

**FACTORS ASSOCIATED WITH MEN'S  
PARTICIPATION IN THE CHOICE OF  
FAMILY PLANNING IN OYE EKITI, NIGERIA.**

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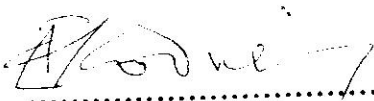
**A RESEARCH PROJECT SUBMITTED TO THE DEPARTMENT OF  
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## CERTIFICATION

This is to certify that OLORUNSOLA TAIWO OLUWAKEMI of the Department of Demography and Social Statistics, Faculty of Social Sciences, carried out a Research on the Topic **FACTORS ASSOCIATED WITH MEN'S PARTICIPATION IN THE CHOICE OF FAMILY PLANNING IN OYE EKITI** in partial fulfillment of the requirement for the award of Bachelor of Science (B.Sc) in Federal University Oye-Ekiti, Nigeria under my Supervision

  
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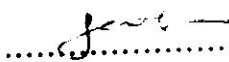
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## **DEDICATION**

The project is dedicated to Almighty God who with his power bestowed on me wisdom, knowledge and understanding during the course of my study in this institution.

## ACKNOWLEDGEMENTS

This research would not have been possible without the guidance and the help of several individuals who in one way or the other contribute and extended their valuable assistance in the preparation and completion of this study

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## ABSTRACT

The study examined men's involvement in the choice of family planning in Oye Ekiti, Nigeria. Using employed self-administered questionnaires, the use of frequency distribution table, Chi square and bivariate logistic model in analyses of variables. The results of the analysis revealed that 89.7% of respondents were involved in the choice of family planning. At bivariate level, wife's age ( $\chi^2$  13.0  $p=0.004$ ) were found to be significantly associated with men's involvement in the choice of family planning. In the multivariate analysis, result from the binary logistic regression revealed significant association between education and men involvement in the choice family planning. In addition age, religion, ethnicity wealth index were also found to be significantly related to men involvement in family planning. The study therefore concluded that education, age, income are the factors to be considered in designing intervention programs to increase men's involvement in the choice of family planning.

# CHAPTER ONE

## INTRODUCTION

### 1.0 BACKGROUND OF THE STUDY

Worldwide, there is a growing consensus that a good approach to family planning would help in achieving the Millennium Development Goals MDGs (Population Reference Bureau, 2014). Fostering family planning practice alleviates poverty, accelerates socio-economic development, increases child schooling, promotes gender equality, and decreases maternal and infant mortality (UNFPA, 2014). In the past five decades, there has been a reproductive revolution in many developing countries, leading to large fertility decreases in Asia, Latin America and North Africa. Sub-Saharan Africa, however, has not experienced the same rapid trend, and today, the region still has total fertility rates (TFR) of around five births per woman (Adagala, 2014).

Family planning utilization is an important factor in demography; in fact, it's a very important factor that aids population change (fertility, mortality and migration) either positively or negatively. Contraception is a method in family planning that is used for the prevention of unwanted pregnancy. Family planning use is the percentage of men or women that are using one method of contraception regardless of the method. According to Nelson 2001, he sees family planning as a system of limiting family size and the frequency of child bearing by the appropriate use of contraceptive techniques. On the issue of health family planning as a health service that keeps couples decide whether to have children and if so, when and how many children they want (Nelson, 2001).

Family planning (FP) refers to practices that help couples to attain certain objectives; avoid unintended pregnancies, regulate intervals between pregnancies; control the time at which birth occurs in relation to the ages of the parents and determine the number of children in the family

(WHO Expert Committee, 1971). It empowers men and women to have control over their own fertility. An important cause for these high fertility rates in African countries is the low availability and use of family planning services. The contraceptive prevalence rate (CPR) and unmet need for family planning in 2012 in Sub-Saharan Africa was 25.7 % and 25.1 % respectively, compared to 62.5 % and 12.4 % in all developing countries combined (Butto, and Mburu, 2015).

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 have all asserted the domineering position of men on reproductive health matters (Capova, 2014). 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, 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 (Egbe and Ketchen, 2016).

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-Sahara Africa could not be used properly because of all kinds of activities and policies are being concentrated mainly for women (Clark, 2008). The World Health Organization (WHO) gives a clear outline of the reproductive health, it declared that reproductive health means a state of total physical, psychological and social well-being, and just not the absence of disease or illness. Reproductive health includes reproductive processes, functions and system at all stages of life

(UNFPA, 2014). 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).

This organization considers all aspects of reproductive life such as people are able to have a responsible, satisfying and safe sexual life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so (UNFPA, 2014). They emphasize that men and women have equal right to get information about reproductive health and access to safe and satisfactory methods of fertility control and the ability to access to appropriate health care services (UNFPA, 2014).

It is clear that male's involvement in family planning and reproductive health may improve equality in gender relation, promoting better relationship between men and women through which they can take decision regarding family planning jointly and equal responsibility of sexual behavior (Hossain, 2003). . This study therefore investigates the men's involvement in the choice of family planning and reproductive health systems. It is designed to identify men's involvement in the choice among men in Oye-Ekiti, Ekiti-State, Nigeria.

### **1.1. STATEMENT OF PROBLEM**

The low contraceptive prevalence rate is a problem common to both urban and rural areas of the country. (UNFPA, 2000); All socio-economic 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 relatively new, it may not be strong enough to motivate new acceptors.

It is therefore very timely to conduct studies into factors influencing non-use of contraceptives 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 (Tilahun, Temmerman, and Degomme. 2015).

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, well-managed family planning programs are highly effective and could achieve smaller family size in a wide variety of socio-cultural and economic setting (Sadik, 1991).

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 high rate of unintended pregnancy in the region. Unintended 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 (Kishore, 2014).

It is widely acknowledge that men in developing countries make most of the decisions regarding family formation (Govinda, 2008). Despite women's increasing influence on household decision making their preferences regarding contraceptive choices and family size may not translate into practice unless they conform to their husbands' wishes. Men, in their capacity as key household decision-makers and community leaders are essential to successful scale-up of strategies designed to increase contraceptive use. Indeed, promoting contraceptive uptake and reducing undesired pregnancies require engaging men as key stakeholders (Hamed, El-gazzar, and Moftah, 2018).



## **1.2 RESEARCH QUESTION**

1. What proportion of men is involving the choice of family planning in Oye-Ekiti, Ekiti-State, Nigeria?
2. Does educational status influence men's involvement in the choice of family planning in Oye-Ekiti, Ekiti-State, Nigeria?
3. What other factors influences men's involvement in the choice of family planning in Oye-Ekiti, Nigeria?

## **1.3 GENERAL OBJECTIVES**

The main objectives of the study is to examine the determinants of men's involvement in the choice of family planning in Oye-Ekiti, Ekiti-State, Nigeria.

### **1.3.1 SPECIFIC OBJECTIVES**

To know the proportion are:

1. To know the proportion of men involving in the choice of family planning in Oye-Ekiti, Ekiti-State, Nigeria.
2. To examine the influence of education on men's involvement in the choice of family planning in Oye-Ekiti, Ekiti-State, Nigeria.
3. To determine other factors influencing the involvement of men in the choice of family planning in Oye-Ekiti, Ekiti-State, Nigeria.

## **1.4. 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 (Butto, and Mburu, 2015).

## 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.

**Family Planning:** Refers to measures that could be adopted in regulating occurrence of birth.

**Choice:** an option, a decision; an opportunity to choose or select something

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.0 INTRODUCTION**

This chapter presents the descriptive study designed to examine the knowledge and choice of men involvement of family planning in oye-ekiti, ekiti-state, Nigeria. This chapter also presents the conceptual framework to be used in the analysis of data.

##### **2.1.1 CONTRACEPTIVE PRACTISE AMONG MEN**

The effort towards contraceptive use focus primarily on women, with less attention to men. Efforts to expand the vision for constructive male engagement are evolving from encouraging men to be supportive partners of women's reproductive health to also focus on meeting men's own reproductive health needs and engaging men as contraceptive users and agents of change in families and communities (Author and Shisoka, 2015).

Contraception is increasing throughout the world. Contraceptive prevalence is defined as a measurement of the percentage of women who report usage of at least one method of contraception by themselves and/or their partners. Globally, contraceptive prevalence has increased from 54.8% in 1990 to 63.3% in 2010, and increasing contraceptive use has decreased the amount of maternal deaths by 40% over the past 20 years (Butto, and Mburu, 2015). Contraception is credited primarily for its role in bringing down the birth rates globally and particularly in developing countries. From 1950 to 2000, the global fertility has fallen by about half - from five children per woman in 1950-1955 to 2.7 children in 2000-2005 (Onyango, Owoko and Oguttu, 2010). However, less well recognized is the contribution of contraceptives to the major social change around the world whereby couples are empowered in regulating their fertility

instead of considering it as a matter of God's will or destiny. Family planning also has an impact on reproductive health and development, an aspect that is often glossed over.

The World Health Organization (WHO) estimated in 2012 that 287,000 maternal deaths occurred in 2010; sub-Saharan Africa (56%) and Southern Asia (29%) accounted for the global burden of maternal deaths (WHO, 2012). Countries still have to solve their rapid and uncontrolled increase in population. It is well documented that men's general knowledge and attitude concern the ideal family size, gender preference of children, ideal spacing between child births, and contraceptive methods used greatly influence women's preferences and opinions (Tilahun, Temmerman, and Degomme, 2015).

The contraceptive method used can help ensure healthiest timing and spacing of pregnancy, hence, regulating fertility. As fertility falls, so do infant, child, and maternal mortality. Women spend decreasing proportions of their lifetimes giving birth and caring for young children (World Bank, 1993). Contraception plays a key role in decreasing maternal mortality. They provide significant protection for women by preventing unintended pregnancies, which often end in unsafe abortions (Butto, and Mburu, 2015). However, fertility and family planning research programs have ignored men's roles in the past, focusing on women's behavior and services are traditionally presented within the context of maternal and child health (Oyediran, Ishola and Feyisetan, 2002). 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 (Oyediran, Ishola and Feyisetan, 2002). While reproduction involves both women and men and some contraceptive methods require the active

participation of men, organized family planning efforts in the developing world since the 1960s and global initiatives focus primarily on women, with less attention to men. Yet, it is increasingly clear that family planning cannot be successful without engaging men and that “unless men are actively engaged in supporting better health and well-being for family and the empowerment of women, progress will remain slow...” (IGWG, 2009). Attention to gender at the 1994 International Conference on Population and Development (ICPD) resulted in a call to involve men more actively in reproductive health (Drennan, 1998; Boender et al. 2004), although some questioned whether attention to men would take away from meeting women’s reproductive health needs (Berer, 1996). Since the ICPD, this expanded perspective on family planning programs has led to a range of strategies to involve men in family planning and reproductive health. Yet, the framing of ICPD emphasized men as partners to support the autonomous decisions of women regarding reproductive health, with less regard for men’s reproductive health and rights (Inhorn, 2014).

### **2.1.2 FAMILY PLANNING IN SUB-SAHARAN AFRICA**

In Sub-Saharan Africa, there is an increased focus on strategies to reduce fertility rates, which has been incorporated in the Millennium Development Goals to improve maternal and child health. In many Sub-Saharan African countries, the goal of increasing contraceptive uptake remains tenuous (Onwejekwe O E, 2012). Many programs throughout the area have received funding in an attempt to address the high levels of unmet needs in family planning. However, despite these programs, uptake of contraceptives in Africa has remained relatively (Cleland and Ali, 2006). According to (Ojediran, 2006 and Abiodun, 2009), The rates of maternal mortality is among the highest in the world in Sub-Saharan Africa, most times high as 1 maternal death per 100 births. Because of the low prevalence of contraceptives usage, rates of unintended pregnancies

are high, and as many as 50% result in elective abortions. Abortions in Sub-Saharan Africa are often performed under unsafe and secretive conditions, with approximately 25% resulting in serious complications which account for 20–40% of maternal death (Oye-Adediran, 2006 and WHO, 2004). Family planning methods such as contraceptives can protect women from unintended pregnancies, thus reducing the number of unsafe pregnancies and abortions that make result. In fact, if high risk pregnancies were eliminated from Sub-Saharan Africa, maternal mortality rates could fall by 25% (Ojediran, 2006).

Many studies have identified misinformation, misperceptions, and fear of health side effects to be barriers to regular contraceptive use in Sub-Saharan Africa. Research also reports severe misconceptions about women's own fertility and reproductive system. For instance, some female adolescents in Ghana did not believe they were old enough to get pregnant, though were at least 15 years of age (Campbell, 2014). Others believed that it was not possible to get pregnant during first intercourse. Also in Ghana, between 2003 and 2008, contraceptive use fell from 26 to 18% in large part due to fear of side effects from modern contraceptives. Hindin and colleagues, 2014 found that women felt that contraceptives caused illness and made them gain weight. Others were concerned that contraceptive use would cause a change in the menstrual patterns that could result in infertility later in life. In Nigeria, reasons for nonuse have included fear of side effects, partner objection, and religious conflicts, with the fear of side effects largely fueled by misinformation (Balogun and Abiodun, 2009). Evidence from other studies in Nigeria support that feared side effects also include damage the womb and difficulties with future ability to have children, and in fact, women who are older and have had children are more likely to being accepting of, and use contraceptives (Zewdie T, 2014).

The role of men in couples' contraceptive choices cannot be ignored either. Because of the patriarchal society present in many Sub-Saharan African countries, men's perceptions regarding contraceptive are the primary influences over couples' behaviors (Nwachukwu and Akinyemi, 2011). Studies have noted that women identify their fear of partner's reaction or disclosure as a barrier to contraceptive uptake and use (Teye J, 2013). One study found that male partners' disapproval for contraceptive use was as high as 84%, and another study concluded that as many as 50% of women said that they would immediately discontinue use of a family planning method if their husband disapproved. The societal importance of large families also poses an extreme challenge to regular uptake and use of modern contraceptives (Eaton, 2003). African men play important roles in the decisions about family life, including fertility and family planning. However, fertility and family planning research and programs have ignored their roles in the past, focusing only on women's behaviors. Since the 1994 International Conference on Population and Development (ICPD), interest in men's involvement in reproductive health has increased. Unfortunately, data on their knowledge and use of contraception are generally scanty.

Nigeria in particular remains a focus for increasing contraceptive use, as it is one of the most populous countries in Sub-Saharan Africa. Nigeria has a high total fertility rate (TFR), estimated to be between 5.5 and 5.7 for women of reproductive age (15–49). Low rates of contraceptive use are also pervasive in Nigeria (NDHS, 2013). Approximately 15% of married women report using contraceptives and 16% report an unmet need for family planning service. The majority of contraceptive users in Nigeria rely on modern methods (10% of currently married women), 5% use traditional methods, 3% use injectible, and 2% use male condoms or pills as a method of (NDHS, 2013).

## **FAMILY PLANNING IN NIGERIA**

There are approximately 35 million women of reproductive age in Nigeria, and the country had nearly 7 million births in 2012 alone (Family planning summit; 2012). According to the 2013 NDHS, 15.1 percent of married women of reproductive age (15-49) are using any contraceptive method; However, only 9.8 percent of these women are using modern FP methods. This national rate has largely remained at this level in the late 1990s. The modern method mix predominantly comprises condoms, pills, and Injectables. The current contraceptives prevalence (CPR) as at 2013 is 15% and the modern CPR is 10%, however, little progress has made over past five years because the goal announced at the London family planning summit was to increase CPR to 36% in 2018(Onyebuchukwu,2014).

Talking about the knowledge of Contraceptive use prevalence and fertility, it has increased worldwide due to the development and introduction of modern contraceptives and the establishment of organized family planning programs. Family planning also ensures that resources are available to raise a child in significant amount which includes time, finance and social information, education and communication strategies to reach men in every part of the federation on the need to actively participate and allow their wives to use contraceptives (Ogunjuyigbe, 2009).

The low rate of contraceptive use in Nigeria results in high fertility rates, particularly in the rural areas and the northern part of the country. This high fertility rate accounts for Nigeria's high maternal, infant, and neonatal mortalities, and the use of modern contraceptive methods has been reported to be very limited in the northern part of Nigeria with only 9% of Nigerian women reported to be using these in 2003. Also, according to the population census of 2006, there were at



that time, 44,152,637 women of reproductive age. The Nigerian Demographic and Health Survey (NDHS) 2013 reported that only 15.1 percent of married women of reproductive age were using any contraceptive method. Ten percent of currently married women reported using a modern method, and 5 percent use other methods of contraception. In addition, there is a significant unmet need for family planning in Nigeria; 16 percent of married women have an unmet need for family planning (NDHS, 2013).

Contraceptive use particularly modern contraceptive use remains prominent in demographic and health literature because of its numerous health benefits to women and families such as preventing unintended pregnancies, promoting healthy birth spacing, reducing life time risk of maternal deaths, and enhancing attainment of development goals (Catesw, 2010; Tsui, 2012). In addition, contraceptive use remains a dominant population and health issue because of its important role in the demographic transitions in different countries with varying degrees of demographic situations (Lesthaeghe, 2016).

Family planning and the problems of population control have been a major concern to both the government and individuals over the years in Nigeria. Sincerely speaking, for some couples of years back, state governments eg Edo State government had made several efforts, especially at the root (beginning) to sensitize people on the needs for family planning in addition to providing adequate basic facilities to meet the needs of the people there. it is annoying to see that all these efforts have not yielded positive results. This negatively could be as a result of lack of Education (illiteracy) on the parts of the parents thereby passing onto the children.

## THE CONTEXT OF FAMILY PLANNING IN NIGERIA

Nigeria's family planning program began in 1964 with the National Family Planning Council of Nigeria (Oyediran, 1969). Before the 1980s, however, family planning programs were not a priority for the government of Nigeria and consequently were driven by development partners and nongovernmental organizations. The consequences of unregulated population growth on health and development in Nigeria, starting in the late 1980s the country began formulating various policies aimed at improving reproductive health outcomes and reducing fertility levels through family planning. These include Nigeria's national population policy, first enunciated in 1988 and revised in 2004. These policies focused on increasing uptake of modern contraceptives for health and national demographic goals (Federal Republic of Nigeria 1988). Targets of the first national population policy included increasing contraceptive prevalence to 80% and limiting the TFR to an average of four children per woman by 2000. The revised population policy calls for a reduction of maternal mortality by 75% by 2015, reduction of the fertility rate by 0.6 children per woman every five years and a 2% annual increase in the proportion of women using contraceptives. More recently, following the 2012 London Summit on Family Planning, Nigeria developed a blueprint for accelerating uptake of family planning with a target of increasing the national contraceptive prevalence rate to 36% by 2018 (Federal Republic of Nigeria 2014). Currently, family planning services are provided by both the public and private sectors, with the commodities provided free in public sector facilities. In spite of the various investments in family planning programs in the country, contraceptive prevalence has not shown any sign of increasing. According to the 2013 NDHS, while knowledge of contraceptives is generally high, uptake is low: only 15% of married women of reproductive age are using any contraceptive method and, as mentioned, only 10% are using a modern family planning method, while unmet need for contraception is 16% (National

Population Commission and ICF 2014). The national rates have shown little change since 1990. Motivation to use contraceptives is low in the country, as pronatalism is one of the reasons for high fertility and low contraceptive prevalence (Federal Ministry of Health 2008).

These national aggregate indicators mask wide variations in the uptake of contraceptives across the country. The southern zones of the country have higher contraceptive prevalence compared with the northern zones. The northern part of Nigeria has one of the lowest rates of contraceptive use in the world. Across the states of the country, contraceptive prevalence ranges from 26% in Lagos State in South-western Nigeria to less than 1% in Jigawa and Kano States, North-western Nigeria. The 2013 NDHS data aggregated by zones showed wide variations in fertility intentions and contraceptive use. While the national total fertility rate is 5.5 children per woman, it ranges from 4.3 children per woman in the South Zone to 6.7 children per woman in the North West Zone. Use of modern contraceptives ranges from 3% in the North East Zone to 25% in the South West Zone (NDHS, 2013). Also, the 2013 NDHS showed variation in the method mix. For example while contraceptive prevalence was comparatively high in some of the eastern states of the country, contraceptive use includes more natural and traditional contraceptive methods. There are also variations in contraceptive use by religion, education, place of residence and socioeconomic status (National Population Commission and ICF International and 2014).

In addition to the many socio-cultural drivers of high fertility, poor investment in strategic behavior change communication has contributed to low demand for family planning. The main sources of information on family planning in the country are friends or siblings, media, formal education and health workers (Ankomah, Anyanti, and Oladosu 2011; Monjok et al. 2010; Oye- Adeniran et al. 2006). Additionally, a number of supply-related factors limit contraceptive use. These include erratic supply of modern contraceptives, gaps in logistics supply chain, donor dependence, poor-

quality services and dearth of skilled health personnel to provide family planning services (Federal Government of Nigeria 2014).

## **CONTRACEPTIVES METHODS FOR MEN**

### **CONDOMS**

Condoms, when used consistently and correctly, result in low rates of unintended pregnancy (2 out of 100 women in the first year of use), are highly effective at preventing sexual transmission of HIV and reduce the risk of other sexually transmitted infections (STIs). Because condoms protect against HIV and other STIs, condom promotion and use of condoms have risen substantially since HIV was first identified in the 1980s. Family planning clients are told that the condom is the only form of contraception that protects against HIV/STIs, and encouraged to use condoms for “dual protection” (against disease and pregnancy) or as part of “dual method” use condoms plus a hormonal method, IUD or a permanent method (Cates and Steiner, 2002; Lopez, 2013). Much of the recent research on condoms has focused on HIV-related outcomes, rather than pregnancy prevention.

Men identify advantages and disadvantages to condoms. The chief advantage is that condoms can be obtained or purchased without interactions with any health service and with relative privacy (Kamran et al., 2015). However, disadvantages may outweigh the condom’s advantages. “The condom’s reputation as a coitus-dependent method that interferes with sexual functioning or enjoyment is difficult to overcome” (Ringheim, 1999: 87). More specifically, men may dislike condoms because of the reduced sensitivity, along with a loss of both pleasure and the possibility of conception. Some men, especially younger men, find obtaining condoms

embarrassing (Kamran et al., 2015). Because of their association with HIV, condoms are often seen by men as only being used for extra-marital sex, or for use with sex workers, and therefore not for use within committed relationships (Ntata et al., 2013). Finally, although the global stock of condoms has risen, men in some studies reported challenges accessing condoms, as well as stock outs (Kamran et al., 2015).

## **WITHDRAWAL**

Withdrawal is the world's oldest method of contraception (Santow, 1993; Bullough, 2001). With perfect use, during the first year of use, 4 percent of women will experience an unintended pregnancy, and with typical use, that rises to 22 percent. According to World Health Organization 2015, notes that the benefits of withdrawal, if used correctly, are that there are no health risks, it does not affect breastfeeding, and it has no economic cost. It can be used as a primary or as a back-up method (WHO, 2015). Withdrawal, labeled a traditional method, is widely disparaged as ineffective and hardly discussed in family planning programming (Piet-Pelon, 1999). It is not counted towards contraceptive use in statistics measuring achievement of the Family Planning 2020 global goal, which only counts modern contraceptive use. Yet, World Health Organization notes that the method may be appropriate for couples "who are highly motivated and able to use this method effectively; with religious or philosophical reasons for not using other methods of contraception; who need contraception immediately and have entered into a sexual act without alternative methods available; who need a temporary method while awaiting the start of another method; or who have intercourse infrequently" (WHO, 2015). Withdrawal can also be used as a back-up method (Higgins et al., 2014).

## CONTEXTUAL FACTORS AND CONTRACEPTIVE USE

Since individuals live in communities, communities evidently influence personal health behavior, as there are usually intersections between personal beliefs and attitudes and community norms. With regard to contraceptive use, women must navigate community norms to fulfill their ideals in terms of fertility and contraceptive decision making (Colleran and Mace 2015). The community influences an individual's use of contraceptives through multiple pathways: socioeconomic characteristics of the community, presence of health facilities and infrastructure and prevailing attitudes and behavior. Consequently, within the reproductive health field attention is now shifting to examining the role of contextual factors in explaining the observed variations in contraceptive use, with increasing attention being given to the role of the community in shaping reproductive health behavior of individuals, including contraception behavior (Dynes et al. 2012).

In recent times, a number of studies have attempted to investigate the role of contextual factors in contraceptive use in African countries (Dynes et al. 2012; Wang et al. 2013). The growing body of knowledge has identified a number of contextual factors that influence contraceptive use; they include presence and quality of reproductive health services, macroeconomic factors, community fertility norms, female autonomy, and availability of physical infrastructure.

These studies suggest that considerable gains in understanding determinants of contraceptive use could be made from studying contextual influences, as they have demonstrated that, beyond individual and family factors; the context in which men live also influences their contraceptive decisions. They posit that a greater understanding of the contextual factors

associated with modern contraceptive use has the potential to inform the development of community-level programs aimed at increasing contraceptive use and to allow for better targeting of programs to align with communities (Elfstrom and Stephenson 2012).

In Nigeria, not much is known about how community characteristics affect contraceptive use among men and about the causes of the observed variations by various characteristics across the zones of the country. There is a dearth of literature on contextual factors influencing contraceptive use in Nigeria. Few studies using multilevel modeling techniques identified contextual factors associated with contraceptive use but they are limited in the number of factors investigated. The study by Aremu was limited to determining contextual factors influencing choice of family planning provider and method choice (Aremu 2013). In a study by Omotola the contextual factors were limited to comparison of contraceptive uptake between the northern and southern parts of the country across a number of variables (Omotola 2013).

## **Socioeconomic Characteristics**

### **Age**

In Nigeria, it is a common phenomenon that older men often get married to younger women. This cuts across all major ethnic groups in the country. The disparity in age permits the husband to autonomously make household decision including those on the use of contraceptives. Older age gives the husband considerable advantage in terms of status, experience and power. Even in a society where men and women share complete equality in education and occupational opportunities, men could always maintain their superior position as long as their status increases with age (Barbieri and Hertrich, 2005).

### **Education**

Men and women often times sit together to take decisions that would be of benefit to both of them. The education enlightens them about gender equity and the need for both parties to equally participate in the decision making of the household (Klassen and Lamanna, 2009). In some households where one of the couples is educated, there is often a power shift in the family. If the wife is the only one who is educated, most times the husband in such family may feel inferior to the wife, and let the wife take many of the decisions in the family, especially when the woman is a career woman, she will most times decide on reproductive issues in the family.

### **Religion**

Religion play important role in the contraceptives use among couples in Nigeria, it is a general belief among the Muslims that the Holy Koran allows them to practice polygamy. It is very difficult to use contraceptives in a polygamous family where every woman in the house wants to birth many children so that their strand of the family will have the largest share of the inheritance. The Christians kick against the use of contraceptives, the Christian doctrines is populationist in outlook but condemns polygamy, divorce, abortion and infanticide, they glorified virginity and continence and frowned upon second marriage. Their views on procreation makes the Vatican City kick against the use of contraceptives as proposed in the 1984 International Population Conference in Mexico City.

### **Place of residence**

The place of residence is considered as a determining factor for the use of contraceptives. It is believed that residents of urban centres are more exposed and educated than people who live in rural areas. They also have better access to modern contraceptive method than those in rural areas and are more likely to use a modern contraceptives method (Rahman 2012; Cleland 1996).



Studies have shown that households in the urban centers are exposed to small family norms and often enjoy far better access to health and family planning than those in rural areas (Khan et al. 2008 ; Cleland, Kamal and Sloggett. 1996).

### **Exposure to Family planning information on Mass media**

According to a baseline survey conducted in 2010 and 2011 across 6 towns in each regions of Nigeria, by the Nigerian Urban Reproductive Health Initiative (NURHI) among women, found out that the mass media (radio, television and newspaper) is an important source of family planning. More than 57 percent of women with knowledge of contraceptives receive the message through the mass media. There are several programs on radio and television on family planning, but most of these programs are targeted at urban residents.

## **THEORITICAL FRAMEWORK**

### **The Social Dominance Theory**

The Social Dominance Theory (SDT) has been used to justify the position of men on decision making on contraceptives use, reproductive health and gendered power in the household. The Theory suggests that the society is hierarchized on social categories such as gender, social status and lack equivalent levels of power because of their group membership. Pratto and Walker (2004) propounded four bases of gendered power that provide those who hold more advantaged statuses better access to power. These include: consensual ideologies and socio-cultural obligations. As a whole, these three bases are useful in outlining the ways that gendered power dynamics in the household contribute to their contraceptives use (Jalal, 2014).

Consensual ideologies include “gender roles and any other beliefs or expectations about men and women that are generally agreed upon in a society or culture, that place women in weaker positions in comparison to men” (Rosenthal and Levy 2010: 26). In Nigeria, the widely held view is that the husband controls the sexuality of their wives and decides on the use of contraceptives (Isiugo-Abanihe, 1994a). Wives must then comply with their husband’s sexual demands since refusal may break the family or lead the husband to marry more wives or keep “outside wives” (Karanja, 1987).

Women in one study described certain gendered norms, including the requirement of the society that married women should bear many children, as reasons why their husbands did not want them to use contraception (Nalwadda et al. 2010). Another study comparing the influence of male dominance on fertility in rural versus urban areas found that in rural areas, where traditional norms provides men with greater power, their fertility desires is dominant more than the desires of their wives, in contrast to urban areas where traditional ideologies were less pervasive and women’s desires held more sway (Dodoo and Tempenis 2002). Similarly, households where both couples are educated or where the husband was more educated, were more likely to use a contraceptive method because his ideology did not put women in as weak a position, further suggesting the importance of ideology (Rosenthal and Levy, 2010)

One form of consensual ideology that can place women at a disadvantage involves gender roles that provide men with more decision-making power (Jalal, 2014). Thus, consensual ideologies – gender roles, norms, or expectations that limit the decision-making power of women within the home and regarding sexual encounters with their partners diminish women’s ability to negotiate the use of contraception.

## **Men Socio-Cultural Obligation**

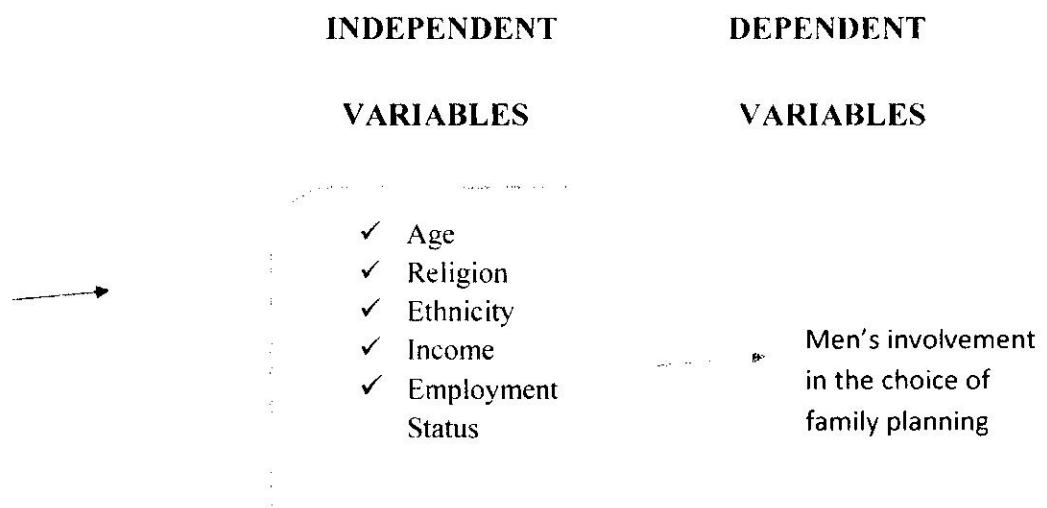
This is the responsibilities that individuals have toward others (Rosenthal and Levy 2010). These social obligations may place women in a weaker position regarding their desire to use contraceptives. Some of these obligations include marital obligations which are childbirth and childcare; women in the sub-Saharan Africa are expected to begin giving birth shortly after marriage to fulfill their roles as wives and mothers (Hindin and Fatusi 2009). Thus, married women may have less power to negotiate the use of contraception because they feel obligated to giving birth to children as part of their marital responsibilities. With this, the higher the number of living children a woman has the more likely the couple should be to use contraception because women with more children feel they have fulfilled their social obligation as wives and are subsequently able to use contraception as they desire (Pratto 2004).

The obligation regarding childbearing is obvious with wives in polygynous relationship as they are less likely to use contraception. However, childbearing may also involve dual social obligations as “reproductive output to a large extent guides subsequent male investment [in the wife],” suggesting that polygynous wives may bear children to access resources husbands provide in view of the presence of offspring (Bove and Vallengia 2009: 24). In addition, in polygynous marriages, couples may be less committed. The likelihood of husbands having affairs is higher and couples communicate less and have looser emotional ties (Bove and Vallengia 2009). If, as this suggests, polygynous husbands are less committed and less communicative with their wives, they may be less likely to listen to her desires regarding contraception use. Thus, polygynous wives are expected to be less likely to use contraception compared to non-polygynous wives.

Another such obligation is faithfulness. Women report that requesting the use of contraceptives can lead their partners to believe they have been unfaithful (Hebling and Guimarães, 2005). This implies that women are expected to show trust toward their partners. However, when women suggest the use of a condom, research indicates that partners perceive this as an accusation of unfaithfulness or lack of trust (Montgomery et al. 2008). Indeed, studies suggest that women in long-term committed relationships (Amaro and Raj 2000) or marital relationships (Maharaj and Cleland 2005) are less likely to use condoms to protect themselves. So, due to the social obligations outlined above, the length of marital relationships is likely to negatively influence the use of condoms. Higher rates of contraction of sexually transmitted diseases among polygynous couples (Bove and Valeggia 2009) suggest women in polygynous relationships may be less likely to use contraceptive, a tendency which may result from the different social obligations inherent in this type of relationship (Bove, Riley and Valeggia, 2009).

### CONCEPTUAL FRAMEWORK

Contraceptive is considered in this conceptual framework as the dependent variable and the unit of analysis. While this model is simple, it is however adequate to explain the contraceptive use in Oye-Ekiti, Ekiti-State, Nigeria. Some important factors influencing contraceptive use will be examined. This framework is schematically presented below.



## HYPOTHESIS

- *H<sub>0</sub>*: Socio-demographic factors do not influence contraceptives use among men inoye-ekiti, ekiti-state, Nigeria.
- *H<sub>0</sub>*: Knowledge of contraceptives methods do not influence non-use of contraceptives among men in south-west, Nigeria.

## **CHAPTER THREE RESEARCH DESIGN AND METHODOLOGY**

### **3.0 INTRODUCTION**

In this chapter, the procedures adopted for the study are presented under the following sub-headings namely: Research design, Area of the study, Population of the study, Sample and Sampling technique, Instrument for data collection, Validation and Reliability of the instrument, Method of data collection and Method of data analysis.

### **3.1. RESEARCH DESIGN**

The design of the study was descriptive survey design. It is a design that seek to collect information from a representative group or sample from which inferences would be made for a much larger population. Therefore, descriptive survey design studies are mainly concerned with describing events as they are, without any manipulation of what caused the event or what is being observed (Nworgu, 1991). This design is suitable for this study because the researcher is interested in the level of frequency of masturbation among undergraduates and the attitudes as well as the practice of masturbation among undergraduate students.

### **3.2 STUDY LOCATION**

The study was carried out in a town in Ekiti state, a state in western Nigeria, Oye is a town and headquarter of oye local government area in Ekiti state. Oye local govt area was carved out from the defunct Ekiti north local government on 17 may 1989.

### **3.3 STUDY POPULATION**

The population of the study was made up of men in Oye-Ekiti, Ekiti-State.aged 15 to 65years

### **3.4 SAMPLE AND SAMPLING PROCEDURES**

The sample for the study comprised men in Ekiti State where 204 respondents was drawn. Stratified random sampling was employed. The sample of the study consisted of 204 respondents.

### **3.5 DATA COLLECTION METHOD**

The instrument for data collection was questionnaire. This questionnaire is titled The Choice of Men's Involvement in Family Planning in Oye-Ekiti, Ekiti-State, Nigeria. The researcher developed the questionnaire items through the information gotten from reviewed literature.

### **3.6 METHODS OF DATA COLLECTION**

Data was collected using semi structured questionnaire with open and closed ended questions. The questionnaire will contain questions on the socio-demographic characteristics of respondents, questions on the general knowledge of abortion and questions on the perceived causes and complications of Abortion among adolescents.

### **3.7 VALIDATION AND RELIABILITY OF THE INSTRUMENT**

To test the validity of the instrument, the instrument was submitted for professional scrutiny and content validation. This was done by my supervisor to examine whether the number and type of items in the questionnaire measured the concept or construct of interest (content validity). Their corrections and comments were used to modify the instrument.

### 3.8 VARIABLE DESCRIPTION AND MEASUREMENT

#### DEPENDENT VARIABLE

VARIABLE NAME	DEFINITION	MEASUREMENT
Currently Contraceptive Use	The act of currently using any Contraceptive method which include Male condom, Male Sterilization and Withdrawal method.	Not Using Using

#### INDEPENDENT VARIABLES

VARIABLE NAME	DEFINITION	MEASUREMENT
Age group	Age the length of an existence extending from the beginning to any given time (Merriam Webster)	
Religion	This indicates the religion of respondent in the study area practise.	Christian Islamic Traditional Others
Place of residence at home	This involve the dwelling place of respondents	Urban Rural



Ethnicity		Yoruba Igbo Hausa Fulani Others
Employment Status	This refers to those that were currently engaged in employment	Not working Working

### 3.9 METHOD OF DATA PROCESSING AND DATA ANALYSIS

The quantitative data that was collected from the field was analyzed using Stata 13 software for the univariate, bivariate and multivariate analysis. The univariate analysis was carried out through the use of frequency distribution table in assessing and describing the socio-demographic characteristics of the respondents. The bivariate analysis would be used to describe and compare the association between dependent and independent variable that is chi-square analysis. The multivariate analysis involved more than two variables, for example; binary logistic regress

### 3.10 FIELD EXPERIENCE

Several experience were encountered in the course of trying to generate correct and accurate data for this study. Part of the males that I approached felt too reluctant to fill the questionnaire because of the content of the questionnaire. Also, some couldn't interpret the content of the questionnaire, the researcher had to interpret it to Yoruba language. Also, the researcher had to employ the face to face method of questionnaire administration as this was time consuming and slowed the pace of data collection.

## CHAPTER FOUR

### DATA PRESENTATION, ANALYSIS AND RESULTS

#### 4.0 INTRODUCTION

This chapter focuses on data presentation and statistical analysis on the involvement of men's in the choice of family planning in Oye-Ekiti. The univariate analysis shows the percentage distribution of respondents' characteristics and information about their participation in the choice of family planning. Chi-square test was used to examine the relationship between socio-demographic factors and men's participation in the choice of family planning. The binary logistic regression model was used to examine the influence of education and other socio-demographic factors on men's participation in the choice of family planning in the study area.

#### 4.1 Distribution of Respondents by Socio-demographic Characteristics

The Table 4.1 below revealed the men's socio-demographic characteristics. The average age of men was approx 40 years with a standard deviation of 10. In all 38.7% of the respondents belonged to age 45 years and above, followed by age range 25-34 years with 31.9% of respondents. In addition, age range 15-24 and 35-44 had 5.9% and 23.5% of respondents respectively. Men in the study area were mostly Christian (69.6%), Muslim men were 23%, traditional and other adherents religion were 6.9% and 0.5% respectively. Men mostly attained post-secondary education (58.3%), those with secondary and primary education were 29.9% and 8.8% respectively, no formal education and other forms of education were 1% and 2% respectively.

Yoruba men were more in the study area (86.3%), followed by Igbo and Hausa/Fulani men with 11.8% and 2% respectively. The average income earning was 73015 naira with a standard deviation of 1756.38. Working men were 88.7% while those who were not working were 11.3%.

The average age of wives as at last birthday was 34 years with a standard deviation of 9. It was revealed that 192 women were within the reproductive age group 15-49 years out of the wives of 204 respondents.

**Table 4.1: Distribution of Respondents by Socio-Demographic Characteristics**

<b>Background Characteristics</b>	<b>Frequency</b>	<b>Percent (%)</b>
<b>Age group</b>		
15 – 24 years	12	5.9
25-34 years	65	31.9
35 – 44 years	48	23.5
45 and above	79	38.7
<b>Mean, S.D</b>	<b>39.82</b>	<b>10.15</b>
<b>Religion</b>		
Christianity	142	69.6
Islam	47	23.0
Traditional	14	6.9
Others	1	0.5
<b>Level of education</b>		
No formal education	2	1.0
Primary education	18	9.0
Secondary education	61	30.5
Post-secondary education	123	59.5
<b>Ethnicity</b>		
Yoruba	176	86.3
Igbo	24	11.8
Hausa/Fulani	4	2.0
<b>Income</b>		
< 20,000	9	4.5
20000-39000	42	21.0
40000-59000	77	38.5
60000 above	72	36.0
<b>Mean, S.D</b>	<b>2.06</b>	<b>0.87</b>
<b>Employment status</b>		
Working	181	88.7
Not working	23	11.3
<b>Wife age at last birthday</b>		
15-24	40	20
25-34	67	33.5
35-44	61	30.5
45 above	32	16
<b>Mean, S.D</b>	<b>1.43</b>	<b>0.99</b>
<b>Total</b>	<b>204</b>	<b>100.0</b>

Source: Taiwo's work, 2019.

#### 4.2 Distribution of Men by Knowledge and Awareness of Contraceptive Methods

The Table 4.2 below revealed the men's knowledge and awareness of contraceptive methods. Men who reported to have heard of contraceptive methods were more 99.5% and those who reported otherwise were 0.5%. Awareness of contraceptive methods were as follows: pills 82.8%, Injection 70.1%, emergency contraceptive 61.3%, Male condoms 88.2%, Female condoms 72.5%, Male sterilization 47.6% and lastly female sterilization 45.5%.

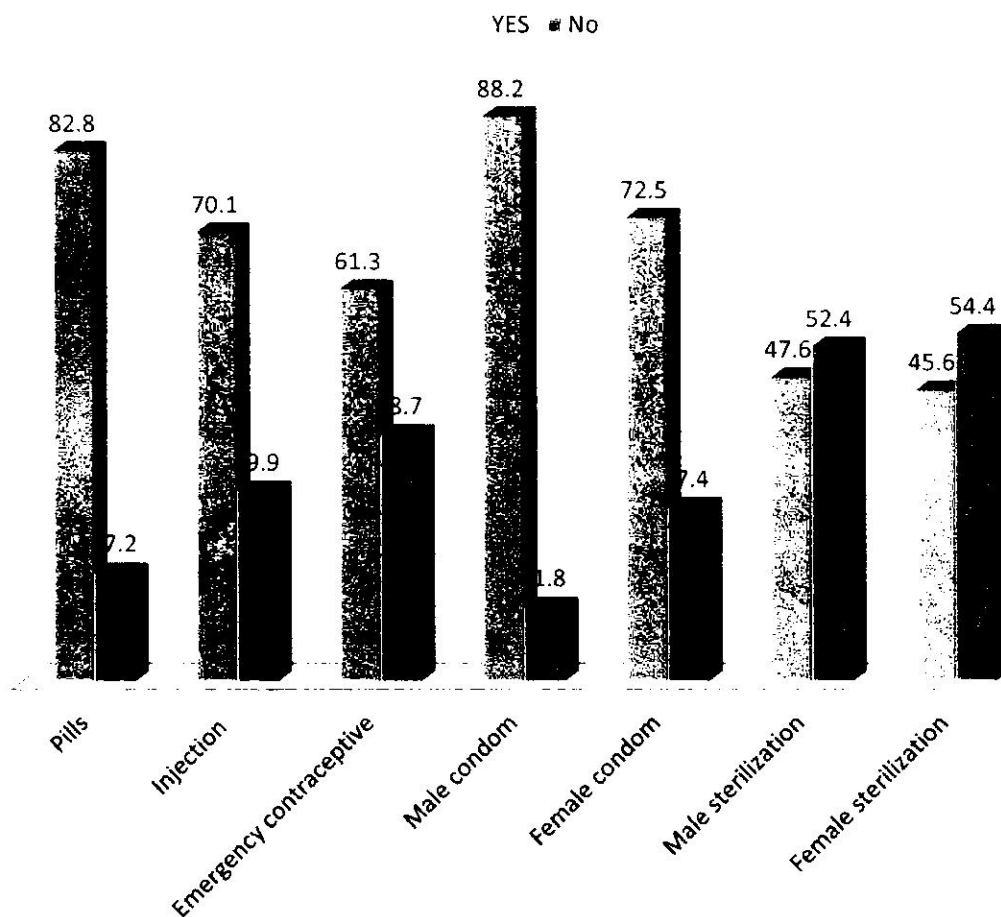
**Table 4.2: Distribution of Men by Knowledge and Awareness of Contraceptive Methods**

<b>Variables</b>	<b>Frequency</b>	<b>Percent (%)</b>
<b>Ever heard of contraceptive methods</b>		
Yes	203	99.5
No	1	0.5
<b>Types of contraceptive methods heard about Pills</b>		
Yes	169	82.8
No	35	17.2
<b>Injection</b>		
Yes	143	70.1
No	61	29.9
<b>Emergency contraceptive</b>		
Yes	125	61.3
No	79	38.7
<b>Male condom</b>		
Yes	180	88.2
No	24	11.8
<b>Female condom</b>		
Yes	148	72.5
No	56	27.4
<b>Male sterilization</b>		
Yes	97	47.6
No	107	52.4
<b>Female sterilization</b>		
Yes	93	45.6
No	111	54.4
<b>Total</b>	<b>204</b>	<b>100.0</b>

Source: TAIWO'S WORK, 2018.

Figure 4.2: Knowledge of Contraceptive Methods

### Knowledge of contraceptive methods



#### 4.3 Distribution of Men by the Use of Contraceptive Methods

The Table 4.3 below revealed the use of contraceptive methods by respondents. Men who reported ever use contraceptive methods were 89.7% and those who reported never use contraceptive methods were 10.3%. Men reported the use of pills were 53.9%, injection were

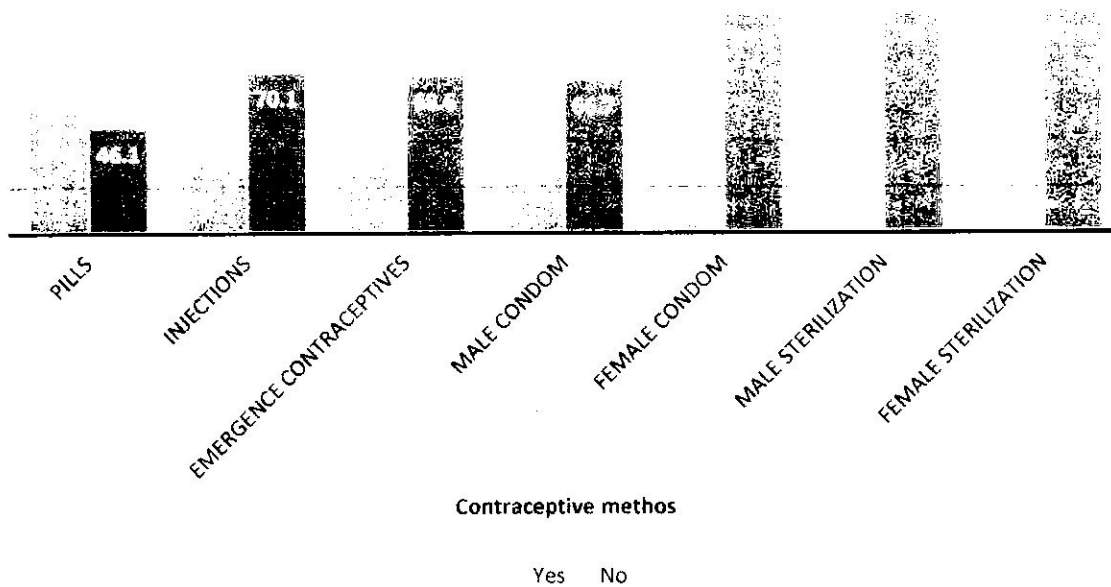
29.9%, those who reported emergency contraceptives were 31.4%, those who reported. Male condom were 33.3% , those who reported female condom were 4.4%, those who reported. Male sterilization were 2%, and who those reported Female sterilization were 2.4%.

**Table 4.3: Distribution of Men by the use of Contraceptive Methods**

<b>Variables</b>	<b>Frequency</b>	<b>Percent (%)</b>
<b>Have you ever used any method of contraceptive</b>		
Yes	183	89.7
No	21	10.3
<b>Types of contraceptive methods ever used</b>		
<b>Pills</b>		
Yes	110	53.9
No	94	46.1
<b>Injection</b>		
Yes	61	29.9
No	143	70.1
<b>Emergency contraceptive</b>		
Yes	64	31.4
No	140	68.6
<b>Male condom</b>		
Yes	68	33.3
No	136	66.7
<b>Female condom</b>		
Yes	9	4.4
No	195	95.6
<b>Male sterilization</b>		
Yes	4	2.0
No	200	98.0
<b>Female sterilization</b>		
Yes	5	2.4
No	199	97.6
<b>Total</b>	<b>204</b>	<b>100.0</b>

Source: Taiwo's work, 2019.

**Figure 4.3: Use of Contraceptive Methods**



#### 4.4 Distribution of Men by Current use of Contraceptive Methods

The Table 4.4 below revealed the current use of method of contraceptive by men. Men currently who claimed they were using contraceptive were 68.1% and those who reported no were 31.9%. Those who reported to be currently using pills were 30.9% and those reported no were 69.1%. Those currently using injection method were 21.1% and those who reported otherwise were 78.9%. Emergency contraceptive method were being currently use by 15.7% and those reported no were 84.3%. Male condom were currently used by 20.1% and those who answered no were 79.9%. For female condom, those currently using were 2.9% and those who claimed otherwise were 97.1%. For male sterilization, 0.5% were currently using 99.5% were not using. Female sterilization were being currently used by 1.5% while those who reported otherwise were 98.5%.

**Table 4.4: Distribution of Men's by Current Use of Contraceptive Methods**

Variables	Frequency	Percent (%)
<b>Are you currently using any method of contraceptive</b>		
Yes	139	68.1
No	65	31.9
<b>Type of contraceptive currently using</b>		
<b>Pills</b>		
Yes	63	30.9
No	141	69.1
<b>Injection</b>		
Yes	43	21.1
No	161	78.9
<b>Emergency contraceptive</b>		
Yes	32	15.7
No	172	84.3
<b>Male condom</b>		
Yes	41	20.1
No	163	79.9
<b>Female condom</b>		
Yes	6	2.9
No	198	97.1
<b>Male sterilization</b>		
Yes	1	0.5
No	203	99.5
<b>Female sterilization</b>		
Yes	3	1.5
No	201	98.5
<b>Total</b>	<b>204</b>	<b>100.0</b>

Source: TAIWO'S WORK, 2018.

#### 4.4 Distribution of Men according to their Involvement in the Choice of Contraceptive Methods

The Table 4.4 below revealed the men's involvement in the choice of contraceptive methods. On decision about method to use, 49.5% and 13.7% of husbands and wives respectively took the decision. Joint decision were taken by 5.9%. Wives who reported they use contraceptives mostly were 56.4% while husband who indicated they used it most were 10.3% and others who reported don't know were 33.3%. Majority of Men did not find it difficult to discussing family planning with partner (82.8%) and those reported yes were 17.2%. Two out of every five respondents (40.7%) indicated they took final decision on family planning at homes. Respondents claimed 4.4% of wives took final decision on family planning while joint decision were taken by



21.6%, 4.4 for more explanation on the current use of contraceptive methods. Also, 3.9% reported relatives made final decision on family planning at home. About 60% (62.7%) of men reported they took part in the choice of family planning at home. Those who reported otherwise were 37.3%. Men that approved contraceptive use were 67.7%.

**Table 4.4: Distribution of Men according to their Involvement in the Choice of Contraceptive Methods**

<b>Variables</b>	<b>Frequency</b>	<b>Percent</b>
<b>Who decide the method to use?</b>		
My wife	28	13.7
Husband	101	49.5
Both	12	5.9
Others	63	30.9
<b>Who used contraceptive most in your family?</b>		
Wife	115	56.4
Husband	21	10.3
Don't know	68	33.3
<b>Do you have problem discussing family planning issues with your partner?</b>		
Yes	35	17.2
No	169	82.8
<b>Who makes the final decision on family planning issues in your home?</b>		
Husband alone	83	40.7
Wife alone	9	4.4
Both of them	44	21.6
Relatives	8	3.9
Others	60	29.4
<b>Do you take part in the choice of family planning in your home?</b>		
Yes	128	62.7
No	76	37.3
<b>What is your say about contraceptive use?</b>		
Approved	138	67.7
Not approved	66	32.3
<b>Total</b>	<b>204</b>	<b>100.0</b>

Source: Taiwo's work, 2019.

#### **4.5: Distribution of Respondents by Socio-demographic Characteristics and Current Contraceptive Use.**

Table 4.5 below revealed significant association between socio-demographic characteristics and current contraceptive use ( $P < 0.05$ ). There was significant relationship between age of men and current contraceptive use ( $X^2 = 9.62$ ,  $Pr = 0.022$ ) among those who reported current use of contraceptives men age group 24-34 years reported more of current use of contraceptives by (36.7%), followed by age group age 35-44 years by (25.9%), age group 45 years and above by (33.1%) and the least were age group 15-24 years by (4.3%). There is significant relationship between wife age as at last birthday and current contraceptive use ( $X^2 = 13.01$ ,  $Pr = 0.005$ ) women age 35-44 years used more contraceptive (32.8%), age 45 years above (26.6%), 15-24 years (21.9%) and lastly was age 15-24 years (21.9%).

**Table 4.5: Distribution of Respondents by Socio-demographic Characteristics and Current Contraceptive Use.**

Background characteristics	Currently using contraceptive		Statistics
	Yes	No	
<b>Age group</b>			
15 – 24 years	6(4.3)	6 (9.2)	$X^2 = 9.62$ $Pr = 0.022$
25-34 years	51(36.7)	14 (21.5)	
35 – 44 years	36(25.9)	12 (18.5)	
45 and above	46(33.1)	33 (50.8)	
<b>Total</b>	<b>139 (100.0)</b>	<b>65 (100.0)</b>	
<b>Religion</b>			
Christianity	98(70.5)	44 (67.7)	$X^2 = 2.36$ $Pr = 0.501$
Islam	31(22.3)	16 (24.6)	
Traditional	10(7.19)	4 (6.2)	
Others	0(0.0)	1 (1.5)	
<b>Total</b>	<b>139 (100.0)</b>	<b>65 (100.0)</b>	
<b>Level of education</b>			
No formal education	2 (1.5)	0 (0.0)	$X^2 = 1.139$ $Pr = 0.768$
Primary education	13 (9.6)	5 (7.8)	
Secondary education	41 (30.2)	20 (31.3)	
Post-secondary education	80 (58.8)	39 (60.9)	
<b>Total</b>	<b>139 (100.0)</b>	<b>65 (100.0)</b>	
<b>Employment status</b>			
Working	129 (92.8)	61 (93.9)	$X^2 = 0.08$ $Pr = 0.784$
Not working	10 (7.2)	4 (6.1)	
<b>Total</b>	<b>139 (100.0)</b>	<b>65 (100.0)</b>	
<b>Ethnicity</b>			

Yoruba	118 (84.9)	58 (89.2)	X <sup>2</sup> =2.05 Pr=0.359
Igbo	17 (12.2)	7 (10.8)	
Hausa/Fulani	4 (2.9)	0 (0.0)	
<b>Total</b>	<b>139 (100.0)</b>	<b>65 (100.0)</b>	
<b>Income</b>			
< 20,000	4 (2.9)	5 (7.8)	X <sup>2</sup> =3.92 Pr= 0.270
20000-39000	31 (22.8)	11 (17.2)	
40000-59000	55 (40.4)	22(34.4)	
60000	46 (33.8)	26 (40.6)	
<b>Total</b>	<b>139 (100.0)</b>	<b>65 (100.0)</b>	
<b>Employment status</b>			
Working	122(87.8)	59 (90.8)	X <sup>2</sup> =0.39 Pr=0.528
Not working	17(12.2)	6 (9.2)	
Total	<b>139 (100.0)</b>	<b>65 (100.0)</b>	
<b>Wife age at last birthday</b>			
15-24	26 (19.1)	14 (21.9)	X <sup>2</sup> =13.0056 Pr=0.004
25-34	55 (40.4)	12 (18.8)	
35-44	40 (29.4)	21 (32.8)	
45 above	15 (11.03)	17 (26.6)	
<b>Total</b>	<b>139 (100.0)</b>	<b>65 (100.0)</b>	

#### 4.6: Distribution of Men's Involvement in the Choice of Family Planning and Current Contraceptive Use.

Table 4.6 below revealed significant association between men's involvement in the choice of family planning and current contraceptive use ( $P < 0.05$ ). There was significant relationship between decision on contraceptive method to use and current contraceptive use ( $X^2 = 153.60$ ,  $Pr = 0.000$ ), among respondents who reported current use of contraceptives 70.5% indicated they decided on method to use while 17.3% of respondents also indicated wives took decision on method to use. Those who made joint decision on method to use by 8.6% and those that reported others decided by 3.6%. There is significant relationship between those who used contraceptive most in your family and current contraceptive use ( $X^2 = 141.62$ ,  $Pr = 0.000$ ). wives were reported to used contraceptive mostly in the family (79.1%) men compared to (14.4%) out of the total number

if respondents who were currently using contraceptives, 76.3 claimed they had no problem discussing family planning issues with their partners.

More so, the statistics showed a significant association at ( $X^2=13.31$ ,  $Pr=0.000$ ,) between those that have problem discussing family planning issues with partner and current contraceptive use. There is significant association between who makes the final decision on family planning issues at home and current contraceptive use ( $X^2=181.96$ ,  $Pr=0.000$ ), majority (56.8) of those who indicated current use of contraceptive methods also claimed husband alone took final decision on family planning issues at home. Also 30.9% of those who were currently using contraceptives indicated joint decision in the family. Only 5.8% of them claimed relatives took final decision on family planning issues at home for them .There is significant association between men's involvement the choice of family planning at home and current contraceptive use ( $X^2=130.70$ ,  $Pr=0.000$ ), those that reported yes were currently using contraceptive by (89.2%) and those reported no were (10.8%) were compared (table 4.6). almost 90% (89.2%) of respondents who were currently using contraceptives claimed they took part in the choice of family planning method at home. There is significant association between attitude about contraceptive use and current contraceptive use ( $X^2=164.82$ ,  $Pr=0.000$ ), those who approved contraceptive method were currently using contraceptive method were 96.4% and those who reported not approved and were currently using contraceptive method were 3.6%

**Table 4.6: Distribution of Men's Involvement in the Choice of Family Planning and Current Contraceptive Use.**

Variables	Currently using contraceptive		Pvalue
	Yes	No	
<b>Who decide the method to use?</b>			
My wife	24 (17.3)	4 (6.2)	$X^2=153.60$ $Pr=0.000$
Husband	98 (70.5)	3 (4.6)	
Both	12 (8.6)	0 (0.0)	

Others	5 (3.6)	58 (89.2)	
<b>Total</b>	<b>139 (100.0)</b>	<b>65 (100.0)</b>	
<b>Who used contraceptive most in your family?</b>			
Wife	110 (79.1)	5 (7.7)	X <sup>2</sup> =141.62 Pr= 0.000
Husband	20 (14.4)	1 (1.5)	
Don't know	9 (6.5)	59 (90.8)	
<b>Total</b>	<b>139 (100.0)</b>	<b>65 (100.0)</b>	
<b>Do you have problem discussing family planning issues with your partner?</b>			
Yes	33 (23.7)	2 (3.1)	X <sup>2</sup> =13.31 Pr= 0.000
No	106 (76.3)	63 (96.9)	
<b>Total</b>	<b>139 (100.0)</b>	<b>65 (100.0)</b>	
<b>Who makes the final decision on family planning issues in your home?</b>			
Husband alone	79 (56.8)	4 (6.2)	X <sup>2</sup> =181.96 Pr=0.000
Wife alone	9 (6.5)	0 (0.0)	
Both of them	43 (30.9)	1 (1.5)	
Relatives	8 (5.8)	0 (0.0)	
Others	0 (0.0)	60 (92.3)	
<b>Total</b>	<b>139 (100.0)</b>	<b>65 (100.0)</b>	
<b>Do you take part in the choice of family planning in your home?</b>			
Yes	124 (89.2)	4 (6.2)	X <sup>2</sup> =130.70 Pr=0.000
No	15 (10.8)	61 (93.9)	
<b>Total</b>	<b>139 (100.0)</b>	<b>65 (100.0)</b>	
<b>What is your say about contraceptive use?</b>			
Approved	134 (96.4)	4 (6.2)	X <sup>2</sup> =164.82 Pr=0.000
Not approved	5 (3.6)	61 (93.9)	
<b>Total</b>	<b>139 (100.0)</b>	<b>65 (100.0)</b>	

#### 4.7: Odds Ratio Based on Binary Logistic Regression Analysis of Socio-Demographic Characteristics Contraceptive Method.

Table 4.7 below showed the result of binary logistic regression on social-demographic of characteristics on current use of contraceptive method. Result from M below revealed that men age 25-34 years were 0.10 less likely to currently use contraceptive methods to compared men age 15-24 years (RC). Men that earned 20000-34000 naira were 0.14 less likely to currently using contraceptive methods compared to men that earn 5000-19000 naira (RC). Men that earned 65000-

79000 naira were 0.09 less likely to currently using contraceptive method compared to men that earn 5000-19000 naira (RC).

**Table 4.7: Odds Ratio Based on Binary Logistic Regression Analysis of Socio-Demographic Characteristics and Currently Using Contraceptive Method.**

Variables	Odd Ratio	Lower Confident Interval	Upper Confident Interval
<b>Age group</b>			
15 – 24 years (RC)	<b>1.00</b>		
25-34 years	0.10*	0.01	0.74
35 – 44 years	0.15	0.01	1.77
45 and above	0.15	0.01	2.04
<b>Religion</b>			
Christianity (RC)	<b>1.00</b>		
Islam	1.02	0.43	2.42
Traditional	1.13	0.29	4.36
Others	1.00	0.0	0.0
<b>Employment status</b>			
Working (RC)	<b>1.00</b>		
Not working	0.66	0.15	2.97
<b>Ethnicity</b>			
Yoruba(RC)	<b>1.00</b>		
Igbo	0.86	0.30	2.47
Hausa/Fulani	1.00	0.0	0.0
<b>Income</b>			
5000-19000(RC)	<b>1.00</b>		
20000-34000	0.14*	0.02	0.95
35000-49000	0.23	0.04	1.42
50000-64000	0.21	0.03	1.38
65000-79000	0.09*	0.01	0.98
80000-94000	0.31	0.04	2.65
95000-109000	0.57	0.05	6.31
110000-above	0.36	0.05	2.72
<b>Employment status</b>			
Working(RC)	<b>1.00</b>		
Not working	0.67	0.19	2.37
<b>Wife age at last birthday</b>			
15-19 years(RC)	<b>1.00</b>		
20-24 years	17.84	0.77	414.86
25-29 years	13.04	0.38	451.47
30-34 years	7.46	0.17	324.39
35-39 years	13.63	0.30	616.05

40-44 years	21.43	0.50	925.34
45-49 years	45.19	0.96	2118.14
50-54 years	33.81	0.66	1739.15

RC means the reference categories \*P<0.05 \*\*p<0.01 \*\*\*p<0.001

## DISCUSSION OF FINDINGS

The knowledge of men concerning family planning was high while practices were low based mainly on culture and religion and the lack of understanding of the advantage of family planning on the family and the nation as a whole. Family planning clinics are not men friendly and most men perceive family planning services to be for women only.

The attitude of men on family planning is poor, majority of African men perceive family planning as a woman affair and if they accompany their wives to the family planning clinic they will be perceived as weak or over ruled by their women. . The average age of men was approx 40 years with a standard deviation of 10. In all 38.7% of the respondents belonged to age 45 years and above, followed by age range 25-34 years with 31.9% of respondents. In addition, age range 15-24 and 35-44 had 5.9% and 23.5% of respondents respectively. Men in the study area were mostly Christian (69.6%). Muslim men were 23%, traditional and other adherents' religion were 6.9% and 0.5% respectively.

## CHAPTER FIVE

### SUMMARY, CONCLUSION AND RECCOMENDATIONS

#### 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 men involvement in the choice of family planning in Oye-Ekiti, Ekiti State, Nigeria. The study was based on the sample size of 204men in the study area.

#### SUMMARY OF THE FINDINGS

The univariate analysis showed the men socio-demographic characteristics, awareness of contraceptive method, use of contraceptive methods, and men involvement in the choice of contraceptive method in the study area.

The bivariate analysis showed the relationship between variables and their significant level . The socio-demographic characteristics and current contraceptive use revealed that there was significant relationship between age of men and contraceptive use. Also, there was significant relationship between wives age and( $X^2=9.62$ ,  $Pr=0.022$ ) (  $X^2=15.33$ ,  $Pr=0.032$ ) current contraceptive use. Also, significant association was observed between men's involvement in the choice of family planning and current contraceptive use. revealed that there was significant association between who decided contraceptive method to use, who used contraceptive most in your family, those that have problem discussing family planning issues with partner, who makes the final decision on family planning issues at home, men take part in the choice of family planning



at home, Attitude about contraceptive use. Current use of contraceptives was significant with the following variables ( $X^2=153.60$ ,  $Pr=0.000$ ;  $X^2=141.62$ ,  $Pr=0.000$ ;  $X^2=13.31$ ,  $Pr=0.000$ ;  $X^2=181.96$ ,  $Pr=0.000$ ;  $X^2=130.70$ ,  $Pr=0.000$ ;  $X^2=164.82$ ,  $Pr=0.000$ ) and men currently using contraceptives.

In the multivariate analysis, result from the binary logistic regression of socio-demographic characteristics on current use of contraceptive methods. Showed the effect of men's age ( $OR=0.10$ ,  $CI= 0.01-0.74$ ) and income ( $OR=0.14$ ,  $CI= 0.02-0.95$ ) ( $OR=0.09$ ,  $CI=0.01-0.98$ ) respectively on men currently using contraceptive method use.

## **CONCLUSION**

Thus this study conclude that base on the facts from the result that some factors such as age of men and wife, decide contraceptive method to use, who used contraceptive most in your family, those that have problem discussing family planning issues with partner, who makes the final decision on family planning issues at home, men take part in the choice of family planning at home, say about contraceptive use had effect on those currently using contraceptives where p-value less than five percent level of significant.

Health care providers need to make a conscious effort of reaching out to men with complete information. Training and sensitization of the health workers at all levels, including training them on the existing national and state policies and guiding them to program implementation will go a long way in ensuring greater reach to men in the communities. This is the need of the hour and more and more innovative strategies need to be developed in order to reach out to target men.

## **RECOMMENDATION**

Based on the study, I recommend that:

- Men should be educated in all aspects of reproductive health as both direct beneficiaries and partners. Current education campaigns need to be reviewed to assess their value in promoting male involvement. Programmers that inadvertently stigmatize condom use so that it is associated only with high-risk situations may reduce condom use in marital relationships.
- Reproductive health education must be linked to service provision. Education alone will be insufficient without a clear understanding of what services are provided, how they can be used, and in what way they benefit both individual males and their families.
- The mass media should be used more frequently and more effectively. Television is widely accessible and can reach even highly remote groups. Also, this medium is hugely popular with the rural youth groups. This media is highly useful in conveying messages in a country with an illiteracy rate of 36 percent. This must, however, be supported by inter-personal communication preferably by the health care providers.

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TOPIC : FACTORS ASSOCIATED WITH MEN'S PARTICIPATION IN THE CHOICE OF FAMILY PLANNING

INTRODUCTION

Dear respondent

My name is Olorunsola Taiwo, an undergraduate student at federal university Oye Ekiti, Ekiti state conducting a research on the above topic. You are kindly requested to take part in this study by completing this questionnaire. Your participation is purely voluntary and you reserve the right to withdraw anytime.

The purpose of the study is to examine the extent of men's involvement in family planning in oye ekiti. The information obtained from you is confidential.

INSTRUCTION

1. Please answer all questions as accurately as appropriate

SECTION A: SOCIO ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS

1. What is your age?.....
2. What is your religion? Christianity.....1 Islam.....2 tradition.....3 others specify.....
3. What is your highest level of education.....1. Primary.....2. Secondary.....3.post- secondary.....4. Others (specify)
4. What is your employment status? Working.....1. Not working..... 2.
5. What is your ethnic group? Yoruba.....1igbo.....2 Hausa/Fulani.....3 others (specify).....
6. How much is your total income per month? .....
7. What is your partner's employment working status? Working.....1. Not working.....2
8. What is your wife's age as at last birthday? .....

SECTION B: FAMILY PLANNING EXPERIENCE

9. Have you ever heard about contraceptive methods? Yes.....1 no .....2

If your answer is no, drop questionnaire.

10. If your answer is yes, please tick the types of family planning methods that you know.  
Pill.....1 injection.....2 emergency contraception.....3 male condom.....4  
female condom.....5. Male sterilization.....6 female sterilization.....7  
others (specify).....

11. Have you ever used any methods of family planning? Yes.....1. No.....2

If your answer is no, drop questionnaire.

12. If your answer is yes, please tick the type of family planning methods that you used.  
Pill.....1 injection.....2 emergency contraception.....3 male condom.....4  
female condom.....5. Male sterilization.....6 female sterilization.....7  
others (specify).....

13. Are you currently using any methods of family planning? Yes.....1 no.....2

If your answer is no, drop the questionnaire.

14. If your answer is yes, please tick the types of family planning methods that use used.  
Pill.....1 injection.....2 emergency contraception.....3 male condom.....4  
female condom.....5. Male sterilization.....6 female sterilization.....7  
others (specify).....

15. Who decide which methods to use? My wife.....1 myself.....2both.....3 others  
(specify)

16. Who uses contraceptives most in your family? Wife.....1 husband.....2 don't  
know.....3

17. Do you have problems discussing family planning issues with your partner? Yes.....1 No.....2

18. Who makes the final decision on family planning issues in your home? Husband.....1  
wife.....2 both of us.....3 relatives.....4 others (specify).....

19. Do you take part in the choice of family planning methods in your family? Yes.....1 no.....2

20. What is your opinion about contraceptive use? Approve.....1 Not  
Approved.....2