of living children, and desired family size, ideal family size and children ever born (CEB).
2. Socioeconomic factors which comprise of religion, education and occupation, wealth status and residence.
3. Program related factors, namely; knowledge of contraceptive methods and source of knowledge of contraceptive methods.

This framework is schematically presented below.

2.5.1 SCHEMATIC REPRESENTATION OF CONCEPTUAL FRAMEWORK:



SOURCE: Author's construct (2015)

Age, Number of living children, desired family size and ethnicity of the respondents are categories of demographic factors of the respondents which will determine the contraceptive use. The socioeconomic factors such as Education, religion and occupation will also determine the contraceptive use. Knowledge of family planning methods will also determine the contraceptive use likewise Knowledge of source of modern methods and availability of services.

2.6 HYPOTHESIS

- H_0 : Knowledge of contraceptive methods does not influence contraceptive use among urban men in Nigeria.
- H_0 : Socio-demographic factors (age, religion, level of education, marital status, employment status, wealth index, ethnicity, number of living children and knowledge of contraceptive methods) do not influence contraceptive use among urban men in Nigeria.

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 and method of data analysis.

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 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).

The South-West region is one of the geo-political zones in Nigeria that consists of six states which include: Lagos state, Ogun state, Ekiti state, Osun state, Oyo state, Ondo state. The main ethnic group in this region of the country is the Yoruba. However, the six states are majorly Yoruba speaking states and all have Yoruba origins so they can be referred to as the Yoruba's. The South-West region shares borders with the Borgu (called the Baruba and Borgawa) in the North-West, the Nupe (called the Tapa) and Ebira in the North, and the Edo, the Esan and the Afemai to the South-East.

The Yoruba kingdom of Oyo in the South-west was founded about 1400 CE and from the 17th to 19th centuries, it attained a high level of political organization and extended as far as

Republic of Togo. The kingdom of Benin had developed an efficient army, an elaborate ceremonial court and artisans whose works in ivory wood bronze and brass in the South central part of the present day Nigeria are prized throughout the world today. European traders established coastal ports for the increasing traffic in the slaves destined for the Americas in the 17th through 19th centuries. Commodity trade especially in palm oil and timber, replaced slave trade in the 19th century, most especially under anti-slavery actions by the British Navy. The Fulani leader, Usman-Dan Fodio promulgated Islam and brought most areas in the North under loose administrative control of an empire centered in Sokoto in the early 19th Century. The geographic location of the South-West fits into the classified double wet season region with the twice yearly passage of the sun. It has distinct dry season from April-July and dry season in July as well as wet season from September through October. Also, the climatic condition and the humid air, and the richness of the soil in the South-west region produce vegetations with thick forest.

Urban population refers to people living in urban areas as defined by national statistical offices. It is calculated using World Bank population estimates and urban ratios from the United Nations World Urbanization Prospects. Urban population in Nigeria was last measured at 88272292 in 2013, according to the World Bank. Urban population refers to people living in urban areas as defined by national statistical offices. It was calculated using World Bank population estimates and urban ratios from the United Nations World Urbanization Prospects. However, this study involves 4,948 respondents who are all men and also residing in the Urban part of Nigeria.

The value for urban population in Nigeria was 90,385,380 as of 2016. Over the past 56 years this indicator reached a maximum value of 90,385,380 in 2016 and a minimum value of 7,422,142 in 1960 (World Bank Staff estimates based on United Nations). Urban population in Nigeria was 48.60% as of 2016. Its highest value over the past 56 years was 48.60% in 2016, while its lowest value was in 1960. Lagos, Kano, Port Harcourt, Maiduguri, Kaduna, Jos and Ilorin had over 1000 per cent increases over three decades. Ibadan rose from 625,000 in 1963 to 2.84 million in 1982 ; Enugu rose from 174,000 in 1963 to 850,000 in 1982 ; Lagos rose from less than 1 million in 1963 to over 4 million in 1982 (Onibokun, 1987).

3.2 TARGET POPULATION

The category of eligible respondents in this study focus currently on men who lived in urban area, which was collected by the Nigeria Demographic Health Survey (NDHS) 2013.

3.3 QUANTITATIVE DATA SOURCE

This study analyses data from men recode of Nigeria Demographic and Heath Survey (NDHS) 2013 dataset.

3.4 SAMPLE DESIGN FOR THE 2013 NDHS

The sample for the 2013 NDHS was nationally representative and covered the entire population residing in non-institutional dwelling units in the country. 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. The sample was designed to provide population and health indicator estimates at the national, zonal, and state levels. The sample design allowed for specific indicators to be calculated for each of the six zones, 36 states, and the Federal Capital Territory, Abuja. The 2013 NDHS sample was selected using a stratified three-stage cluster design consisting of 904 clusters, 372 in urban areas and 532

in rural areas. A representative sample of 30,327 households was selected for the survey, with a minimum target of 943 completed interviews per state. A fixed sample take of 45 households were selected per cluster.

All men who was either permanent residents in urban area of the households in the 2013 NDHS sample or visitors present in the households on the night before the survey were eligible to be interviewed (Nation Population NPC&ICF International Commission, 2014).

3.4 SAMPLE SIZE

All men age 15-49 years who were either permanent residents in urban area of the households in the 2013 NDHS sample or visitors present in the households on the night before the survey were eligible to be interviewed. The sample size of men age 15-49 years that will be used are 15, 545 respondents in urban area of Nigeria.

3.5 DEPENDENT VARIABLE: FAMILY PLANNING

This study use the NDHS concepts of contraceptives use to denote the prevalence of family planning. The criteria of contraceptive that is use of contraception. Current contraceptive use, the dependent variable will be classified as 'using', 'not using' male condom.

According to the DHS 2013 men's recode data sets, male contraceptive methods includes male condom, male sterilization and withdrawal. However, this study focuses on male condom only and this is due to the fact that the percentage of men using male sterilization method is not significant and it is also difficult to measure the number of men using the withdrawal method.

3.6 INDEPENDENT VARIABLE

NAME OF VARIABLE	VARIABLE MEASUREMENT AND CODES	DATA RECORDED AND MANIPULATION
Dependent Variable: <ul style="list-style-type: none"> • Contraceptive use 	mv761 (Categorical)	Yes, No
INDEPENDENT VARIABLE:		
Socio economic factors: <ul style="list-style-type: none"> • Level of education 	mv106 (Categorical) No education, primary, secondary, Higher.	The same categories
<ul style="list-style-type: none"> • Wealth index 	mv190 (categorical) Poorest, Poorer, Middle, richer, richest.	Poor Middle Rich

<ul style="list-style-type: none"> • Occupation 	mv717(categorical) not working, sales, professional/technical/managerial, agricultural, household and domestic service, manual, clerical	Not employed Employed
<ul style="list-style-type: none"> • Religion 	mv130(Categorical) Catholic, Other Christian, Islam, Tradition, Others	Three main ethnic group: Yoruba, Hausa, Igbo and other Minority ethnic groups
Socio-demographic Factors <ul style="list-style-type: none"> • Age 	mv013(categorical) 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, and 45-49.	The same categories
<ul style="list-style-type: none"> • Number of living children 	mv218(continuous)	No children,1-4 children, more than 4 children

<ul style="list-style-type: none"> Desired family size. 	Mv614 (categorical) 0, 1, 2, 3, 4, 5, 6+	The same categories
Program related factors: <ul style="list-style-type: none"> Knowledge of contraceptive methods 	Mv301 (categorical) Knows no method Knows only folkloric method Knows only traditional method Knows modern method	The same categories

3.7 DATA PROCESSING AND ANALYSIS

The NDHS datasets from 2013 women recode will be processed and analyzed using Stata application package (STATA 13.0). The data processing will be 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 will be carried out using tables of frequency distribution to describe the background characteristics of the respondents and the bivariate analysis will be done using the Chi-square (χ^2) test to show the association between contraceptive use and 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 the influence of socio economic and demographic characteristics on contraceptive use in the study area.

3.8 LIMITATIONS OF THE STUDY

- One of the limitations of this study is that not all the data contained in the NDHS for Male respondents which constitutes the quantitative data was able to serve adequately the purpose of this work, there may be some other factors influencing use of any contraceptive method that are not contained in the NDHS 2008.
- Also only data about the men age 15-49 was available; there was no information for age 50 and above.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.0 INTRODUCTION

This chapter deals with presentation, analysis and interpretation of the data collected from secondary sources Nigeria Demographic and Health Survey (NDHS, 2013) to show the socio-demographic characteristics effect on contraceptive use among urban men in Nigeria. For the purpose of analysis, this study makes use of descriptive analysis and inferential analysis. However, in supportive of descriptive statistics, inferential analysis, pearson Chi-square test was used to ascertain relationship while binary logistic regression analysis was used in testing the study hypothesis.

4.1: Distribution of Urban Men by Socio-Demographic Characteristics by Weighted Percentage.

Results in Table 4.1 below showed men socio-economic and demographic characteristics. It was reported that urban men age 15-19 years were 21.4%, age 20-24 years by 17.4%, age 25-29 years by 15.8%, age 30-34 years and 35-39 years by 14.7% and 12.3% respectively, age 40-44 years and 45-49 years were 9.6% each. Urban men reported mostly from northern region by 8.7% and those from southern region reported by 41.2%. Urban men attained secondary education by 59.1%, no formal education by 6.2%. primary education and highest education were reported by 12.5% and 22.2% respectively. Also, urban men were mostly hausa by 24.1%, Yoruba and Igbo ethnic group were reported by 25.2% and 22.5% respectively. Muslim men were reported by 43.4%, Christian and traditional region were reported by 56.1% and 0.5% respectively. Men reported more to be rich by 79.4%, poor and middle wealth status were reported by 6.8% and 13.8% respectively. Urban men were employed by 74.7% and those that are not employed were 25.2%. Urban men reported no number of living children by 59.2%, 1-4 children by 30.5% and those reported to have living children above 4 children were 10.3%. Ideal number of children was reported mostly above 6 children above by 36.9%, 4 children by 26.6%,

5 children by 19.6%, those reported to have 3 children and 2 children ideal number were 12.9% and 3.1% respectively and less than 2 children were 0.9%. Urban men reported to know modern contraceptive method by 97.6%, know no method were 2.3%, know traditional and folkloric methods by 0.1% and 0.0% respectively.

Background Characteristics	Frequency	Percent (%)
Age		
15-19	1,541	21.4
20-24	1,255	17.4
25-29	1,139	15.8
30-34	1,054	14.7
35-39	886	12.3
40-44	693	9.6
45-49	626	8.7
Total	7,194	100.0
Region		
North Central	980	14.5
North East	621	9.2
North West	1,197	17.8
South East	1,045	15.5
South South	1,004	14.9
South West	1,892	28.1
Total	6,739	100.0
Educational level		
No education	445	6.2
Primary	901	12.5
Secondary	4,249	59.1
Highest	1,599	22.2
Total	7,194	100.0

Ethnicity		
Yoruba	1,811	25.2
Hausa	1,735	24.1
Igbo	1,618	22.5
Others	2,031	28.2
Total	7,194	100.0
Religion		
Christian	4,015	56.1
Islam	3,112	43.4
Traditional	37	0.5
Total	7,163	100.0
Wealth Index		
Poor	485	6.8
Middle	994	13.8
Rich	5,714	79.4
Total	7,194	100.0
Occupation		
Not employed	1,802	25.2
Employed	5,326	74.7
Total	7,128	100.0
Number of living children		
No children	4,262	59.2
1-4 children	2,195	30.5
More than 4 children	737	10.3
Total	7,194	100.0
Condom used during sex with most recent partner		
Yes	3,239	72.2

No	1,247	27.8
Total	4,487	100.0
Ideal number of children (grouped)		
0	37	0.5
1	30	0.4
2	224	3.1
3	928	12.9
4	1,916	26.6
5	1,408	19.6
6+	2,651	36.9
Total	7,194	100.0
Knowledge of any contraceptive method		
Knows no method	163	2.3
Knows only folkloric method	1	0.0
Knows only traditional method	7	0.1
Knows modern method	7,023	97.6
Total	7,194	100.0
Contraceptive Use		
Not using	4,849	71.9
Using	1,890	28.1
Total	6,739	100.0

4.2.: Distribution of Urban Men by Socio-Demographic Characteristics and of Contraceptives use.

Result from table 4.2 below revealed that there is significant association between women socio-demographic characteristics and contraceptives use among men ($P < 0.05$). There is significant association between age and contraceptives use ($X^2 = 1270.70$, $P = 0.0000$) urban men age 20-24 years reported contraceptive use by 28.8%, age 25-29 years by 26.9%, age 30-34 years and age 35-39 years by 17.2% and 10.1%, age 15-19 years by 8.7%, age 40-44 years and age 45-49 years by 4.8% and 3.6% respectively compare to those reported non-using of contraceptives. There is significant association between age and contraceptives use ($X^2 = 1070.21$, $P = 0.0000$) urban men from southern region reported contraceptive use by 70.1% where those from northern region reported by 30.1% compare to those reported non-using of contraceptives. There is significant association between level of education and contraceptives use ($X^2 = 985.95$, $P = 0.0000$) urban men that attained secondary education use contraceptive by 59.1%, highest education by 29.2%, primary education and no formal education by 9.8% and 1.8% respectively compare to those reported non-using of contraceptives. There is significant association between ethnicity and contraceptives use ($X^2 = 952.94$, $P = 0.0000$) urban men that were Igbo use contraceptives by 25%, Yoruba and Hausa by 23.4% and 3.5% respectively compare to those reported non-using of contraceptives.

Furthermore, there is significant association between religion and contraceptives use ($X^2 = 717.57$, $P = 0.0000$) urban men that were Christian uses contraceptives by 78.9%, muslim and traditional religion by 20.7% and 0.4% respectively compare to those reported non-using of contraceptives. There is significant association between wealth index and contraceptives use ($X^2 = 852.85$, $P = 0.0000$) urban rich men uses contraceptive by 74.9%, middle wealth status and poor

urban men by 17.4% and 7.7% respectively compare to those reported non-using of contraceptives. There is significant association between occupation and contraceptives use ($X^2 = 672.4$, $P = 0.0000$) urban men that were employed uses contraceptives by 80.3% and those that were not employed by 19.7% compare to those reported non-using of contraceptives. There is significant association between number of living and contraceptives use ($X^2 = 2176.58$, $P = 0.0000$) urban men reveal no children by 74.5%, 1-4 children by 21.4% and those with 4 children above were 4.1% compare to those reported non-using of contraceptives. There is significant association between ideal number of children and contraceptives use ($X^2 = 1241.79$, $P = 0.0000$) urban men reported to have ideal number to be 4 children by 35.5%, 5 children by 21.5%, more than 6 children above were 20%, those reported to have 3 children and 2 children as ideal number were 18.8% and 3.8% respectively, those urban men reported to have less than 2 children as ideal were 1.7% compare to those reported non-using of contraceptives. There is significant association between knowledge of contraceptives method and contraceptives use ($X^2 = 78.35$, $P = 0.0004$) urban men that knows modern methods uses contraceptives by 100% compare to those reported non-using of contraceptives.

Table 4.2.: Distribution of Urban Men by Socio-Demographic Characteristics and of Contraceptives use.

Background characteristics	Condom used during last sex with most recent partner		Statistics
	No	Yes	
Age			
15-19	2.6	8.7	
20-24	8.4	28.8	
25-29	16.6	26.9	$X^2=1270.70$
30-34	19.1	17.2	$Pr=0.0000$
35-39	19.7	10.1	
40-44	17.0	4.8	
45-49	16.6	3.6	
Region			
North Central	13.9	20.9	
North East	14.8	4.1	$X^2=1070.21$
North West	33.0	5.1	$Pr=0.0000$
South East	7.6	17.4	
South South	14.5	26.1	
South West	16.2	26.6	
Educational level			
No education	27.6	1.9	
Primary	20.7	9.8	$X^2=985.95$
Secondary	37.0	59.1	$Pr=0.0000$
Highest	14.7	29.2	
Ethnicity			

Yoruba	13.0	23.4	$X^2= 952.94$ Pr=0.0000
Hausa	35.1	3.5	
Igbo	10.9	25.0	
Others	41.0	48.1	
Religion			
Christian	46.1	78.9	$X^2=717.57$ Pr=0.0000
Islam	52.6	20.7	
Traditional	1.4	0.4	
Wealth Index			
Poor	39.5	7.7	$X^2=852.85$ Pr=0.0000
Middle	17.8	17.4	
Rich	42.7	74.9	
Occupation			
Not employed	3.7	19.7	$X^2=672.45$ Pr=0.0000
Employed	96.3	80.3	
Number of living children			
No children	21.7	74.5	$X^2=2176.58$ Pr=0.0000
1-4 children	52.3	21.4	
More than 4 children	26.0	4.1	
Desire number of family size			
0	0.2	1.4	$X^2=1241.79$ Pr=0.0000
1	0.1	0.3	
2	1.8	3.8	
3	6.0	18.8	
4	15.6	35.5	
5	16.1	21.5	
6+	60.2	20.0	
Knowledge of any contraceptive			

method			
Knows no method	2.7	0.0	X ² = 78.35 Pr=0.0004
Knows only traditional method	0.4	0.0	
Knows modern method	0.6	0.0	
	96.3	100.0	

SOURCE: AUTHOR'S CONSTRUCT 2018

4.3: Odds Ratio Based on Logistic Regression Analysis of Socio-Demographic Characteristics and Contraceptives Use.

Table 4.3 below showed the result of binary logistic regression of the effect of men socio-demographic characteristics on contraceptives use among men. Result revealed that urban men age 40-44 years were 57% less likely to use contraceptives to urban men age 15-19 years (RC). Urban men age 45-49 years were 59% less likely to use contraceptives to urban men age 15-19 years (RC). Urban men from north-east were 0.40 times less likely to use contraceptives to urban men from north-central (RC). Urban men from north-west were 0.29 times less likely to use contraceptives to urban men from north-central (RC). Urban men from south-west were 0.66 times less likely to use contraceptives to urban men from north-central (RC). Also, urban men with primary education were 2.13 times more likely to use contraceptives than urban men with no formal education (RC). Urban men with secondary education were 2.92 times more likely to use contraceptives than urban men with no formal education (RC). Urban men with highest level of education were 2.92 times more likely to use contraceptives than urban men with no formal education (RC). Hausa men from urban area were 0.46 times less likely to use contraceptives than urban men from Yoruba ethnic group (RC). Urban men with middle wealth status were 76%

more likely to use contraceptives than urban men that are poor (RC). Rich urban men were 2.39 times more likely to use contraceptives than urban men that are poor (RC).

Table 4.3: Odds Ratio Based on Logistic Regression Analysis of Socio-Demographic Characteristics and Contraceptives Use.

BACKGROUND	Odd Ratio	Lower-Upper confidence interval	Upper-Lower confidence interval
Age			
15-19 (RC)	1.00		
20-24	1.4	0.97	2.01
25-29	0.98	0.67	1.42
30-34	0.77	0.5	1.15
35-39	0.64	0.4	1.01
40-44	0.43**	0.26	0.71
45-49	0.41**	0.24	0.69
Region			
North Central (RC)	1.00		
North East	0.40***	0.27	0.61
North West	0.29***	0.18	0.45
South East	0.88	0.6	1.29
South South	0.81	0.6	1.07
South West	0.66**	0.48	0.9
Educational level			
No education (RC)	1.00		
Primary	2.13**	1.27	3.57
Secondary	2.92***	1.84	4.65

Highest	3.58***	2.21	5.8
Ethnicity			
Yoruba (RC)	1.00		
Hausa	0.46**	0.28	0.74
Igbo	1.03	0.74	1.44
Others	0.75	0.58	0.98
Religion			
Christian (RC)	1.00		
Islam	1.19	0.88	1.41
Traditional	0.38	0.17	0.85
Wealth Index			
Poor (RC)	1.00		
Middle	1.76***	1.29	2.41
Rich	2.39***	1.73	3.3
Desire number of family size			
0 (RC)	1.00		
1	14.09	1.55	128.03
2	8.72	1.39	54.85
3	8.62	1.41	52.7
4	7.01	1.15	42.68
5	5.18	0.85	31.68
6+	3.56	0.58	21.76
Occupation			
Not employed	1.00		
Employed	0.74	0.59	0.93
Number of living children			
No children (RC)	1.00		
1-4 children	0.22	0.18	0.27

More than 4 children	0.24	0.18	0.34
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RC means the reference categories *P<0.05 **p<0.01 ***p<0.001

HYPOTHESIS TESTING

- *H₀*: Socio-demographic factors (age, religion, level of education, marital status, employment status, residence, wealth index, ethnicity, number of living children and knowledge of contraceptive methods) do not influence contraceptives use among urban men in Nigeria.
- *H₀*: Knowledge of contraceptives methods do not influence non-use of contraceptives among urban men in Nigeria.

Decision

From the binary logistic regression, the relationship between socio demographic determinants and family planning utilization is statistically significant in ($P < 0.05$), from this, we can conclude that there is a significant relationship between socio-demographic characteristics among women (Desired number of children and number of living children) and non-use of contraceptives among men.. Therefore we fail to accept the first null hypothesis.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECCOMENDATIONS

5.0 INTRODUCTION

This chapter is devoted to the presentation of the summary of findings, conclusion and recommendations drawn from the analysis of the research study. The overall objective of this study is to explore the factors that influence contraceptive use among urban men in Nigeria. The study was based on the sample size of 16,324 men of reproductive ages in the study area.

5.1 SUMMARY OF THE FINDINGS

The result from the univariate analysis showed that urban men age 15-19 years was highly reported, followed by age 20-24 years, age 25-29 years, age 30-34 years and 35-39 years, the least reported were age 40-44 years and 45-49 years. Urban men reported mostly from northern region than those reported from southern region. Urban men attained secondary education more, followed no formal education, primary education and highest education. Also, urban men were mostly hausa, followed by Yoruba and Igbo ethnic group. Muslim men was mostly reported, followed by Christian and traditional religion. Men reported more to be rich, followed by poor and middle wealth status. Urban men was employed than those that are not employed. Urban men reported no number of living children more, followed by 1-4 children and those reported to have living children above 4 children. Ideal number of children was reported mostly above 6 children above, followed by 4 children, 5 children, those reported to have 3 children and 2 children ideal number and less than 2 children was least reported. Urban men reported more to knows modern contraceptive method, followed by knows no method, knows traditional and folkloric methods. Source of contraceptive was reported from private sector, followed by other sources and public sector.

The result from the bivariate analysis showed significant association between age, region, level of education, ethnicity, religion, wealth index, occupation, number of living children, ideal number of children, knowledge of contraceptive method and contraceptives use ($X^2 = 1270.70$, P

=0.0000, $X^2 = 1070.21$, $P = 0.0000$, $X^2 = 985.95$, $P = 0.0000$, $X^2 = 952.94$, $P = 0.0000$, $X^2 = 717.57$, $P = 0.0000$, $X^2 = 852.85$, $P = 0.0000$, $X^2 = 672.4$, $P = 0.0000$, $X^2 = 2176.58$, $P = 0.0000$, $X^2 = 1241.79$, $P = 0.0000$, $X^2 = 78.35$, $P = 0.0004$).

Result revealed that urban men age 40-44 years were 57% less likely to use contraceptives to urban men age 15-19 years (RC). Urban men age 45-49 years were 59% less likely to use contraceptives to urban men age 15-19 years (RC). Urban men from north-east were 0.40 times less likely to use contraceptives to urban men from north-central (RC). Urban men from north-west were 0.29 times less likely to use contraceptives to urban men from north-central (RC). Urban men from south-west were 0.66 times less likely to use contraceptives to urban men from north-central (RC). Also, urban men with primary education were 2.13 times more likely to use contraceptives than urban men with no formal education (RC). Urban men with secondary education were 2.92 times more likely to use contraceptives than urban men with no formal education (RC). Urban men with highest level of education were 2.92 times more likely to use contraceptives than urban men with no formal education (RC). Hausa men from urban area were 0.46 times less likely to use contraceptives than urban men from Yoruba ethnic group (RC). Urban men with middle wealth status were 76% more likely to use contraceptives than urban men that are poor (RC). Rich urban men were 2.39 times more likely to use contraceptives than urban men that are poor (RC).

CONCLUSION

This study conclude that base on the facts from the result that some factors such age, region, level of education, wealth index, ethnicity on non-use of contraceptive among urban men in Nigeria where p-value less than five percent level of significant.

RECOMMENDATION

1. Education is one way of empowering the men utilization of contraceptives. Hence the high existing knowledge as showed in this study should be encouraged. It may be the only way that men in urban area have access to appropriate reproductive health education in situations where discussion of this is a taboo at their homes and community and hence they have to rely on the peers who are poorly informed.
2. The Ministry of Health (MOH) should promote use of dual protection that is condoms: The study showed more use of the Emergency pill as compared to condoms, therefore, it should be emphasized that if men have to have safe sexual activities, both prevention of STIs as well as unplanned pregnancy is very important; knowledge about condom use should be a priority.
3. Parents and teachers were the least sources of information on SRH hence, the Ministry of Education & Sub- County education office should develop age specific SRH curriculum that is, tailored age specific information on adolescent SRH to strengthen parent- child communication.
5. Male involvement in ASRH: Men in the community should be involved in shouldering the burden of adolescent contraception and pregnancy.

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