

**MALE'S INVOLVEMENT IN SPOUSAL FERTILITY CONTROL  
MEASURES IN IFE CENTRAL LOCAL GOVERNMENT AREA OF  
OSUN STATE**

By

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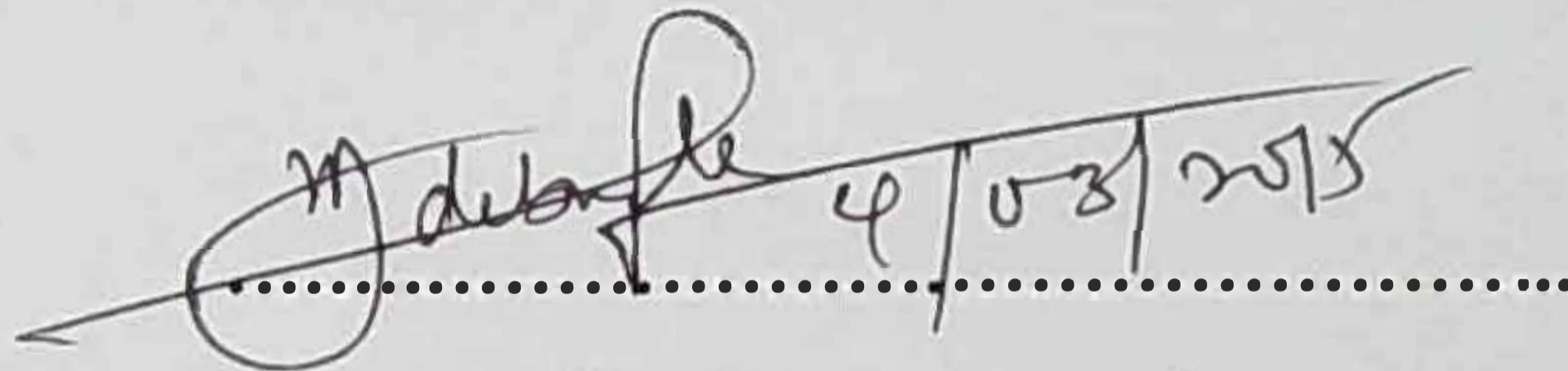
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## CERTIFICATION

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## DEDICATION

This work is dedicated to Almighty God and my parents Alhaji & Mrs. Adefeso.

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## ABSTRACT

**Background:** Male's involvement in spousal fertility control measures is very important in the use of Contraceptive method. Fertility can be controlled through the use of contraceptives particularly modern methods. Fertility rate in Nigeria is high but the use of modern contraceptive is low. Male involvement in Family Planning has positive influence on the use of contraceptive. This study documented information about male's involvement in spousal fertility control measures in Ife Central Local Government, Osun State.

**Methods:** The study was community based and cross-sectional in design. It made use of methods mixed approach which consisted of quantitative and qualitative research methods. The quantitative method was a semi-structured questionnaire and qualitative methods were Key Informant Interview (KII) and Focus Group Discussions (FDG). The study included 1000 married men in stable union aged 15-59 years. Data were analyzed using descriptive statistics, Chi-square and multiple Logistic regression models.

**Results:** Mean age was  $38.2 \pm 11.0$  years and the prevalence of modern contraceptive currently used was 29.0%. Factors associated with the use of modern contraceptives were age, level of education, occupation, place of residence, monthly income and Children Ever Born. Also, age, place of residence, level of education, occupation and income were significantly associated with knowledge of vasectomy ( $p < 0.05$ ). About 35.0% of the respondents who have adequate knowledge of vasectomy and also 35.6% of those who have higher level of education were currently using modern contraceptive. Men in age group 50-59 were less likely ( $OR = 0.35$ ;  $C.I = 0.19 - 0.645$ ,  $p < 0.05$ ) to use modern contraceptive than those in age group less than 30. Respondents who were earning more than 70,000 naira were highly likely ( $OR = 4.516$ ;  $C.I = 2.479 - 8.227$ ,  $p < 0.001$ ) to use modern contraceptive than those who were earning less than 10,000. Men who were earning more than 70,000 naira monthly were higher likely to have adequate knowledge of vasectomy than those who were earning less than 10,000 naira ( $OR = 1.84$ ;  $C.I = 1.108 - 3.563$ ,  $p < 0.05$ ).

**Conclusion:** The use of modern contraceptive in Ife central Local Government Area was low. Reasons such as poor sexual performance, infertility and spousal promiscuity were identified as responsible for non-involvement in contraceptive practices. Men in the study area need more education on the services available and their consequences.

**Key word:** Contraceptive use, knowledge of vasectomy, Fertility Control Measure, Male's involvement, Ife Central Local Government of Osun State.

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## LIST OF ACRONYMS

WHO-	WORLD HEALTH ORGANIZATION
MDGs-	MILLENNIUM DEVELOPMENT GOALS
HIV-	HUMAN IMMUNODEFICIENCY VIRUS
STDs-	SEXUALLY TRANSMITTED DISEASES
AIDS-	ACQUIRED IMMUNE DEFICIENCY SYNDROME
TFR-	TOTAL FERTILITY RATE
UNPD	UNITED NATION POPULATION DIVISION
LGA-	LOCAL GOVERNMENT AREA
OR-	ODD RATIO
CI-	CONFIDENCE INTERVAL
NDHS-	NIGERIAN DEMOGRAPHIC HEALTH SURVEY
NPopC-	NATIONAL POPULATION COMMISSION
SPSS-	STATISTICAL PACKAGE FOR SOCIAL SCIENCE
CEB-	CHILDREN EVER BORN
NGO-	NON GOVERNMENTAL ORGANIZATION

# CHAPTER ONE

## 1.0 INTRODUCTION

### 1.1 BACKGROUND OF THE STUDY

Family Planning allows individuals and couples to anticipate and attain their desired number of children, spacing and timing of their births. It is achieved through use of modern contraceptive methods and the treatment of involuntary infertility. Contraceptive methods are classified as modern or traditional methods. Modern methods include female sterilisation, male sterilisation, the pill, intra-uterine device (IUD), Injectables, implants, male condom, female condom, diaphragm, foam/jelly, Lactational amenorrhoea method (LAM), and emergency contraception. Methods such as rhythm (periodic abstinence) and withdrawal are grouped as traditional methods. A woman's ability to space and limit her pregnancies has a direct impact on her health, children, family and also well-being of each outcome of pregnancy (Almuam, 2007). Family Planning can delay pregnancies in young women at increased risk of health problems and death from early childbearing, and can prevent pregnancies among older women who also face increased risks (Falode et al, 2007).

Evidence suggests that women who have more than four children are at increased risk of maternal mortality (WHO, 2013). Family Planning services have become the interventions of choice to slow population growth. It is believed that child spacing or the timing of every birth can improve survival of the child and can maintain good physical and emotional health for the whole family (Pradhan et al, 1996). Despite awareness of the implications of Family

Planning on reducing population growth, it is possible to raise a question as to why Family Planning Programs have failed in Nigeria. Social and cultural factors have been shown to influence contraceptive use in Nigeria. For instance, the role of man as the head of the family, communication between spouses and the fear of side effects have been shown to be among factors that influence use of modern contraceptives (Tsedeke et al, 2003). The most recent United Nations statistics on prevalence of contraceptive use showed that in Nigeria, the prevalence is 15% and 8% using any contraceptive methods and only modern methods respectively in 2008. During same period, the prevalence was 79% versus 73% in United States of America and 80% versus 69% in Viet Nam (Karin, 2001). Low prevalence of contraceptive use has been attributed to be a prominent cause of high fertility rate in Nigeria (Akintaro, 2007). The relatively high birth rate in Nigeria has contributed to high rates of population growth.

Delay and postponement of child bearing have been shown to reduce population growth in advanced nations (Khan et al, 2009). Also, birth spacing has the tendency to reduce the number of children a woman bears within the childbearing period. Birth Spacing refers to the time interval from one child's birth date until the next child's birth date. It is often recommended that a woman space her consecutive births for at least 24 months. This is to enable the woman to recuperate from the previous births. Even in recent times, spacing for more than 24 months has been advocated (WHO, 2005). There is an increased risk of having a poor birth outcome such as a premature birth or a low birth weight baby if the interval is shorter. These conditions can threaten the health of the child, the mother and the whole family and also associated

with infant mortality and other short- term and long-term health complications (Salle et al, 2009). Increasing the interval between births and delaying the age at first motherhood can significantly reduce infant, child and maternal mortality (Geneva et al, 2005). Healthy Timing and Spacing of Pregnancy can save lives and improve the health and wellbeing of mothers and their families (Meridian Group International, 2011). Central to birth spacing in any nation is contraceptive use. However, Cultural practices and male dominance role in the family are important challenges. To overcome some of the challenges and barriers to contraceptive use in a traditional society like Ife, men must be adequate involved.

Male involvement in Family Planning means more than increasing the number of men using condoms and having vasectomies, it includes the number of men who encourage and support their partner and their peers to use modern contraceptives (Almuam, 2007). Also, it influences the policy environment to be more conducive to developing male-related programmes (Williamson et al, 2009). The involvement of men in reproductive health encompasses activities at many levels. It involves planning the number of offspring and their structure with the partner, approving of contraceptive use and using them, taking special care of wives and partners when they are pregnant, seeking skilled health care, taking care of the wife after the baby is born, and being responsible fathers (WHO, 2005). Methods that require male involvement such as condoms, periodic abstinence, withdrawal and vasectomy are used less often. Men in many developing countries generally desire larger families than their wives do (Family Health international, 2010). Also, men are proud of the number of their children, particularly sons because of the current and future benefits

derived from them (Tuloro et al, 2009). More children are desired by their parents for later social and old age support (WHO, 2011). Spousal communication can improve Family Planning use and continuation. Yet, in countries with high fertility rates and unmet need, men have often been regarded as unsupportive of their partner's use of Family Planning methods (Allen et al, 2012).

Men's support or opposition to their partners' practice of family planning has a strong impact on contraceptive use in many parts of the world, including Africa. Within marriage in Africa, men typically have more say than women in the decision to use contraception and in the number of children that the couple will have. Involving men actively in reproductive decision making will reduce the incidence of unwanted pregnancy. Men are recognized to be responsible for the large proportion of ill reproductive health suffered by their female partners (Petro-Nustas, 1997). Male involvement helps not only in accepting a contraceptive but also in its effective use and continuation (Macellina et al, 2010). By reducing unintended pregnancies and abortions, and facilitating family planning or spacing of births, effective contraception provides both health and social benefits to mothers and their children (Salle et al, 2009). In addition to preventing mortality, effective contraception improves maternal health, social and economic role of women and enables them to participate in society fully (WHO, 2011). Cognisance of the role that male spouses play in uptake of contraceptive and with the observed low prevalence of contraceptive use in Nigeria, this study therefore explored male's involvement in modern contraceptive use against the backdrop of limited

research that have documented this area in Ife Central Local Government, Osun-State and Nigeria.

## 1.2 STATEMENT OF THE PROBLEM

Research suggests that male involvement can increase uptake and continuation of Family Planning methods by improving spousal communication through pathways of increased knowledge or decreased male opposition (Osemwenkha, 2004). Yet, despite growing evidence on the benefits of engaging men in reproductive health decision-making, fertility rates and unmet need for Family Planning remain high in many sub-Saharan African countries (Obasi, 2008). While there are many influential factors, low contraceptive prevalence has been attributed in part to men's opposition to or non-involvement in Family Planning (Stermbag and Hubley, 2004). It is estimated that half of all births in many less developed countries, including Nigeria pose high risks to the health of both mother and child (Nwachukwu and Obasi, 2008). This expansive population growth rate has been attributed to some factors which includes low contraceptive usage (Olugbenga-Bello, 2005). Negative effects and consequences of lack of utilization of Family Planning by individuals, families, communities and the nation at large result in high maternal morbidity and mortality rate, high infant mortality rates. In Nigeria, modern contraceptive is low and is among the country with least prevalence in sub-Sahara Africa (Nwachukwu, 2008).

The family unit in Ile-Ife is essentially patriarchal, 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 (Macellina et al, 2012). In most families in Ife, wives are usually socially and economically dependent on their husbands including making of decisions on issues that are beneficial to the women. It is rare for a woman to disagree with a man if he wants more children or refuse sex when they are not safe or not contracepting. These situations have led to high frequency of births in households and families through poor birth spacing. Poor births spacing and high births frequency predispose women to morbidity, poor health and mortality during childbearing and post-childbearing periods (WHO, 2005). Failure of male's involvement in Family Planning programmes implies a failure to assess the potential acceptability of existing male methods (Macellina et al, 2012). Male engagement in Nigeria has historically been depicted as obstructive by impeding women's decision-making on use of family planning or non-existent among male partners who are absent altogether due to lack of interest in matters related to reproductive health (WHO, 2012). Involving men stem not only from women's reproductive health needs, but also to address men's own sexual health concerns, as well as efforts to achieve the Millennium Development Goals (MDGs) for reduction of maternal mortality in Nigeria.

### **1.3 JUSTIFICATION**

Nigeria is the most populous country in Africa with a Total Fertility Rate (TFR) of 5.5 children (NDHS, 2013). This may be explained by underutilization of contraceptives, high unmet need for Family Planning, poor quality of health services (PRB, 2011). In addition, Nigeria is the seventh most populous country in the world with population ranked after China (1.346m),

India (1,241m), United States (312m), Indonesia (238m), Brazil (197m), and Pakistan (177m). It had an estimated population of about 162 million in 2011 and a projected population of about 433 million in 2050, indicating a projected change in population of over 167 percent between 2011 and 2050 (PRB, 2011). At this rate, the country may eventually experience overpopulation, a situation whereby the growth of the population is to such a size that space, food, water, or other resources available to support it are insufficient (Encarta, 2009), hence the need for fertility regulation.

Underutilization of contraceptive services may be explained by some factors (Bogale et al, 2011). Fertility regulation programmes will be better implemented if factors affecting male involvement in modern contraceptive use are well understood. This will increase the low prevalence use and as well reducing the rate of population growth in the country by informing policy and program development in this regard. 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 (Oyeniran et al, 2002). However, fertility and Family Planning research and programs have ignored men's roles in the past, focusing on women's behaviour (Oyeniran et al, 2002), and services are traditionally presented within the context of maternal and child health (Mason and Lynam, 1992).

While studies on male involvement in Family Planning decision making have been reported for selected areas in Ile-Ife (Titilayo et al, 2010), in-depth analysis of male's involvement in spousal fertility control measures in Ile Central Local Government has not been reported.

## 1.4 OBJECTIVES OF THE STUDY

**GENERAL OBJECTIVE:** To document information about male's involvement in spousal fertility control measures in Ife Central Local Government, Osun State.

**SPECIFIC OBJECTIVES:** The specific objectives of the study are to;

1. examine the knowledge of vasectomy among married men in Ife Central Local Government Area of Osun State.
2. identify factors influencing knowledge of vasectomy and spousal use of modern contraceptive in Ife Central Local Government Area of Osun State.
3. explore factors associated with male involvement in fertility control measures.

## 1.5 RESEARCH QUESTIONS

1. What is the proportion of those that have knowledge of vasectomy among married men in stable union?
2. What are the factors influencing knowledge of vasectomy and spousal use of modern contraceptive in Ife Central Local Government of Osun State?
3. What are the factors associated with male involvement in fertility control measure?

## CHAPTER TWO

### 2.0 LITERATURE REVIEW

#### 2.1 Introduction

Male involvement in Family Planning and reproductive health is most important in fertility control measures in Ife Central Local Government Area of Osun State. The primary aim of Family Planning is to enable women and men to plan their families and space their children through the use of modern contraceptives. It also embraces activities such as infertility and genetic counselling, contraception, abortion and sterilization. Family Planning programs, policies and methods have become increasingly important in the last decade as a result of the socio-economic problems influencing rapid population growth as well as public health problems, especially control of sexually transmitted diseases (STDs) such as AIDS (United Nations, 1995). Family Planning Programs have always been considered as the intervention of choices for slowing population growth. These programs are seen to give relatively little attention to the roles that could be played by men regarding fertility regulation. Also, it enables people to make informed choices about their sexual and reproductive health and represents an opportunity for women to enhanced education and participation in public life including paid employment in non-family organizations. Additionally, having smaller families allows parents to invest more in each child. Children with fewer siblings tend to stay in school longer than those with many siblings (WHO, 2005).

#### 2.2 Fertility Control Measures

The ability to control fertility can have broad social and economic consequences since families experiencing unwanted pregnancies may find it harder to pay for their children's education, healthcare and general wellbeing.

Recent evidence suggests that access to contraceptives may improve economic outcomes and reduce poverty by allowing women to optimally time births, increasing investment in education and participation in the labour market at childbearing ages (Nava et al, 2010). As much as 75 percent of all pregnancies worldwide are unplanned or unwanted, accounting for nearly 300,000 new pregnancies every day. One possible reason is that in many countries, men dominate decisions regarding sexual relations and contraception, and spousal discordance may influence fertility outcomes (Erica et al, 2011). Methods of fertility control have been known from olden times, but it is difficult to establish to what extent they may have been used (Coitus and Sheila, 2001). In past eras, the desire of couples to exercise control over their reproductive abilities may have been directed towards the promotion of conception rather than its prevention (Angus, 1992). This explains one of the reasons for large size in Africa.

Colin and Sheila (2001) postulated in their work, that economic, social, and cultural factors led to increasing debate on the subject of fertility control during the nineteenth century. This was particularly associated with the name of the political economist T.R Malthus and his calculation that the population would always tend to outrun the means of subsistence, though he did not recommend artificial interference with his state of affairs. Records show that as far back as the 18<sup>th</sup> century, French peasants were limiting their births through coitus interruptus because they never wanted family properties to be divided between several heirs. It was thought at that time that the smaller the number of children given birth to by parents, the larger the chance of their survival. This idea encourages parents to reduce their family size. In addition,

it was seen that infants born at wider intervals into smaller families have a better chance of survival though access to more maternal attention, and division of family resources between fewer family members (Colin and Sheila, 2001).

### **2.3 Male Involvement and Roles in Fertility**

Male involvement is a growing trend in reproductive health, but has the potential to do more harm than good if men oppose contraceptive use due to misinformation or personal biases. A past study found that women were less likely to seek Family Planning services if their husbands were present when the services were offered, implying that unmet need for fertility and excess fertility may reflect underlying differences between partner preferences (Enca et al, 2010). However, because survey responses indicated that Family Planning was primarily being used for child spacing, rather than controlling total family size. Male preferences may be malleable if they are educated on the adverse health effects of bearing multiple children close together without adequate time for the mother's recovery.

A study conducted in Pakistan (1991-1992) shows that men are significantly more likely than women to approve of Family Planning. Also, men are more likely than women to know of a source of supply. Multivariate analyses indicate that a couple's approval of Family Planning, knowledge of a source of Family Planning and discussion about Family Planning is correlated with desire to have no additional children, and the relationship is particularly strong among rural residents. The influence of the spouse's fertility desire and of communication about Family Planning suggest that concerted efforts to

educate men about reproductive and child health and to facilitate communication between husbands and wives would assist couples in agreeing upon and meeting their reproductive goals (International Family Planning Perspective, 1997).

## **2.4 Contraceptive Use**

### **2.4.1 The Concept of Contraception**

The term contraception refers to the means of avoiding pregnancy despite sexual activity (Harvey, 2005). Contraceptives are used for achievement of Family Planning, but in this case apply mostly to couples (WHO, 2005). Family Planning is a process whereby couples can determine the number of children they would like to have and the spacing of one birth from another, taking into account the health of the mother as well as that of last child. It also includes the choice of an appropriate method that will help the women and men to realize their goals for using contraceptives (Noami and Teri, 2004).

### **2.4.2 Methods of Contraception**

Broadly, contraceptive methods can be classified into two groups; modern contraceptive method and traditional contraceptive method, but the Nigeria Demographic and Health Survey (NDHS) 2013 identified contraceptive methods as modern, traditional and folkloric methods. Modern methods include female sterilization, male sterilization, the pill, intra-uterine device (IUD), injectable, implants, male condom, female condom, diaphragm, foam/jelly, Lactational amenorrhoea method (LAM), and emergency

contraception. Methods such as rhythm (periodic abstinence) and withdrawal were grouped as traditional methods (NPopC and ICF Macro, 2009).

### **2.4.3 Prevalence of Contraception**

The world-wide prevalence of contraceptive use was reported to be 62.7 percent, with the more developed regions of the world having a contraceptive prevalence of 72.4 percent, and less developed region having the prevalence of 61.2 percent. The least developed countries of the world was reported to have 31.4 percent prevalence, while other less developed countries have a prevalence of 66.0 percent (WHO, 2011). WHO also reported in 2011, that the prevalence of use of any contraceptive method in Africa was 28.6 percent, with West Africa having the lowest contraceptive use (14.4 percent), and North Africa having the highest prevalence (60.5 percent), excluding Sudan. According to NDHS 2013, prevalence of current contraceptive use for men was 3.7 percent while prevalence for currently using of contraceptive method among women was 15.0 percent, an increase of only 2.0 percentage points from 2003 NDHS.

## **2.5 Male's Involvement and Fertility Control**

### **2.5.1 Globally**

Contraceptive use has increased in many parts of the world, especially in Asia and Latin America, but continues to be low in sub-Saharan Africa (WHO, 2013). Globally, use of modern contraception has risen slightly from 54% in 1990 to 57% in 2012. Regionally, the proportion of women aged 15–49 reporting use of a modern contraceptive method has risen minimally



between 2008 and 2012. In Africa it went from 23% to 24%, in Asia it has remained at 62%, and in Latin America and the Caribbean it rose slightly from 64% to 67% (WHO, 2013). Use of contraception by men makes up a relatively small subset of the above prevalence rates. Also, the modern contraceptive methods for men are limited to male condoms and sterilization (vasectomy). The prevalence of vasectomy exceeds 10 percent in Australia, China, Korea, the Netherlands, North America and the United Kingdom but it is a method that is still largely unknown in Africa (Sekadde *et al*, 1991). Most of these studies have confirmed dissatisfaction with some aspects of the condom (Kirumira, 1991). Condom is used by 75 percent of Japanese couples perhaps largely, because of the lack of alternative methods of contraception such as the oral pill. While the condom is the most effective in preventing pregnancy, the principal reason that men discontinue use of the condom, withdrawal or periodic abstinence is method failure (Lamptey *et al*, 1978). Vasectomy has been known for a century and is the method used by about 5 percent of couples of reproductive age worldwide (Mbizvo and Adamchak, 1989).

An analysis from PDHS surveys (2008), the mean ideal family size for currently married men is higher than for married women. This difference is significant in West Africa ranging from about two children in Burkina Faso to more than four children in Niger and Senegal, in East and North Africa no significant difference in fertility desire was found. This shows the importance of targeting men with Family Planning programs (Ezeh *et al*, 1996). Increasing the use of Family Planning methods and decreasing fertility levels are important components of the development strategies of many poor countries. Throughout Latin America and the Caribbean, a number of countries have

experienced marked changes in this sphere during the past three decades. The contraceptive prevalence rate in the region has risen from 38 percent to 73 percent (UN Population Division 2003).

A study conducted in Kenya and Zambia 2013 shows a correlation between ante-natal care use and post-partum contraceptive use which suggests that contraceptive use could be increased by promoting ante-natal care services (Hotchkiss et al, 2013). Another study conducted in Zambia again in 1996 cites the importance of educating both men and women, and also states that single mothers and teenagers should be the primary focus of birth control education (Kamau et al, 1996). Of all the 376 women recruited after giving birth at the hospital, 34% had previously used Family Planning, and 64% had used Family Planning a year after giving birth. Of all the women who did not use Family Planning, 39% cited spousal disapproval as the reason, 84% of single mothers had never used Family Planning before and 56% of teenagers did not know anything about Family Planning.

### 2.5.2 Africa

In Africa, 53% of women of reproductive age have an unmet need for modern contraception. Namibia, with a contraceptive use rate of 46% in 2006 to 2007 has one of the highest rates in Africa, while Senegal with a rate of 8.7% in 2005 has one of the lowest rates (WHO, 2013). In Sub-Saharan Africa, extreme poverty, lack of access to birth control, and restrictive abortion laws caused about 3% of women to have unsafe abortions (kazi, 2003). South Africa, Botswana, and Zimbabwe have successful Family Planning Programs, but other Central and Southern African countries continue to encounter

difficulties in achieving higher contraceptive prevalence and lower fertility rates. Rwanda and Uganda have the highest unmet need for contraception rates. The Total Fertility Rate (TFR) for sub-Saharan Africa countries remains one of the highest among different regions worldwide, whereas, Nigeria with the TFR of 5.7 births per woman is greater than the figure for sub-Saharan Africa (5.2). High TFR in Nigeria and sub-Saharan African countries resulted from low level of contraceptive use in terms of acceptability, affordability and accessibility (Lalla, 2005).

Studies confirm that involving men can lead to better health outcomes including those specific to Family Planning knowledge, Intra-spousal communication, and Family Planning use and continuation. Engaging men can foster a positive environment for the couple's broader sexual, emotional and spiritual health (Cohen et al, 1997). Most of the countries with the lowest rates of contraceptive use, highest maternal, infant, and child mortality rates, and highest fertility rates are in Africa. Approximately 30% of all women use birth control, although over half of all African women would like to use birth control if it were available. The main problems that prevent access to and use of birth control are unavailability, poor health care services, spousal disapproval, religious concerns, and misinformation about the effects of birth control (Obasi et al, 2008). Another Studies conducted in African contexts also found that limited knowledge about Family Planning is a key determinant of men's negative perception of and lack of engagement in Family Planning as well as gender norms regarding men's roles (Kaida et al, 2005). Some studies suggested that spousal communication is low even in cases where men approve the family planning (Ijadunola et al, 2010). Despite these initial

findings, less is known regarding the full range of men's perspectives towards male and female contraceptive use.

### 2.5.3 Nigeria

A study of reproductive motivation conducted in four Nigerian cities and a large semi-urban settlement by the developmental agencies revealed that men wanted more children than women did, as children were believed to give status to men, often it was the men who decided whether to have another child. Oni and McCarthy (1999) working in Ilorin also found that even though virtually all men in their sample knew of at least one method of contraception but they were less knowledgeable about where to obtain contraceptives. They also thought that women should take responsibility for using contraception and men should control the decision making. According to a study done by Nwachukwu and Obasi in Nigeria 2008, modern birth control methods were used by 30% of respondents (Lawoyin et al, 2002).

In Nigeria, Oyedokun (2007) in his study on the determination of contraceptive use in Osun State showed that less than ten percent of the women he studied were currently using any modern method of contraception due to the husband disapproval. Also, Odimegwu et al (1997) in their study on contraceptive use for any method was 28.5% in Enugu State of Nigeria, 20.6% in Kano State, and 23.5 % in Lagos State respectively. They further showed that the prevalence of current use of traditional method was 18.3% in Enugu State, 10.5% in Kano State, and 8.2% in Lagos State of Nigeria respectively. They also reported that the prevalence of current contraceptive use for modern

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method was 13.6%, 16.8% and 20.1% in Enugu, Kano and Lagos State of Nigeria respectively (Oye-adeniran et al, 2005).

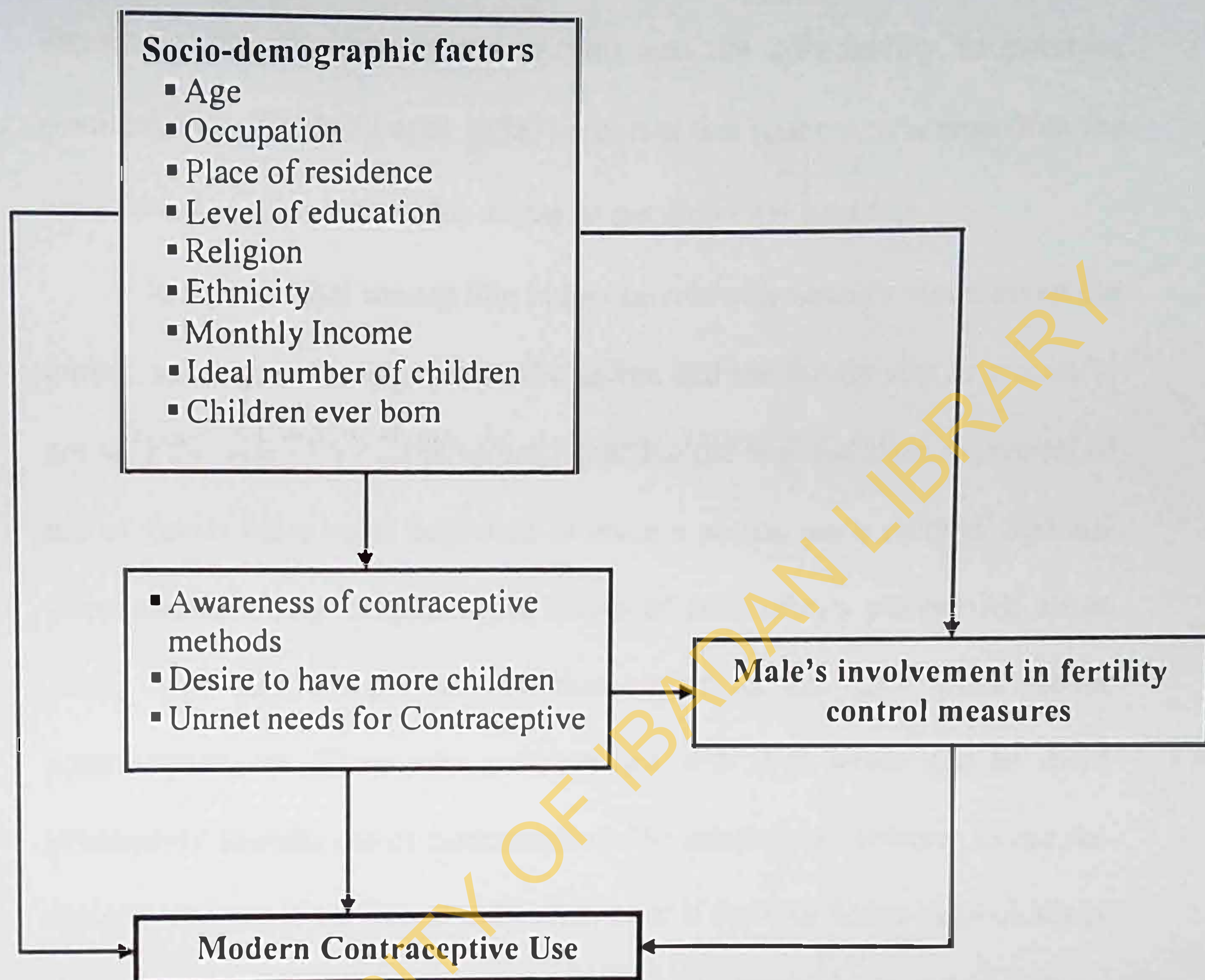
#### **2.5.4 Osun State**

Study conducted in Osun State reported that eighty-nine percent of men approved of their spouses using family planning while only 11 percent of them objected to it. 65.2 percent of the men disapproved of attending Family Planning clinics with their spouses, while only 26 percent of them had ever done so (Titilayo et al, 2012). The popular reasons given by men for approving of Family Planning use by their spouses were birth spacing (71 percent) and achievement of desired family size (20 percent), and also, the reason given for disapproving of Family Planning use was religious dictates (44 percent).

#### **2.6 Conceptual Framework**

Contraceptive use has been shown to be affected by the interplay of various social, psychological, and cultural factors related to approval from friends and family members (Van Rossem and Meekers, 2011), women's belief in child spacing, perceived competence of a health personnel, fear of side effects (Agha, 2010), age, education, religion, ethnicity, region of residence, media exposure (Odimegwu et al, 1997).

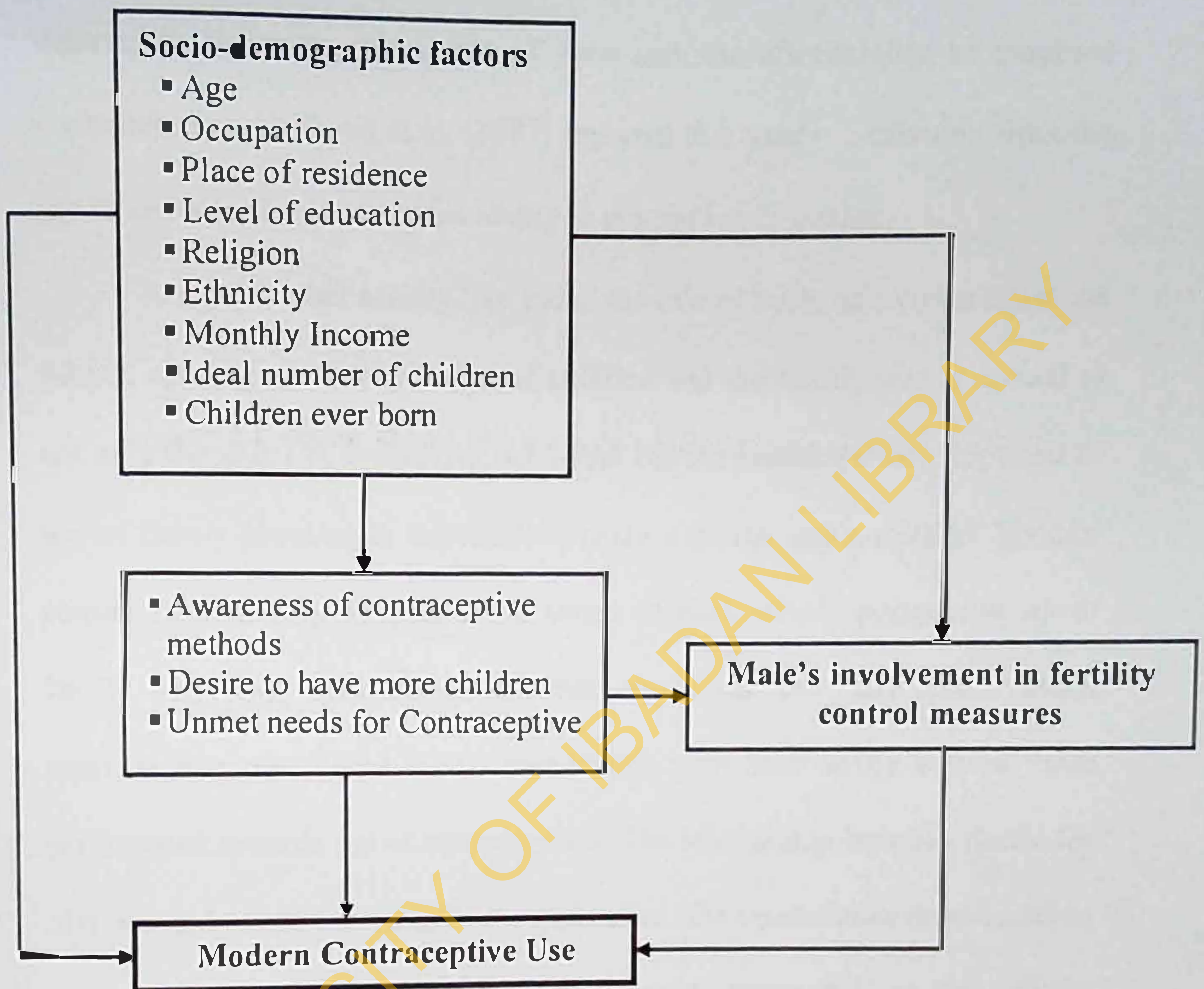
Figure 2.1 below shows the conceptual framework applied in studying male's involvement in spousal fertility control measures in Ife Central Local Government Area of Osun State.



## 2.7 Determinants of Contraceptive Use

Urban men are more likely to use contraception than rural men as they are exposed to more modern ideas due to greater exposure to media. Moreover, they have better access to information of contraception and contraceptive methods (Brachett, 1978). Education forebear's modern ideas of small family size as it means better standard of living. It also ensures greater knowledge about various methods and their effectiveness. Religious affiliations determine customs and practices regarding norms about childbearing and Family Planning. The current attitude of a particular religion

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influences the method to be used (Ringheim, 1993, Caldwell et al, 1987). Men with better standard of living are more likely to be educated, exposed to mass media, have better knowledge of contraceptive methods. Occupation determines the economic status of men and the affordability to purchase contraceptives. Caldwell et al. (1987) reported that user's satisfaction from the use of condoms is related to his ability to pay for better quality.

In a patriarchal society like India, the role of husband's views about the timing, spacing, sex composition of children and the family size is crucial to not only the wife's contraceptive behaviour but the husband's too. Approval of use of family planning is important to make a person use a method. Spousal communication help couples to be aware of each other's perspective about family size and composition so that consensus can take place about contraceptive use. Those who communicate with their wives will be more predisposed towards use of contraception. The relationship between desire for children and use of contraception is quite clear if the men desire more children they will not be contracepting and if they want to space children they will be using the spacing methods (Amrita et al, 2012).

## 2.8 Barriers to Contraceptive Use

A study conducted in the cities of Nairobi and Bungoma in Kenya, major barriers to contraceptive use included lack of agreement on contraceptive use and on reproductive intentions. There were also gaps in knowledge on contraceptive methods, fears from rumours, misconceptions about specific methods, perceived undesirable effects and availability and poor quality of services in the areas studied. About 33% of wives in Nairobi and

50% in Bungoma desired no more children however husbands desired about four or more children than wives wanted, lack of couple agreement and communication were primary reasons for non-use. Compared to Ghana, the man is considered the decision maker. The husband has a greater desire for more children preferably sons because they are able to provide financial security for their parents (Kabagenyi et al, 2014). In other Sub-Saharan African cultures, spousal discussion of sexual matters is discouraged. Couples in these cultures may use other forms of communication, such as specific music, wearing specific waist beads, acting a certain way and preparing of favourite meals to convey unambiguous sex-related messages to each other. In the case of contraception, a man's use of a contraceptive may itself be a nonverbal indicator of approval (Eze et al, 2004). Therefore, discussion may improve knowledge of Family Planning attitudes only when it is more efficient than the effectiveness of other forms of communication.

Men's lack of access to services has been a barrier to Family Planning use and they cannot share responsibility for reproductive health and Family Planning if services and information do not reach them. Most Family Planning clinics cater for women, so men are uncomfortable about going to the clinics (Population Report, 1994).

## **2.9 Population Policy in Nigeria**

The first Nigerian population policy was written in 1988 to reduce population growth as collaboration between the Federal Ministry of Health and the World Bank. Whether this policy was successful is in contention. Some schools of thought argue that it was unsuccessful due to cultural, religious and

financial factors in play. However, a positive demographic change was noticed statistically after the policy goals were implemented. Achievement of policy goals were limited due to flaws in the implementation strategy adopted for the National Population Program as well as due to a cultural aversion to Family Planning in Northern Nigeria, among other factors. The success of the policy was greatest in Southern Nigeria where social advancement also played an integral role. Specifically, the policy seeks to reduce fertility from the present level of 6 children or family to an average of 4 children or family, also suggest an optimum marriage age of 18 years for women and 24 years for men, and advocates that pregnancies must be restricted to the 18-35 years range and at intervals of 2 years (Mazzocco, K., 1988).

The general goal of the national policy on population for sustainable development is to improve the quality of life and standard of living for the Nigerian population (NPopC, 2004). This policy operates on the principle that achieving a higher quality of life for people today should not jeopardize the ability of future generations to meet their own needs (NPopC, 2004). To guide policy, programme planning, and implementation, the following targets were set: to reduce the total fertility rate by at least 0.6 children every five years by encouraging child spacing through the use of family planning, increase the contraceptive prevalence rate for modern method by at least two percentage points per year through the use of Family Planning, reduce the infant mortality rate to 35 per 1,000 live births by 2015, reduce the child mortality rate to 45 per 1,000 live births by 2010, reduce the maternal mortality ratio to 125 per 100,000 live births by 2010 and to 75 by 2015, achieve sustainable universal basic education as soon as possible before 2015, eliminate the gap between

males and females in school enrolment at all levels and in vocational and technical education by 2015, eliminate illiteracy by 2020, achieve at least a 25 percent reduction in HIV/AIDS adult prevalence every five years (NPopC and ICF Macro, 2009).

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## CHAPTER THREE

### 3.0 METHODOLOGY

#### 3.1 BRIEF DESCRIPTION OF THE STUDY AREA

The study was conducted in Ile-Ife, headquarters of Ife Central Local Government Area in Osun State, Southwest Nigeria. Ile-Ife houses two Local Government Areas (LGAs) namely, Ife Central and Ife East LGAs. Specifically, Ife Central LGA consists of 11 political wards. Ife town is one of the largest urban centers in Osun State, Nigeria and the oldest town of the Yoruba people according to history. Obafemi Awolowo University is domiciled in this city and its sister institution, the Obafemi Awolowo University Teaching Hospitals Complex. There is also a public secondary health care facility (the State Hospital, Aderemi Road), a mission hospital (the Seventh Day Adventist Hospital), and a number of primary health care facilities. A few private maternity homes and hospitals also form part of the health care facilities utilized by the community. Almost all these health care facilities provide Family Planning services. Hence, Ile-Ife is considered as highly urbanized city. The population of the area is about 170,000 persons consisting of 88,403 males and 78,801 females based on the 2006 census result (NPC, 2007).

There are 38 primary schools, 27 secondary schools and 3 tertiary institutions in Ife Central. Also, there are 5 health centres and Maternity wards that train people about Family Planning programmes. The only cultural practices about the births control are exclusive breast feeding. A comprehensive contraceptive promotion and distribution had been carried out

in the areas by the University Teaching Hospital, the State Ministry of Health and many Non-Governmental Organizations (NGOs) in the past ten years. It is therefore expected that the contraceptive awareness and use in this environment would be high.

### 3.2 STUDY DESIGN

This study was a community based cross-sectional in design and made use of methods mix approach which consisted of quantitative and qualitative research methods.

### 3.3 STUDY SUBJECTS

Study participants were married men in stable unions aged 15-59 years.

### 3.4 SAMPLE SIZE DETERMINATION

The sample size was determined using the formula  $n = (Z_{\alpha}^2 pq)/d^2$  where  $n$  is the sample size,  $\alpha$  is 0.05,  $z_{\alpha}$  is the standard normal deviate, set at 1.96 (for 95% confidence interval),  $p$  = proportion of men using modern contraceptive method in Demographic Health Survey (2013) was 3.7 percent,  $d$  is the degree of precision (taken as 0.015). Therefore,  $n = [1.96^2 \times 0.037 \times (1 - 0.037)] / (0.015^2) = 608.44$  Considering 10% non-response rate this was increased to 669, for the accuracy of result the sample size was increased to 1000.

### **3.5 SAMPLING TECHNIQUES**

The sample for this study was selected from the Enumeration Areas designed for the Local Government during 2006 Population Census exercise. At the first stage, the whole local government was stratified into 4 based on the map of the Local Government Area. Thereafter, 5 Enumeration Areas each were randomly selected from each stratum. In each of the selected Enumeration Areas, 50 households were randomly picked. This was done by constructing a sampling frame for all eligible households in each Enumeration Area and as such systematic random sampling was used to pick the households.

### **3.6 DATA COLLECTION METHODS AND TOOLS**

#### **3.6.1 Quantitative**

- A semi-structured questionnaire was used to collect information on socio-demographic characteristics of the study participants, modern contraceptive use, and knowledge of vasectomy. Questions were also asked from their wives on contraceptive use.

#### **3.6.2 Qualitative**

- Key Informant Interview (KII) with two Family Planning Care Providers was conducted in the study area.
- Three Focus Group Discussions (FDGs) were also conducted at different locations in the study areas. Eight respondents in each group in a comfortable environment with about 3 hours per group.

### 3.7 DATA MANAGEMENT AND ANALYSIS

- Data were entered using SPSS software version 16. Data were also edited and cleaned to correct data imputation errors.
- Descriptive statistics, frequencies and percentages were used to describe the background characteristics of the respondents, knowledge and use of modern contraceptive methods.
- Cross tabulation were carried out using dependent variables and independent variables.
- Multivariate analysis was carried out to determine the association between socio-demographic characteristics and currently using contraceptives, knowledge of vasectomy.

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SPECIFIC OBJECTIVES	VARIABLES	ANALYSIS
* Examine the knowledge of vasectomy among married men in Ife Central Local Government Area of Osun State.	Knowledge of vasectomy	Descriptive Statistics
* Identify factors influencing knowledge of vasectomy among married men in Ife Central Local Government Area of Osun State.	<u>Dependent:</u> Knowledge of vasectomy  <u>Independent:</u> Socio-demographic factors	Chi-square  Logistic regression
* Identify factors influencing spousal use of modern contraceptive in Ife Central Local Government Area of Osun State.	<u>Dependent:</u> Modern contraceptive use  <u>Independent:</u> Socio-demographic factors	Chi-square  Logistic regression
* Explore factors associated with male involvement in fertility control measures.	FGD	Thematic approach from verbal reporting

### 3.9 ETHICAL CONSIDERATIONS

Ethical approval was obtained from Ethical Review Committee of Obafemi Awolowo University, Ile-Ife. Individual consent was also obtained from each of the participants and their confidentiality assured before the study began.

## CHAPTER FOUR

### 4.0 RESULTS

#### 4.1 Frequency Distribution of respondents by selected Socio-Demographic Characteristics

Table 4.1.1 presents the socio-demographic variables of the respondents in the study areas. The data show that the mean age of the men was  $38.2 \pm 11.055$  years, over half of the respondents (55.8%) are less than 40 years old and 23.8% of the respondents are between the age group 40 to 49 years. Also, more than half of the respondents were Christians (59.4%) and Islam constituted 39.1% of the respondents. Most of the respondents (69.8%) were resident in the urban areas, while 30.2% of the participants lived in the rural areas.

The highest proportion of the respondents was seen to have received higher level of education (41.3%). About a fifth (18.3%) had less or equal to primary level of education, while 40.4% of the respondents had attained secondary level of education. From the distribution of the respondents by ethnic groups, almost all the respondents (83.0%) belong to Yoruba, while the remaining (17.0%) of the respondents belong to other ethnic groups. The highest proportion of the respondents (29.4%) were civil servants while 25.5% were traders, 18.9% were professionals, 14.2% were artisans and the remaining 12.1 were in occupation groups.

The data further shows that 41.4% of the respondents were earning 10,000-39,999 naira, 26.0% were earning 40,000-69,999 naira, while 17.7% of the respondents were earning more than 70,000 naira every month. The

remaining 14.9% of the respondents were earning less than 10,000 naira monthly. About 49.1% of the respondents have either three or four children, 36.3% of the respondents have at least five children while about 15.0% have at most two children.

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**Table 4.1.1 Frequency distribution of the respondents by socio-demographic variables**

<b>Background Characteristics</b>	<b>Number (1000)</b>	<b>Percent</b>
<b>Age Group (years)</b>		
< 30	235	23.5
30 - 39	323	32.3
40 - 49	238	23.8
50 – 59	204	20.4
<b>Religion</b>		
Islam	391	39.1
Christianity	594	59.4
Traditionalist	15	1.5
<b>Place of Residence</b>		
Urban	698	69.8
Rural	302	30.2
<b>Level of Education</b>		
≤Primary	183	18.3
Secondary	404	40.4
Higher	413	41.3
<b>Ethnicity</b>		
Yoruba	830	83.0
Others	170	17.0
<b>Occupation</b>		
Trading	254	25.4
Professionals	189	18.9
Civil servants	294	29.4
Artisans	142	14.2
Others	121	12.1
<b>Income</b>		
<10000	149	14.9
10000-39999	414	41.4
40000-69999	260	26.0
70000+	177	17.7
<b>Children Ever Born (CEB)</b>		
0-2	146	14.6
3-4	491	49.1
5+	363	36.3

## 4.2 Prevalence of current contraceptive use

As shown in table 4.2.1, almost all the respondents have heard of any contraceptive methods (99.4%) while 98.8% have heard of any modern methods. 90% of the respondents have used any method while 83.0% of the respondents have used modern method.

**Table 4.2.1: Knowledge and ever used of contraceptive methods**

Responses on Types of Contraceptive	Yes (%)	No (%)
Ever heard of any contraceptive method	994 (99.4)	6 (0.6)
Ever heard of any modern	988 (98.8)	12 (1.2)
Ever used any method	900 (90.0)	100(10.0)
Ever used modern method	830 (83.0)	170(17.0)

*N=1000*

Table 4.2.2 below shows that 88.9% of the respondents were ever heard of condom while 71% of the respondents were ever heard of pills. Also, respondents that ever heard of periodic abstinence were about 60% while respondents that ever heard of emergency contraceptive were 39.2%.

**Table 4.2.2: Frequency distribution of respondents based on the type of ever heard and ever used of contraceptives by either themselves or their spouse**

MODERN CONTRACEPTIVE USE	EVER HEARD		EVER USED/YOUR PARTNER	
	Yes (%)	No (%)	Yes (%)	No (%)
Female sterilization	513 (61.3)	487 (38.7)	33 (3.3)	967 (96.7)
Male sterilization	418 (61.8)	582 (38.2)	13 (1.3)	987 (98.7)
Pill	710 (71.0)	290 (29.0)	268 (26.8)	732 (73.2)
IUD	512 (51.2)	488 (48.8)	197 (19.7)	803 (80.3)
Injectables	640 (64.0)	360 (36.0)	246 (24.6)	754 (75.4)
Implants	458 (45.8)	542 (54.2)	160 (16.0)	840 (84.0)
Condom	889 (88.9)	111 (11.1)	621 (62.1)	379 (37.9)
Foam or Jelly	405 (40.5)	595 (59.5)	207 (20.7)	793 (79.3)
LAM	113 (11.3)	887 (88.7)	17 (1.7)	983 (98.3)
Periodic Abstinence	563 (56.3)	437 (43.7)	229 (22.9)	771 (77.1)
Withdrawal	645 (64.5)	355 (35.5)	310 (31.0)	690 (69.0)
EC	392 (39.2)	608 (60.8)	76 (7.6)	924 (92.4)
Traditional Methods	589 (58.9)	411 (41.1)	186 (18.6)	814 (81.4)

N=1000, LAM: Lactational Amenorrhea Method, EC: Emergency Contraception

The data below show that the percentage frequency of condom used was the highest (62.1%) while the male sterilization was the least (1.3%) among men. Also, the highest percentage frequency used by their wives was the pill (26.8%) and the lowest was the Lactational Amenorrhea (1.7%).

**Figure 4.1: Percentage frequency distribution of respondents based on the type of contraceptive use by either themselves or their spouse**

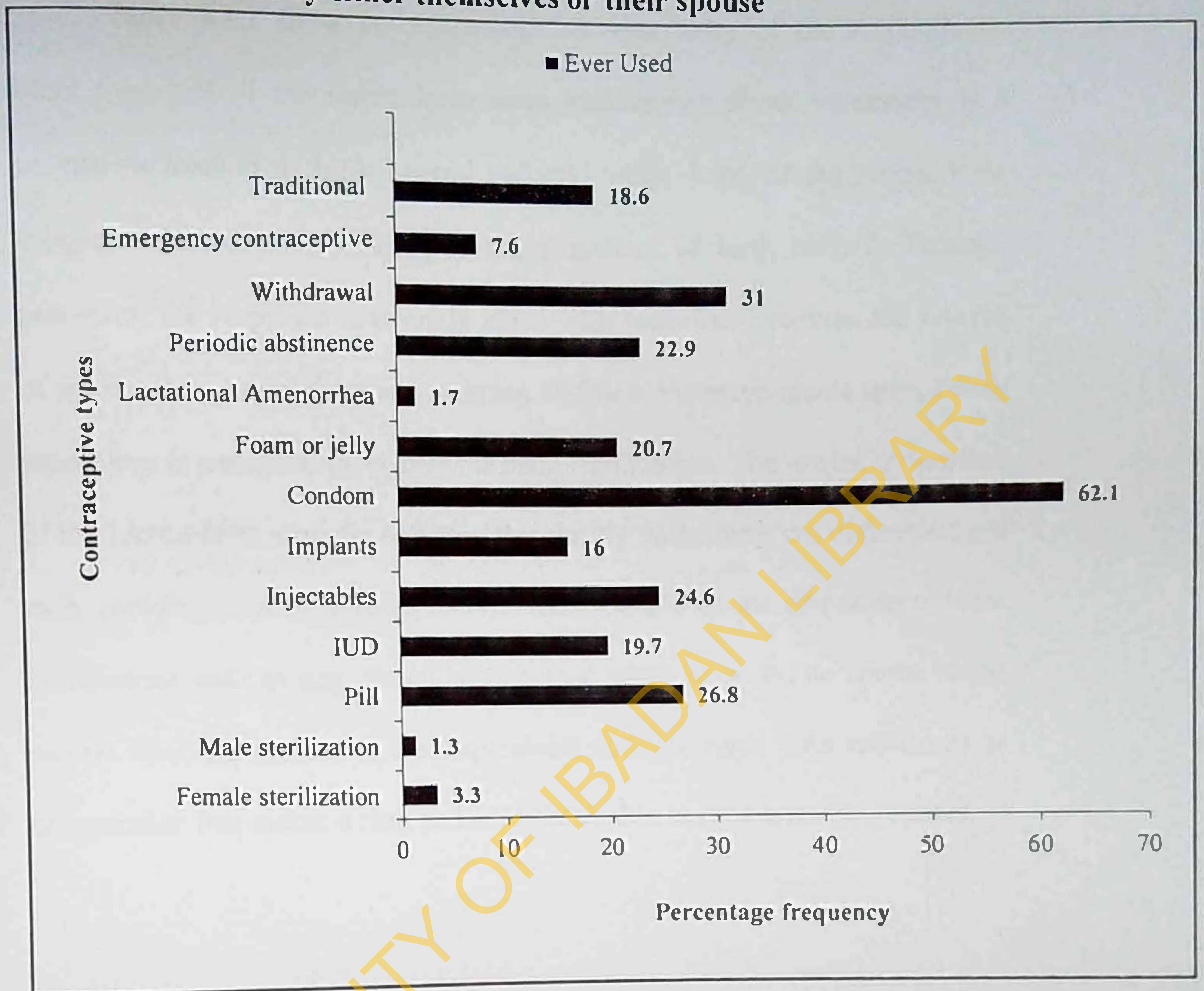


Table 4.2.2 show the prevalence rate of currently using modern contraceptives. It shows that 29.0% of the respondents were currently using modern contraceptives.

**Table 4.2.3: Prevalence of currently using modern contraceptives**

	Number	Percent
Currently using contraception	290	29.0
Yes	710	71.0
No		

*N=1000*

### 4.3 Knowledge of vasectomy

Table 4.3.1 show the knowledge of vasectomy of the respondents. More than half of the respondents were indifference about vasectomy is a permanent method of birth control (65.2%) while 2.0% of the respondents disagree with vasectomy is a permanent method of birth control. Thirteen percent of the respondents strongly agree with vasectomy prevent the release of sperm when a man ejaculates. Almost 20.0% of the respondents agreed with vasectomy is a surgical procedure for male sterilization. The lowest proportion of the respondents strongly disagree that during vasectomy vas deferens from each testicle is cut or sealed (1.8%). About 50.0% of the respondents were indifference with an egg cannot be fertilized when there are no sperm in the semen. Fourteen percent of the respondents strongly agree with vasectomy is an operation that makes a man permanently unable to get a woman pregnant.

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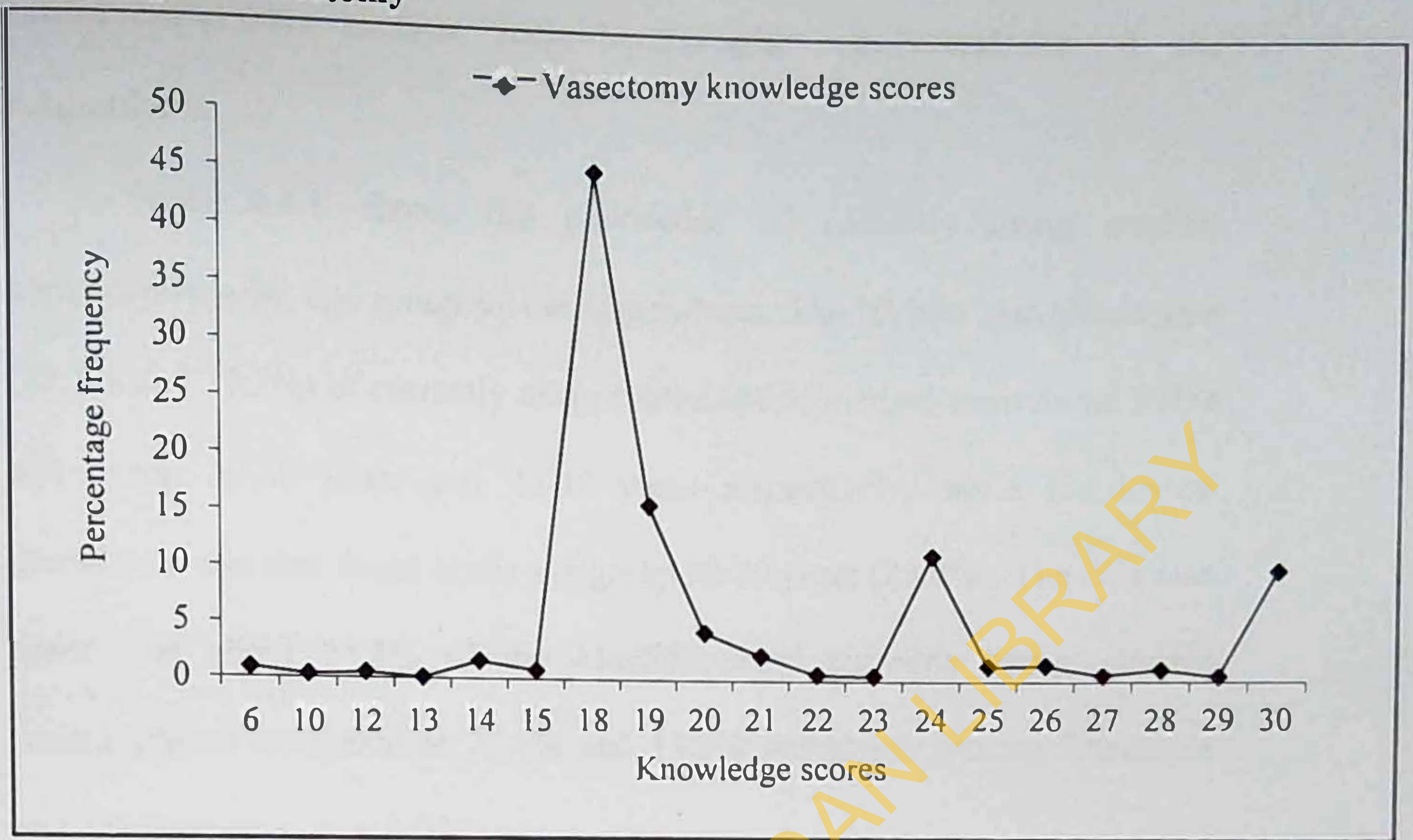


**Table 4.3.1 Percentage distribution of the respondents by knowledge of vasectomy**

Knowledge of vasectomy	Strongly Disagree	Disagree	Indifference	Agree	Strongly Agree	Total
<u>Vasectomy is a permanent method of birth control</u>	3.9 (39)	2.0 (20)	65.2 (652)	16.3 (163)	12.6 (126)	100.0
<u>Vasectomy prevents the release of sperm when a man ejaculates</u>	3.2 (32)	2.2 (22)	65.6 (656)	16.0 (160)	13.0 (130)	100.0
<u>Vasectomy is a surgical procedure for male sterilization</u>	2.5 (25)	1.8 (18)	66.0 (660)	17.1 (170)	12.6 (126)	100.0
<u>During vasectomy Vas deferens from each testicle is cut or sealed</u>	2.7 (27)	1.8 (18)	65.7 (657)	16.8 (168)	13.0 (130)	100.0
<u>An egg cannot be fertilized when there are no sperm in the semen</u>	1.2 (12)	0.5 (5)	47.7 (477)	33.0 (330)	17.6 (176)	100.0
<u>Vasectomy is an operation that makes a man permanently unable to get a woman pregnant</u>	1.3 (13)	0.7 (7)	65.3 (653)	18.7 (187)	14.0 (140)	100.0

Figure 4.2 shows the percentage frequency curve of knowledge of vasectomy among men in stable union. The curve shows that there was a higher percentage frequency level of knowledge of vasectomy among men aged 15 to 19 years while the knowledge of vasectomy continue to reduced down ward was lower at the age of 22 upward.

**Figure 4.2: Percentage frequency curve of respondents based on the knowledge of vasectomy**



In table 4.3.2; knowledge of vasectomy was categorized into two as adequate and inadequate. The data show that fewer proportions had adequate knowledge of vasectomy (34.5%).

**Table 4.3.7: Percentage distribution of the respondents by knowledge of vasectomy**

Knowledge of vasectomy	Number	Percent
Inadequate	655	65.5
Adequate	345	34.5

*N=1000*

#### 4.4 Distribution of the prevalence rate of currently using modern contraceptive over various socio-demographic characteristics of the respondents

Table 4.4.1 shows the prevalence of currently using modern contraceptives by age group of the respondents. The highest prevalence rate (31.3% and 35.3%) of currently using contraceptive method were found in the age group 30-39 years and 40-49 years respectively, while the lowest prevalence was also found in the age group 50-59 years (23.0%). The data also show that about 34.8% of the Muslims were currently using modern contraceptives compared to 25.6% and 13.3% prevalence among Christians and Traditionalists ( $p = 0.003$ ).

The data show there was a strong statistically significant association between currently using modern contraceptives and place of residence. Modern contraceptive use was found to be higher (33.8%) among urban resident compared to rural resident (17.9%). About 35.6% of the respondents with higher level of education are currently using modern contraceptive, compared to secondary level of education (25.7%) and those with less or equal primary level of education (21.3%,  $p < 0.001$ ). Almost 30.0% among the Yoruba's were currently using modern contraceptives while 26.5% among other ethnic group were currently using modern contraceptive methods. No significant association was found between the ethnicity and currently using modern contraceptive methods ( $p = 0.425$ ).

The highest prevalence (40.1%) of currently using modern contraceptive was among civil servants, 28.6% and least (21.1%) among professionals and artisans. There was a statistically significant association between currently

using modern contraceptives and occupation ( $p=0.000$ ). The data reveal that about 50.3% of the respondents who were earning more than 70,000 naira monthly were currently using modern contraceptives, while only 16.8% of the respondents who were earning less than 10,000 naira monthly were currently using modern contraceptives. There was a strong statistically significant relationship between currently using modern contraceptives and respondents' monthly income ( $p=0.000$ ).

The highest prevalence rate of currently using modern contraceptives was found among the respondents who have given birth to more than five children was 31.1%, whereas the respondents (30.8%) who gave birth to three to four children were currently using modern contraceptives.

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**Table 4.4.1 Distribution of respondents' currently using modern contraceptives by socio-demographic characteristics**

Background Characteristics	Currently using modern contraceptives		Total men	Chi- square	p-value
	Yes	No			
<b>Age</b>				11.110	0.011
< 30	23.0 (54)	77.0 (181)	235		
30 - 39	31.3 (101)	68.7 (222)	323		
40 - 49	35.3 (84)	64.7 (154)	238		
50 - 59	25.0 (51)	75.0 (153)	204		
<b>Religion</b>				11.494	0.003
Islam	34.8 (136)	65.2 (255)	391		
Christianity	25.6 (152)	74.4 (442)	594		
Traditionalist	13.3 (2)	86.7 (13)	15		
<b>Place of Residence</b>				25.980	0.000
Urban	33.8 (236)	66.2 (462)	698		
Rural	17.9 (54)	82.1 (248)	302		
<b>Level of Education</b>				16.055	0.000
≤Primary	21.3 (39)	78.7 (144)	183		
Secondary	25.7 (104)	74.3 (300)	404		
Higher	35.6 (147)	64.4 (266)	413		
<b>Ethnicity</b>				0.636	0.425
Yoruba	29.5 (245)	70.5 (585)	830		
Others	26.5 (45)	73.5 (125)	170		
<b>Occupation</b>				27.597	0.000
Trading	23.2 (59)	76.8 (195)	254		
Professionals	28.6 (54)	71.4 (135)	189		
Civil servants	40.1 (118)	59.9 (176)	294		
Artisans	21.1 (30)	78.9 (112)	142		
Others	24.0 (29)	76.0 (92)	121		
<b>Income</b>				54.010	0.000
<10000	16.8 (25)	83.2 (124)	149		
10000-39999	24.4 (101)	75.6 (313)	414		
40000-69999	28.8 (75)	71.2 (185)	260		
70000+	50.3 (89)	49.7 (88)	177		
<b>CEB</b>				10.414	0.005
0-2	17.8 (26)	82.2 (120)	146		
3-4	30.8 (151)	69.2 (340)	491		
5+	31.1 (113)	68.9 (250)	363		

CEB: Children ever born

#### 4.5 Socio-demographic distribution of respondents by knowledge of vasectomy

As shown in the table below, almost half of the respondents (41.6%) within the age group 40-49 years have adequate knowledge of vasectomy, follow by 38.7%, 34.1% and 24.3% of the respondents within the age group 50-59 years, 30-39 years and less than 30 years respectively have adequate knowledge of vasectomy. There was a strong statistically significant association between the knowledge of vasectomy and age of the respondents ( $p=0.000$ ). Also, about 35.9% of the respondents that have adequate knowledge of vasectomy were Christians as against 33.0% among the Muslims ( $p=0.321$ ).

About 43.0% of the respondents that have the highest adequate knowledge of vasectomy were resident of the urban areas while 15.6% who reside in rural areas have the lowest adequate knowledge of vasectomy. There was a significant association between the knowledge of vasectomy and place of residence ( $p<0.001$ ). Respondents with higher level of education have the highest adequate knowledge of vasectomy (49.6%). The table also shows that there is a little difference of adequate knowledge of vasectomy between the respondents with less or equal to primary (26.8%) and secondary level of education (22.5%,  $p<0.001$ ).

There was no statistically significant relationship between the knowledge of vasectomy and ethnicity ( $P=0.770$ ). A little difference of adequate knowledge of vasectomy between the Yoruba's (34.7%) and other ethnic group (33.5% was found). Men who are professionals (52.4%) and civil servants (48.0%)

vasectomy. However, the data is evidenced that, significant association existed between occupation and knowledge of vasectomy ( $p < 0.001$ ).

Respondents who were earning less than ten thousand naira has the lowest adequate knowledge of vasectomy (17.4%), while the highest adequate knowledge of vasectomy were among those who were earning more than seventy thousand naira every months.

**Table 4.5.1: Distribution of respondents' knowledge of vasectomy by socio-demographic characteristics**

Background Characteristics	Knowledge of Vasectomy		Total men	Chi-square	P-value
	Inadequate	Adequate			
<b>Age</b>				17.859	0.000
< 30	75.7 (178)	24.3 (57)	235		
30 - 39	65.9 (213)	34.1 (110)	323		
40 - 49	58.4 (139)	41.6 (99)	238		
50 - 59	61.3 (125)	38.7 (79)	204		
<b>Religion</b>				2.274	0.321
Islam	67.0 (262)	33.0 (129)	391		
Christianity	64.1 (381)	35.9 (213)	594		
Traditionalist	80.0 (12)	20.0 (3)	15		
<b>Place of Residence</b>				68.662	0.000
Urban	57.3 (400)	42.7 (298)	698		
Rural	84.4 (255)	15.6 (47)	302		
<b>Level of Education</b>				72.345	0.000
≤Primary	73.2 (134)	26.8 (49)	183		
Secondary	77.5 (313)	22.5 (91)	404		
Higher	50.4 (208)	49.6 (205)	413		
<b>Ethnicity</b>				0.085	0.770
Yoruba	65.3 (542)	34.7 (288)	830		
Others	66.5 (113)	33.5 (57)	170		
<b>Occupation</b>				96.483	0.000
Trading	79.9 (203)	20.1 (51)	254		
Professionals	47.6 (90)	52.4 (99)	189		
Civil servants	52.0 (153)	48.0 (141)	294		
Artisans	80.3 (114)	19.7 (28)	142		
Others	78.5 (95)	21.5 (26)	121		
<b>Income</b>				58.721	0.000
<10000	82.6 (123)	17.4 (26)	149		
10000-39999	70.8 (293)	29.2 (121)	414		
40000-69999	61.2 (159)	38.8 (101)	260		
70000+	45.2 (80)	54.8 (97)	177		
<b>Children Ever Born</b>				1.360	0.507
0-2	65.1 (95)	34.9 (51)	146		
3-4	64.0 (314)	36.0 (177)	491		
5+	67.8 (246)	32.2 (117)	363		



Table 4.5.2 show the output of the multiple logistic regression model generated for factors influencing adequate knowledge of vasectomy among married men in stable union. The data shows that men in the rural areas were less likely (OR=0.399; C.I=0.271-0.586,  $p<0.001$ ) to have adequate knowledge of vasectomy than those in urban areas. There was higher odd ratio among men who were professionals (OR=3.22; C.I=2.052-5.052,  $p<0.001$ ) and civil servants (OR=2.064; C.I=1.1358-3.137,  $p<0.05$ ) than those who were traders. Men who were earning more than 70,000 naira monthly were higher likely to have adequate knowledge of vasectomy than those who were earning less than 10,000 naira (OR=1.84; C.I=1.108-3.563,  $p<0.05$ ).

**Table 4.5.2: Logistic regression of factors influencing adequate knowledge of vasectomy among married men in stable union in Ile-Ife central local government area, Osun State**

Background Characteristics	B	Wald	Sig.	Exp(B)	95.0% C.I. for EXP(B)	
					Lower	Upper
<b>Age</b>						
<30 (Ref. Cat.)				1.000		
30-39	0.190	0.801	0.371	1.209	0.797	1.834
40-49	0.394	2.934	0.087	1.483	0.945	2.327
50-59	0.268	1.204	0.272	1.308	0.810	2.111
<b>Place of residence</b>						
Urban (Ref. Cat.)				1.000		
Rural	-0.920	21.921	0.000	0.399*	0.271	0.586
<b>Religion</b>						
Islam (Ref. Cat.)				1.000		
Christianity	-0.333	2.169	0.141	0.717	0.460	1.117
Traditional	0.426	3.690	0.055	1.531	0.991	2.363
<b>Occupation</b>						
Trading (Ref. Cat.)				1.000		
Professional	1.169	25.898	0.000	3.220*	2.052	5.052
Civil servant	0.725	11.495	0.001	2.064**	1.358	3.137
Artisan	0.090	0.109	0.742	1.094	0.641	1.867
Others	0.057	0.039	0.843	1.058	0.604	1.855
<b>Income</b>						
<10000 (Ref. Cat.)				1.000		
10000-39999	0.462	3.247	0.072	1.588	0.960	2.625
40000-69999	0.523	3.683	0.055	1.687	0.989	2.876
70000+	0.685	5.264	0.022	1.984*	1.105	3.563

The data as shown in table 4.5.3 revealed that men in age group 50-59 were less likely (OR=0.35; C.I=0.19-0.645, p<0.05) to use modern contraceptive than those in age group less than 30. Men who are Christians were less likely (OR=0.35; C.I=0.190-0.645, p<0.05) to use modern contraceptive than men who are Muslims. Men who reside in rural areas were

than those who reside in the urban areas. Respondents who were earning more than 70,000 were higher likely (OR=4.516; C.I=2.479-8.227,  $p<0.001$ ) to use modern contraceptive than those who were earning less than 10,000. Men who have given birth to three or four children were higher likely (OR=1.879; C.I=1.132-3.094,  $p<0.05$ ) to use modern contraceptive than those who have no child or one child or two children, likewise men who have more than five children were higher likely (OR=2.342; C.I=1.298-4.226,  $p<0.05$ ) to use modern contraceptive than those who have no child or one child or two children.

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**Table 4.5.3: Logistic regression of factors influencing current use of modern contraceptive among married men in stable union in Ile-Ife central local government area, Osun State**

Background Characteristics	B	Wald	Sig.	Exp(B)	95.0% C.I. for EXP(B)	
					Lower	Upper
<b>Age</b>						
<30 ( <i>Ref. Cat.</i> )				1.000		
30-39	-0.033	0.022	0.881	0.968	0.630	1.486
40-49	-0.173	0.462	0.497	0.841	0.510	1.386
50-59	-1.049	11.340	0.001	0.350**	0.190	0.645
<b>Religion</b>						
Islam ( <i>Ref. Cat.</i> )				1.000		
Christianity	-0.545	12.874	0.000	0.580*	0.431	0.781
Traditional	-1.301	2.718	0.099	0.272	0.058	1.279
<b>Place of residence</b>						
Urban ( <i>Ref. Cat.</i> )				1.000		
Rural	-0.569	8.388	0.004	0.566**	0.385	0.832
<b>Level of education</b>						
≤Primary		2.955	0.228			
Secondary	0.310	1.769	0.184	1.364	0.863	2.155
Higher	0.402	2.928	0.087	1.494	0.943	2.367
<b>Occupation</b>						
Trading ( <i>Ref. Cat.</i> )				1.000		
Professional	-0.130	0.289	0.591	0.878	0.546	1.411
Civil servant	0.332	2.403	0.121	1.394	0.916	2.120
Artisan	-0.074	0.078	0.781	0.929	0.551	1.564
Others	0.138	0.245	0.621	1.148	0.664	1.984
<b>Income</b>						
<10000 ( <i>Ref. Cat.</i> )				1.000		
10000-39999	0.436	2.799	0.094	1.546	0.928	2.575
40000-69999	0.462	2.760	0.097	1.587	0.920	2.735
70000+	1.508	24.265	0.000	4.516*	2.479	8.227
<b>Children ever born</b>						
≤2				1.000		
3-4	0.626	5.962	0.015	1.871***	1.132	3.094
5+	0.851	7.980	0.005	2.342**	1.298	4.226

## Reason why men were not using modern contraceptive methods

Male involvement in modern contraceptive use is very important in Nigeria due to the high rate of TFR (5.5 children per woman, NDHS, 2013). The prevalence rate of currently using modern contraceptives among men in Nigeria was 3.7% (NDHS, 2013). While the modern contraceptive prevalence rate among men in stable union in the study areas was 29.0%. Information about the reason why men were not using modern contraceptive method and factors affecting male's involvement in modern contraceptive use will assist policy makers and Family Planning programmers to improve frame work on utilization strategies for modern contraceptive use in Nigeria.

In this study, question was asked to ascertain the reasons why men are not using modern contraceptive in the study area. The responses of the participants were similar in some ways and as such one of these was captured in this dissertation as presented here. They mentioned awareness, flesh to flesh contact (inhibiting condom use) and fear of side effect.

*"Some men were not aware of contraceptive use due to their level of exposure and some complaint about the side effects of modern contraceptive use. Like me, I don't like using condom because am not really enjoying myself during sexual intercourse and whenever I wanted to have sex with my wife, I prefer flesh to flesh but immediately after the sex I told my wife to stand up so as not to get pregnant because I didn't allow her to use any of the methods of contraception. One of my friends that his wife used one of the methods of contraception, his wife was having stomach problem".*  
FGD1 IFC

Another common response was that contraceptive choices are limited in number for men unlike women who have several alternatives. They believed that one of the two choices for men (vasectomy) can affect sexual performance

## QUALITATIVE RESULTS

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and even their wives do not encourage them to use the method. The other also does not make couples to have enjoyable sex (condom). As an example, one of the participants said;

*"We have only two methods of contraception from the health facility which is vasectomy and condom while vasectomy lasts until death. As for me, I cannot do vasectomy because if something happen to my children or wife, I would not be able to give birth to any child and nobody knows tomorrow. However, women have many short term methods such as injections, pills, Implant, and so on which they can use but my wife prefers using injectable without my approval"* FGD2 IFC

Some of the respondents mentioned that they would not allow their wives to use contraception because of promiscuity. In traditional Africa culture, having child for another man when a woman is in marriage is seen as a taboo and such women are often ostracized in the community. The men believe that once a woman is contracepting, she can begin to have sexual affair with other men since she knows that she would not be pregnant. Also they suggested that if options for men can be modified in some ways, they would be willing to use contraceptive other than their wives using any method.

*"I can only use condom which I know that is available for us but the other one you are talking about I have not heard about it. Even though I knew about the injectable and pill, I cannot allow my wife to use it because most women that were using it have another partner outside their matrimonial home which I also believed. If we had something that we would use and attached somewhere to space children rather than those two methods you mentioned, then we would directly get involved in Family Planning to avoid giving birth to too many children."* FGD3 IFC

### **Factors affecting male's involvement in modern contraceptive use**

Questions were asked to identify factors that do hinder men from involving in modern contraceptive use either as individual or as family. Most

of the men seem to have common factors as hindrances to their involvement in Family Planning uptake. They mentioned; perceived side effect, lack of sexual pleasure, contraceptive often leads to infertility among men and women, lack of time to follow their wives to the clinic since they are the breadwinner of the family and some see Family Planning matters as women business. These factors were adequately captured in one of the participants view as stated below;

*"Majority of men were not available to follow their wife to Family Planning Clinic due to the situation of their work. Also, among the available ones, most of them will ignore it and say they don't have time that is women's business not for them, some will even discourage their wife not to go to Family Planning Clinic that what were they teaching them. A commonly reported factor among married men to support their partner's use of contraceptive methods related to perceived side effects which were blamed for reducing sexual pleasure and increasing women's risks of infertility and illness. KIII IFC*

Some of the respondents also said that;

*"I encourage my wife to go to Family Planning Clinic so that they will counsel her about different methods of modern contraceptive use, and she will be able to choose the one that she prefers." FGD1 IFC*

*"The reason why am not involved in modern contraceptive use was because of excessive bleeding among women after using contraceptive methods". FGD2 IFC*

*"Some of the women lose their sexual appetite, and no longer want to be with a man and others bleed for all the three months. Sometimes this causes problems in the marriages. When you are with your wife, the feeling is as though you do not have a wife. One ends up looking for sex outside their marriage". KII2 IFC*



Another respondent also said that men should be educating about Family Planning;

*“Men are not fully involved in Family Planning and promotion of contraceptive use because they do not know. It is common for women to be sensitized because they go for antenatal care, but men do not go for antenatal care. There are only few who go there with their wives. At our area, there are no sensitizations targeting men. It is only a few women who educate their men about the use of contraceptive, and they can't really explain to them very well”.*  
FGD3 IFC

Some of their responses are men should encourage their wife to use modern contraceptive method, some of the side effects which made them ignore the contraceptive use by their wives was over bleeding, dizziness and nausea.

*“If you have a wife that use pills, these pills have some side effects on those women like dizziness, nausea and bleeding. Like me now, am a farmer, so when my wife go to farm, she return late without any work done and complaining of sickness. If your wife has no side effects in using Family Planning pills then it is okay. But the problem is that my wife asked for money from me because she was sick and need treatment for the side effects which I don't like.”*  
FGD3 IFC

## CHAPTER FIVE

### DISCUSSION, CONCLUSION, AND RECOMMENDATIONS

#### 5.0 DISCUSSION

This study examined contraceptive practices among married men and also identified factors that influences male's involvement in Family Planning practices in Ife Central Local Government Area, Osun State. The study was conceived against the background of limited information on male involvement in fertility control measures in the study area.

The mean age of men was  $38.1 \pm 11.0$  years and about 60.0% had at least secondary education. The observed means age of the men is expected as the study focused on married men in stable union. In Nigeria context men married at old age as reported in a notional survey, where the mean age of men aged (15-59 years) was found to be  $29.12 \pm 9.29$  (NDHS, 2013). In this study, almost all the men had at least primary education with majority having at least secondary education. This is in line with men's educational distribution profile in Nigeria (NPC, 2006).

The level of awareness of modern contraceptives by men was quite high in this study. The pattern was similar to the current report from national survey in which nine out of every 10 currently married men and women knew of at least one modern contraceptive use in the south-western region of the country (NDHS, 2013). This finding is in line with Lawoyin et al, 2002, in their study of Family Planning in rural Nigeria, which revealed that, generally, knowledge was high for any modern contraceptive method. Although, generally knowledge of modern contraceptive is high in Nigeria and there are variations

across the regions in Nigeria with south-west, the region where this study was conducted as being highest so the finding from this study is in order.

Among men in Ife Central LGA, the condom was the most common contraceptive method ever used. This finding was in agreement with that of Orji and Onwudiegwu, 2000 and the 2013 NDHS, which both showed that the male condom was also the most common modern method ever used by married men (Titilayo et al, 2012). Only 1.3% of the men had been sterilized. This percentage is quite higher than the national figure which was as low as 0.7% (NDHS, 2013). The reason for the finding in this study could be due to the presence of a tertiary health institution.

The study revealed that 34.5% of the respondents had adequate knowledge of vasectomy; men who were earning more than 70,000 were more likely to have knowledge of vasectomy than those who were earning less than 10,000. This pattern was similar to the findings of Caldwell et al, 1987 who reported that men with better standard of living are more likely to be educated, exposed to mass media and have better knowledge of vasectomy. Respondents in the ages between 40-49 years have adequate knowledge of vasectomy (41.6%) in the study area, where as findings by Sakadde at al, 1999 shows that those who reported that they had knowledge of vasectomy only exceeds ten percent among the same age group.

There are variations in the types of contraceptive methods that are practiced in the study area. Male modern contraceptive methods such as vasectomy were poorly utilized. A desire to have more children, fear of side effects among contraceptive users and religious prohibitions were some of the reasons reported for the low utilization of family planning methods. More

couples used contraceptive methods for birth spacing than for stopping childbearing and the family planning decision making role was mostly influenced by both couples, where the role of men could be very high. These results are in line with other studies conducted in Ethiopia and other developing countries (Mesfin G. 2002). The desire for more children among men, particularly in rural areas, was explained by the fact that men culturally consider children as an asset and think that they socially and economically gain from having a large number of children (Caldwell JC & Caldwell P., 1990). The ideal number of children in this study group was also high

## 5.2. Conclusion

In spite of a high level of knowledge of the modern contraceptive methods among married men in Ife Central LGA, modern contraceptive prevalence rates was low in the study area. This study has found the factors influencing contraceptive use as age, occupation, place of residence, level of education, religion, ethnicity, monthly Income, ideal number of children, number of children given birth to, lack of awareness, desire to have more children, fear of side effect and health concern. The key predictors of adequate knowledge of vasectomy were; place of residence, occupation and income. Poor sexual performance, infertility, spousal promiscuity, lack of varieties of men's methods were sighted as hindrances to uptake of Family Planning in the study area.

### 5.3 Recommendation

- (1) Family Planning services and information should be made available to the men in the community. Information and communication for promoting Family Planning methods should also be strengthened. Since nearly one-third of the births are accidental, educating men in proper use of contraceptives would reduce birth rate.
- (2) Men should encourage their wives to go for proper counselling in the Family Planning Clinic to choose any one of the type of contraceptive methods that are suitable with their body system. This will reduce the side effect like bleeding among the users. A significant number of men still need to be motivated to adopt permanent methods of Family Planning after achieving the desired family size.
- (3) Family Planning programs should not focus only on women, but also address men as principal stakeholders. Men should be encouraged to apply their decision-making power to influence their wives in the use of Family Planning methods. This will ultimately empower them to make the right decision for the better health of their family. There is a real need to provide precise knowledge on vasectomy (which seems to be lacking a lot among the men) and dispel misconceptions about it.
- (4) Involving men in fertility control measures can have tremendous influence on Family Planning uptake in the study area. Counselling services may be provided to men to enhance their knowledge and bring about attitudinal change for better utilization of family welfare services.

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