SPOUSAL COMMUNICATION AND USE OF FAMILY PLANNING METHODS AMONG MEN IN SABO COMMUNITY IN IBADAN NORTH LOCAL GOVERNMENT OF OYO STATE.

BY

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DEDICATION

This project is dedicated to God Almighty, the most beneficent, the most merciful and the all knowing.

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ABSTRACT

Family planning is important in many areas, both to the economy, education, individual, family and the nation at large. But recent research shows that 222 million women in developing countries today do not have the means to delay pregnancies and childbearing even when most of the family planning programmes are focused on the women. From the report of the NDHS 2013, current use of contraception is low. Nigeria is known for its patriarchal and its patrilineal family unit where the most important decisions are being made by the man. Therefore this study investigated spousal communication and use of family planning methods among men in Sabo community in Ibadan north local government.

This study employed descriptive cross-sectional study design using both qualitative and quantitative methods of data collection. A three stage sampling technique was used in the study. Systematic sampling technique was used to select the households at an interval of two buildings and a proportionate sampling technique was used to select the respondents until the estimated number is completed. Three sessions of FGD were organized with a session each among the Muslim young and old married men and a session among Christians and an interviewer administered questionnaire which investigated knowledge of FP use and level of spousal communication, factors that affect spousal communication and pattern of contraceptive use and factors promoting and hindering use of contraceptives. Knowledge of FP was categorized as poor, fair and good using a 26 point scale. The result of the FGD was manually analyzed while quantitative data obtained were analyzed using descriptive statistics and chi-square test at p-0.05.

From the FGD findings, most of the respondents expressed lack of interest in FP contraceptive and the reasons given were religion, negative health implication and lack of personal interest. Most of the respondents mentioned God as the determinant of the number of children couples should have and to some, they give birth to many in order to help them in time of war, farming and also to see their children occupying top government offices. The age of respondents ranged from 20-81 years of age with a mean age of 43.36±10.247. Level of spousal communication is (16.8%), men were the major initiators of the discussion 64.5% and the use of contraceptive is (15.4%). The condom was the most currently used modern method of contraceptive, 56% while

withdrawal method was the most currently used traditional method of FP 41.7%. There was an evidence of statistically significantly positive association between spousal communication and use of FP with p-value= 0.001, and level of education and use of FP with P-value= 0.002. However, there was no association between age and use of FP with p-value = 0.893.

Men's level of spousal communication was low, which in turn undermined proper utilization of family planning methods. Therefore multiple interventions such as awareness and health education programmes, community participation and training should be used in addressing the gap.

Key word: spousal communication, use, family planning

Word count 492.

CERTIFICATION

I certify that this project was carried out by Tomere Fiyejuna Bekewei in the department of health promotion and education, faculty of public health, college of medicine, university of Ibadan, Ibadan, Nigeria

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Glossary of Abbreviations

LAM	Lactational Amenorrhea Methods
IUD	Intrauterine Devices
FP	Family Planning
NDHS	National Demographic Health Survey
TFR	Total Fertility Rate
CCIH	Christian Connection for International Health
ICPD	International Conference on Population Development

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

According to the National Demographic Health Survey NDHS 2013, Fertility is one of the principal components of population dynamics that determine the size, structure, and composition of the population in any country.(National Population Commission Federal Republic of Nigeria Abuja, 2013). The survey result indicates that the Total Fertility Rate (TFR) in Nigeria is 5.5 births per woman. This means that, on average, Nigerian women will give birth to 5.5 children by the end of their childbearing years. The current TFR of 5.5 is 0.2 children per woman less than that reported in the 2003 and 2008 NDHS surveys (5.7 each). Fertility peaks in the 25-29 age group in urban areas (237 births per 1,000 women) and the 20-24 age group in rural areas (267 births per 1,000 women) and declines thereafter.(National Population Commission Federal Republic of Nigeria Abuja, 2013)

Considering the variations in TFR by residence, zone, states, education, and wealth quintile, it was discovered that the more urbanized zones, the South East (4.7), South-South (4.3), and South West (4.6), have lower fertility rates than the three mostly rural northern zones. The highest TFR is seen in the North West (6.7), followed by the North East (6.3). The TFR decreases with increasing level of education. Women with more than a secondary education have a TFR of 3.1, as compared with a TFR of 6.9 among women with no education. Women in the highest wealth quintile have an average of three fewer children than women in the lowest quintile (3.9 and 7.0 births per woman, respectively).(National Population Commission Federal Republic of Nigeria Abuja, 2013).Information on current and cumulative fertility is essential to project population growth. Data on birth intervals are important because short intervals are associated with higher childhood mortality. The age at which childbearing begins can also have a major impact on the health and well-being of both the mother and the child. (National Population Commission Federal Republic of Nigeria Abuja, 2013)

Family Planning(FP) refers to a conscious effort by a couple to limit or space the number of children they want to have through the use of contraceptive methods

(National Population Commission Federal Republic of Nigeria Abuja, 2013). It is also defined as the use of modern and other methods of birth control to regulate the number, timing and spacing of human births. FP is one of the fundamental pillars of safe motherhood and one of the means of addressing maternal morbidity and mortality. Studies have shown that an effective FP programme will reduce maternal deaths by 30 per cent and child deaths by 20 per cent. Effective FP plays a pivotal role in delaying the first pregnancy, child-spacing and the prevention of sexually transmitted infections (STIs), including HIV(Nigeria MDG acceleration framework, 2013)

Family planning is very important in many areas, both to the economy, education, individual, family and the nation at large. For instance, countless studies have shown that women who use family planning are generally healthier, better educated, more empowered in their households and communities and are more economically productive. And in homes where parents have the power and the means to decide on the number and spacing of pregnancies, their children tend to be healthier, do better in school and grow up to earn higher incomes. And now there is indisputable evidence that when family planning is integrated into broader economic and social development initiatives, it can have a positive multiplier effect on human development and the well-being of entire nations.(Greene, 2012)

Contraceptive methods are classified as modern or traditional methods. Modern methods include female sterilization, male sterilization, the pill, the intrauterine device (IUD), injectables, implants, male condoms, female condoms, the diaphragm, foam/jelly, the lactational amenorrhea method (LAM), and emergency contraception. Traditional methods include the rhythm (periodic abstinence) and withdrawal methods. It was also reported that the knowledge of any contraceptive method is widespread in Nigeria, with 85percent of all women and 95 percent of all men knowing at least one method of contraception. Modern methods are more widely known than traditional methods; 84 percent of all women know of a modern method, while only 56 percent know a traditional method. Similarly, 94 percent of all men know of a modern method, while 65 percent know of a traditional method.(National Population Commission Federal Republic of Nigeria Abuja, 2013)

However, despite the high knowledge of contraceptive methods as reported by previous studies, it was documented from the report of NDHS, 2013 that overall; only 15 percent of currently married women in Nigeria are using a contraceptive method, an increase of only 2 percentage points since the 2003 NDHS. Most of these contraceptive users rely on a modern method (10 percent); 5 percent use traditional methods. Injectable (3 percent), male condoms (2 percent), and the pill (2 percent) are the most commonly used modern methods. Other modern methods are used by 1 percent of women or less. Interestingly, 3 percent of currently married women use withdrawal as a method of contraception.(National Population Commission Federal Republic of Nigeria Abuja, 2013)

The survey results also indicate that the total fertility rate (TFR) in Nigeria is 5.5 births per woman. This means that, on average, Nigerian women will give birth to 5.5 children by the end of their childbearing years. The current TFR of 5.5 is 0.2 children per woman less than that reported in the 2003 and 2008 NDHS surveys (5.7 each).(National Population Commission Federal Republic of Nigeria Abuja, 2013)

Though it is realized from most studies and programs that the target group in family planning are the females and especially, women of childbearing age, it is verified that the male is an important factor with far reaching positive or negative implications for the practice. In this context, the decision to have or not to have children is male's and invariably his decision is usually in favour of having children, as more and more children further enhance his status as a man in the society. In a study carried out in 1994, it was noted that male dominance is particularly profound in matters of reproduction. They generally view reproduction as their prerogative, an issue in which the compliance of their wives is taken for granted.(Ogunjuyigbe, 2002)

It is well documented that men's general knowledge and attitudes concerning the ideal family size, gender preference of children, ideal spacing between child births, and contraceptive method use greatly influence women's preferences and opinions. However, fertility and family planning research and programs have ignored men's roles in the past focusing on women's behaviour, and services are traditionally presented within the context of maternal and child health. However, the family unit in Nigeria is essentially patriarchal and patrilineal, with all the important decisions taken by the male head while the woman's fundamental social role is to bear and raise

children and engage in productive tasks within the household. Wives are usually socially and economically dependent on their husbands. 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 decide whether to have another child. (Ijadunola Abiona,ijadunola, Afolabi,Esaimo and Olaolorun., 2010).

However, it was discovered that studies on spousal communication on family planning methods are very limited and the few that were conducted between 1991-2010 reveals that knowledge of contraceptive use is high among both male and the female gender. However, the rate of contraceptive use by women from NDHS 2013 is still very low, 15 percent and fertility rate is also high; 5.5 children per woman

Therefore this study further investigated the level of communication and use of family planning methods focusing on men who is the decision maker in the home in the Nigerian setting, in Sabo community in Ibadan north local government of Oyo state, Nigeria.

1.2 Statement of the problem

Family planning refers to a conscious effort by a couple to limit or space the number of children they want to have through the use of contraceptive methods (National Population Commission Federal Republic of Nigeria Abuja, 2013). Family planning is very important in many areas, both to the economy, education, individual, family and the nation at large. For instance, countless studies have shown that women who use family planning are generally healthier, better educated, more empowered in their households and communities and are more economically productive. And in homes where parents have the power and the means to decide on the number and spacing of pregnancies, their children tend to be healthier, do better in school and grow up to earn higher incomes. And now there is indisputable evidence that when family planning is integrated into broader economic and social development initiatives, it can have a positive multiplier effect on human development and the well-being of entire nations.(Greene, 2012)

But recent research shows that 222 million women in developing countries today do not have the means to delay pregnancies and childbearing(Greene, 2012). From the report of the NDHS 2013, current use of contraception is low and varies with residence, zone, education, and wealth quintile. Women in rural areas are less likely to use contraceptive methods than their counterparts in urban areas (9 percent versus 27 percent). This trend is observed across all modern methods of contraception. This probably could be due to poor access, affordability or low support from spouse. The South West zone has the highest proportion of women currently using a family planning method (38 percent), followed by the South East (29 percent). The lowest proportion of married women using a family planning method, according to NDHS 2013, is in the North East (3 percent). Among the states, Lagos and Kwara have the highest percentages of women using any method (having 48 percent and 40 percent respectively). In six states, Jigawa, Kano, Katsina, Kebbi, Sokoto, and Yobe, only 1 percent of women use any method of contraception.(National Population Commission Federal Republic of Nigeria Abuja, 2013)

Despite all the programmes by government to improve family planning and the considerably high knowledge of contraceptive method use among men and women in Nigeria according to NDHS 2013, the overall current contraceptive prevalence among married women in Nigeria is still 15 percent, an increase of only 2% since 2003. This could be due to several factors. The fertility rate is still high, that is, 5.5 children per woman. Likewise, maternal and child mortality is on the increase. On studying the NDHS 2013, it was observed that focus on contraceptive use was majorly on women.

The importance of spousal communication is often emphasized in family planning programs and researches as far back as 2002. In some analysts' view, it is the first step in a rational fertility decision-making process. However, numerous studies show that the amount of communication that occurs between partners is positively associated with contraceptive use and spousal communication concerning contraception, especially in developing countries, remains poor. (Sharan & Valente, 2002)

Nigeria is known for its patriarchal and its patrilineal family unit where the most important decisions are being made by the man, due to the fact that he is the head of the family by virtue of cultural and religious placement (Ijadunola et al., 2010).

Most studies on family planning methods and other reproductive issues in developing countries especially in Nigeria are focused on the on the female gender.

Therefore this study focused on men, determining their knowledge of family planning methods, level of communication with their partner and use of family planning methods in Sabo community in Ibadan north local government of Oyo state, Nigeria.

1.3 Justification of the study

From the report of previous studies, knowledge of contraceptive methods use is high among both the male and female gender. However the actual use of contraceptive methods is low; 15 percent and the fertility rate is still on the increase 5.5 children per woman. It was also reported that spousal communication is poor and Nigeria is known for its patriarchal and patrilineal family unit where most of the decisions in the home are being made by the man.

This study is therefore very important for the following reasons; first, it further explored the knowledge of family planning methods among men and also determined the level of spousal communication on family planning methods, then determined the possible factors that affect spousal communication. Few studies have been carried out in this area in developing countries, especially Nigeria and on further studies of literature, it was observed that despite the high knowledge of contraceptive use among both gender, the utilization is actually poor as even confirmed by NDHS 2013.

Secondly, the study described the pattern of use of FP contraceptive and further identified the factors which promotes or hinder the use of contraceptive which according to NDHS 2013, is low.

1.4 Research Questions

1. How much do men know about family planning methods?
2. To what extent do men discuss family planning with their wife?
3. What are the factors that influence spousal communication among men?
4. What type of contraceptives do men use?

5. What are the factors which promote or hinder the use of contraceptive among men?

1.5 General Objective

To investigate the knowledge, level of communication and use of family planning methods among men in Sabo community in Ibadan North Local Government.

1.6 Specific Objectives

1. To assess the knowledge of family planning methods among men
2. To determine the level of spousal communication on family planning among men
3. To determine possible factors that affect the spousal communication among men
4. To describe pattern of use of Family Planning contraceptive among men
5. To identify factors promoting or hindering use of contraceptives among men

1.7 Research Hypothesis

1. There is no relationship between socio-demographic characteristics and spousal communication
2. There is no significant relationship between socio-demographic characteristics and use of contraceptives
3. There is no association between spousal communication and use of family planning contraceptives

1.8 Variables

The dependent variables include spousal communication and use of family planning methods. The independent variables include the socio-demographic variables: age, sex, religion, occupation, educational qualification, socioeconomic status.

CHAPTER TWO

LITERATURE REVIEW

2.1 Family Planning

Family planning (FP) is defined as the use of modern contraception and other methods of birth control to regulate the number, timing and spacing of human birth. FP is one of the Fundamental pillars of safe motherhood and one of the quick ways of addressing maternal morbidity and mortality. Studies have shown that an effective FP programme will reduce maternal deaths by 30 per cent and child deaths by 20 per cent. Currently, use of FP is low, with a contraceptive prevalence rate (CPR) of 15 per cent (NDHS 2013) and an unmet need for FP of 21.5 per cent (MICS, 2012).

FP addresses high-risk pregnancies, which constitute about two-thirds of all pregnancies. According to NDHS 2013 family planning is also defined as the conscious effort by a couple to limit or space the number of children they want to have through the use of contraceptive methods (National Population Commission Federal Republic of Nigeria Abuja, 2013)

Family planning programs have yielded dramatically positive gains over the past 50 years, However, there are still 123 million women around the world, mostly in developing countries, who are not using contraception in spite of an expressed desire to space or limit the number of births, Contraceptive use is still low and the need high in some of the world's poorest and most populous places. In the past two decades, Nigeria has made very bold efforts to achieve rapid economic development. However, amongst other factors, rapid population growth has affected the quality of life and made achievement of socio-economic development goals difficult (Tsui, Williamson (2008).

The World Health Organization define family planning as use of measures designed to regulate the number and spacing of children within a family, largely to curb population growth and ensure each family's access to limited resources. It also means plan intended to determine the number and spacing of one's children through effective methods of birth control. Tsui,Williamson (2008)

Isiugo-Abanihe, (1996) in D. Ofemegbe, M. Gabriel 2015) contends that family planning is an organized effort essentially to ensure that couples, who want to have fluent family size or to space their children have access to contraceptive information and services and are encouraged to use them as needed. (Ofomegbe & Gabriel, 2015).

Parker, (2005) defined family planning as a way of living which is adopted voluntarily upon the basis of knowledge, attitude and responsible decision-making by individuals or couples in order to pin the number, family and spacing of the children that they want, so as to promote the health and welfare of the family group and contribute to the advancement of the society.

Tsui,et al (2008) defined family planning services as "educational, comprehensive medical or social activities which enable individuals, including minors, to determine freely the number and spacing of their children and to select the means by which this may be achieved".

Family planning programs provide a win-win solution. The welfare of individual women and children is improved, and the national economy and the local and global environment benefit. The international consensus on this issue is reflected in the UN Millennium Development Goals, specifically the goals of providing universal access to reproductive health by 2015 and reducing the unmet need for family planning

“Family planning”, as used by Christian Connections for International Health (CCIH), means enabling individuals and couples to determine the frequency and timing of pregnancies, including the use of a variety of methods for voluntary prevention of pregnancy.

Family planning improves health, reduces poverty, and empowers women. Yet, today, more than 200 million women in the developing world want to avoid pregnancy but are not using a modern method of contraception. They face many obstacles, including lack of access to information and health care services, opposition from their husbands and communities, misperceptions about side effects, and cost. If these obstacles could be overcome and the demand for family planning met, 54 million unintended pregnancies, more than 79,000 maternal deaths, and more than a million infant deaths could be averted each year. Families could save more and begin to break the grip of poverty. And communities could make greater investments in education, health care, and infrastructure. (John, 2012)

In spite of the benefits of contraceptive use to women and societal well-being, the use of modern contraceptives by couples and individuals to limit or plan the spacing and timing of births is low in Nigeria. Though with marked geographical and individual level variations, contraceptive knowledge is high in the country, however substantial

gap exist between contraceptive knowledge and use in the country. (Solanke and Ogunjuyigbe, 2014)

2.2 Types of Family Planning Methods

Family Planning Methods or contraceptive methods by definition are preventive methods to help couples to avoid unwanted pregnancies. There are a number of methods which are commonly used by people. These methods includes;

Condom

Condom is the most widely used barrier device by the males around the world. Condom is receiving new attention today as an effective simple "spacing" method of contraception, without side effects. In addition to preventing pregnancies, condom protects both men and women form sexually transmitted diseases.

There are two kinds of condoms, latex and skin. Latex condoms are by far the most widely used.

The condom is fitted on the erect penis before intercourse. The air must be expelled from teat end to make room for the ejaculation. The condom must be held carefully when withdrawing it from the vagina to avoid spilling seminal fluid into the vagina after intercourse. A new condom should be used for each sexual act. Condom prevents the semen from being deposited in the vagina.

The advantages of condom;

Condom use has the following advantages;

- They are easily available, safe and inexpensive, easy to use and do not require medical supervision.
- It has no side no side effects, Light, compact and disposable, and
- They provide protection not only against pregnancy, but also against sexually transmitted diseases (STD).

The Disadvantages

The disadvantages include;

- it may slip off or tear during intercourse due to incorrect use and
- Interferes with sex sensation locally about which some complain while others get used to it, by repeated use.

Although there is much publicity about the use of condoms to avoid pregnancy and getting infected with STDs and HIV/AIDS the knowledge of the fact that condom

does not guarantee hundred per cent safety is important. There is certainly a risk involved. There are several reported and confirmed cases of condom failure as a preventive method for pregnancy as well as HIV/AIDS infection.

2) **Diaphragm**

The diaphragm is a vaginal barrier. It was invented by a German Physician in 1882. It is a shallow cap made of synthetic rubber or plastic material. It has flexible rim made of spring or metal. The diaphragm is inserted before sexual intercourse and must remain in place for not less than 6 hours after sexual intercourse. A spermicidal jelly is always fused along with the diaphragm. Side effects are practically nil.

Advantages

The primary advantage of the diaphragm is the almost total absence of risk

Disadvantages

Initially a physician or some other trained person will be needed to demonstrate the technique of inserting the diaphragm into the vagina to ensure a proper fit. After delivery, it can be used only after involution of the uterus is completed.

3) Intra-Uterine Devices (IUDs)

The IUD are devices used for the control of conception by introducing a foreign body into the uterus. There are two basic types of IUD: 'non-medicated' and 'medicated'. Both are usually made of polyethylene or other polymers. In addition the medicated or bioactive IUDs release either metal ions (copper) or hormones (progestogens).The IUDs are of different generations such as:

the non-medicated or insert IUDs - First generation IUDs, the copper IUDs - Second generation IUDs The hormone releasing IUDs - third generation IUDs, The medicated IUDs or the second and third generation IUDs were developed to reduce the incidence of side-effects and to increase the contraceptive effectiveness. However, they are more expensive and must be changed after

4) Hormonal Contraceptives

Hormonal contraceptives when properly used are the most effective spacing methods of contraception. They provide the best means of ensuring spacing between one child birth and another.

.2.3 Other Methods of Family Planning

i) **Abstinence**

The only method of birth control which is completely effective is complete sexual abstinence. It is sound in theory, in practice it amounts to repression of a natural force and is liable to manifest itself in other directions such as temperamental changes and even nervous breakdown. Therefore, it can hardly be considered a method of contraception to be advocated to the masses.

ii) **Coitus Interruptus**

This is the oldest method of voluntary fertility control. It involves no costor appliances. In this method, the male withdraws before ejaculation, and thereby tries to prevent deposition of semen into the vagina. Some couples are able to practice this method successfully, while others find it difficult to manage. The chief drawback of this method is that, the precoital secretion of the male may contain sperm, and even a drop of semen is sufficient to cause pregnancy. Further, the slightest mistake in timing the withdrawal may lead to the deposition of a certain amount of semen. The alleged side effects (eg. Pelvic congestion, vaginismus, anxiety neurosis) were highly magnified. It is better than using no family planning methods at all. It is admitted to be true that coitus interrupts along with abstinence and abortion played a major role in reducing birth rates in the developed world during the l8th and 19thcenturies.

iii **Safe Period (Rhythm Method)**

This is also known as the "Calendar method, first described by Ogino in1930. The method is based on the fact that ovulation occurs from 12 to16 days before the onset of menstruation.

2.4 Benefits of Family Planning;

Family planning is one of the most successful development interventions of the past 50 years. It is unique in its range of potential benefits, encompassing economic development, maternal and child health, educational advances, and women's empowerment. Research shows that with high-quality voluntary family planning programs, governments are able to reduce fertility and produce large- scale improvements in health, wealth, human rights, and education. (John, 2012).

The benefits of family planning to include limiting of family size, child spacing, prevention of unwanted pregnancy, and prevention of sexually transmitted disease.(Onwuzurike & Uzochukwu, 2001), Family planning helps everyone (women, children, men, families, nations, the earth). Specifically, it protects women from unwanted pregnancies, thereby saving them from high risk pregnancies or unsafe abortions. If all women could avoid high-risk pregnancies, the number of maternal deaths could fall by one-quarter. Also other benefits accruing from family planning methods include prevention from cancers, sexually transmitted infections and HIV/AIDS. Review of literature shows that the advantages of proper family planning are enormous as high fertility rate has been linked with underdevelopment in developing country. (Moronkola, Ojediran, & Amosu, 2006).

2.5 Men involvement in family planning

Family planning programs are often directed toward women with little attention to the way that traditional gender norms, that is, the societal and cultural expectations of what it means to be a man or a woman – impact modern contraceptive use. Gender norms shape fertility desires and affect couples' ability to discuss and make informed decisions about contraception; gender norms also can influence access to information and services. Gender-related power dynamics which position men at the head of the household with decision-making power often mean that men have greater say in whether and when sex occurs and if contraception is used. (USAID from the american people, 2013).

Men can and should be engaged in family planning both as clients and as women's partners. Engaging men in family planning programming is critical not only to create educated consumers but also because men's understanding of family planning can affect women's use of contraception both directly and indirectly. Both men and women should be targeted for family planning outreach because, in most cases, interventions that involve both partners are more effective than those aimed at women only in terms of contraceptive use and continuation, pregnancy or abortion (Lundgren, 2012; Shattuck et al, 2011).

Evidence has also shown that in the absence of direct discussion, women often assume, sometimes incorrectly, that their partner is opposed to family planning (Hartmann, Gilles, Shattuck, Kerner, and Guest 2012). Programs involving men can

enhance spousal communication, improve gender equitable attitudes and increase family planning use (Lundgren, Cachan, Jennins, 2012).

A study suggests that more egalitarian attitudes among men and women can affect a range of positive health-related outcomes such as "improved communication, shared decision-making, condom use, contraceptive use, access to health services and non-violence" (Greene and Barker, 2010).

2.6 Importance of involving men in family planning

Though it is realized that the target group in family planning are the females and especially, women of childbearing age, it is averred that the male is an important factor with far reaching positive or negative implications for the practice. In this context, the decision to have or not to have children is male's and invariably his decision is usually in favour of having children, as more and more children further enhance his status as a man in the society (Ogunjuyigbe, 2002).

Engaging men can directly address their concerns about contraception that hinder their own use and that of their partner. A systematic review of studies on men's beliefs and attitudes toward contraception identified the main reasons men did not want to use contraception. These reasons included concerns from men as partners, "fear of losing authority within the family context; fear of presumed collateral effects of contraceptive use [e.g., infidelity]; association between withdrawal and the reduction in spontaneous sexual intercourse", as well as concerns from men as family planning clients, "an association between vasectomy and castration; a mistrust of the effectiveness of condoms; and a perceived decline in virility and sexual pleasure after vasectomy" (Hoga,Rodolpho, Sato, Nunes, Borges 2013,). An additional important finding was that men felt that health care services were not sensitive to their needs in terms of time available for services or sufficient depth of information (Hoga et al, 2013).

Engaging men can create more gender equitable attitudes that support family planning use. Inequitable gender norms hinder family planning. Women are often not valued as equal partners in a relationship, yet contraceptive use is seen as a woman's responsibility. Meanwhile, men are not usually targeted for family planning services and information, yet they are often the decision-makers. Programs that provide men and women the opportunity to engage in family planning discussions—together or separately—can directly address these inequitable norms and create space for joint

decision-making for effective use of family planning. There is abundant evidence that partner communication and support is associated with effective contraceptive use (Harvey et al., 2006; Sable et al., 2006) in (USAID from the american people, 2013). As Hartmann et al. (2012) notes, "Research has repeatedly shown that men are interested and will positively contribute to family planning discussions when provided the opportunity, and that spousal communication can increase contraceptive uptake and continuation" (Hartmann et al., 2012).

In another studies, Men play a key role in the decision to adopt a contraceptive method and which method will be adopted. This study has shown that when the husband comes to the health facility with his wife, his resistance to contraception is likely to be broken and the couples are likely to adopt a method. (Babalola & John, 2012). The study also documented that Lack of support from the husband not only hinders contraceptive use but may also lead to premature termination of use of a long-acting method (Babalola & John, 2012).

2.7 Role of Communication In the Use of Family Planning

The recognition that communication between husband and wife plays an important role in determining reproductive preference dates back to at least the 1950s. The International Conference on Population and Development (ICPD) held in Cairo in 1994, the donors and policy makers emphasized to involve men in decision making on women's reproductive health, rights and preferences. It is assumed that in the patriarchal settings women do not have control over their own reproductive behavior, as because men are dominant decision makers within the family. In patriarchal society, the role of husband-wife communication in fertility preference and in fertility regulation is critical (Kamal, 2011).

Communication plays a very important role in the adoption and use of family planning. Spousal communication and agreement are crucial for the functioning of family, allowing the couple to process and share information, ideas, and feelings and make decisions about important issues, including family planning, that ensure family stability (Esere, 2008; Hybels& Weaver, 2001; Noller& Fitzpatrick, 1990; Peterson, 2009).

Communication between spouses is very important in fertility making decisions. Such communication should be among the most important precursors of lower desired family size and increase contraceptive use (Mosha & Ruben, 2013).

Spousal communication about family Planning is part of the rational decision-making process in fertility plans and one of the factors associated with its approval (Smith, 2008).

In a study carried out in the northern part of the country, it was documented that spousal contraceptive communication could facilitate the realization of childbearing aspirations. They recognized its potential to prevent divorce, promote better childbearing, encourage positive couple engagement, and facilitate planning and co-operation in marriage. It also reportedly could facilitate better use of family resources and even prevent polygyny. (Izugbara, Ibisomi, Ezeh, & Mandara, 2010).

However in another study carried out in the west it was documented that, Spousal communication about family planning and other family reproductive goals was quite poor. The socio-demographic correlates of men's opinions included religion, marriage type, educational attainment, and occupation ($p<0.05$). The study concluded that male involvement in family planning decision making was poor and their patronage of family planning services was low (Ijadunola et al., 2010). Therefore it is important that further study is made to assess or determine possible factors that could prevent men from discussing with their partners on family planning methods and regular use. In another study, it was also documented that While many researchers have shown that contraceptive use tends to increase where there is spousal communication it remains to be conclusively shown, whether couples' joint decision- making is more strongly associated with family planning use than is decision-making by either spouse alone. Of particular interest are the dynamics of the decision-making process and whether and how spousal communication affects this dynamic. The study examined the inter-relationship between spousal communication and level of family planning use. It also determined who makes the decision on family planning and the influence of the decider on family planning use. (Orji et al 2010).

2.8 The role of Significant others in Family Planning

Use of contraception was found to be strongly influenced by the level of support or lack of it from persons within an individual's social network. It was reported in a qualitative study that some of the women currently using contraceptives mentioned that it was their friends who introduced them to family planning, by explaining how to use them or in some instances, actually took them to the family planning clinic.

(Ankomah, Anyanti, Adebayo, & Giwa, 2013). Below is a statement made by one of the respondents in the study.

It was my friend. She asked if I was doing anything. She meant contraceptives. She was not happy I was taking chances. She warned me. The following week she asked me to accompany her to the clinic. There I got some pills. (Female, age 25-34 user of contraceptives, urban dweller).

Still in the study, it was also documented that, other participants stated that, for them, it was neighbours and not friends. They argued that their friends usually do not 'interfere' in such private areas. But some neighbours can. They cited neighbours as more helpful in the area of family planning than friends as they were likely to observe the daily challenges a mother may face as a result of excessive childbearing. But they pointed out that neighbours do so sometimes after they have gossiped about you in the community. A participant said that after a neighbour saw how she was struggling to cater for her children she advised her to use family planning:

The neighbours; they are likely to gossip about you and when they always see you when you are pregnant, they even wonder if you are weaning the baby correctly… But she was kind enough to call me and say I should do something about my frequent deliveries. (Female, user of contraceptives, age 25-34 years, rural dweller).

On the whole, it was agreed that neighbours were more likely to influence one to use family planning than friends. (Ankomah et al., 2013)

It was also documented that, the critical role mothers-in-law play in contraceptive decision-making in many traditional African societies is legendary. Participants, particularly from southern Nigeria, perceived mothers- in-law as being at best non-supportive and at worst overtly anti-family planning. Most participants described them as controlling their sons and encouraging them against the use of contraceptives because it will offer 'license for women to be loose'. A female participant who desired to use family planning was unsure because of the attitudes of mother-in-laws in her community:

"Some mother in-laws feel that if the wife of their son should do family planning she will be promiscuous and she can bring disease to her son (Female, non-user of contraceptives but desire to, age 20-24 rural dweller).

For some women, it was not the mother-in-law but their own mothers who were asking them to discontinue the use of contraceptives. The mothers think that having more children ensures marital stability*: My mother is presently worrying me now that*

I should have more children now to please my husband (Female, user of contraceptives, age 25-34; rural dweller). (Ankomah et al., 2013)

2.9 Use of Family Planning By Men

Reproductive health programs have traditionally focused on women. However, since the International Conference on Population and Development (ICPD) conference of 1994, programs have paid attention to male involvement in reproductive health services ICPD (1994). The 1994 ICPD and the 1995 fourth world conference on women acknowledged the role of men in improving reproductive health.(Berhane et al., 2011)

The ICPD Programme of Action noted as a "high priority the development of new methods for the regulation of fertility for men," and called for the involvement of private industry. It urged countries to take special efforts to enhance male involvement and responsibility in family planning. Nearly 20 years later, no new male methods have been widely introduced to the public. With few contraceptive options for men, men's use of family planning has been less than envisioned by the ICPD. Today, even if all traditional methods requiring men's cooperation (rhythm, withdrawal and others) are counted together with male condoms, male methods account for about 26 per cent of global contraceptive prevalence.(Greene, 2012)

It was also ascertained that reproductive health programs are likely to be more effective for women when men are involved. The role of men in the family, their relationships with their partners, gender patterns of society, male-oriented educational programs, and counseling activities on family planning all influence men's knowledge and behavior regarding family planning (Berhane et al., 2011)

In Nigeria, unfortunately, data on the knowledge and use of modern contraception among men and on male participation in reproductive health are generally few, (Ijadunola et al., 2010).

Family planning use continues to be low especially in developing countries where use of any method is only 27 %. In Africa, there are many obstacles that impede people from using contraceptives ranging from cultural, social factors and structural factors like less access, availability and affordability of contraceptives. (Mosha & Ruben, 2013)

The use of any method of FP by women is often influenced by their husbands(Okwor and Olaseha 2010) .Men have rarely been involved in either receiving or providing

information on sexuality, reproductive health, or birth spacing. They have also been ignored or excluded in one way or the other from participating in many FP programmes as FP is viewed as a woman's affair (Wambi, Ke and Fakokunde 2009)
Traditionally, men are the heads of households and decision makers in all issues in their respective households. Men decide on FP and the number of children as well as how to use what is produced by the family. (Adelekan, Omoregie, & Edoni, 2014). Also, findings have shown that since men were the decision makers, they were expected to initiate discussions on FP and the number of the children the couple want to have (Wambi, Ke and Fakokunde 2009)

2.10 Factors Promoting And Hindering Use of FP Methods

Family planning can be affected by varieties of factors which can be Positive or negative.

A study identified several factors, (social, psychological, and cultural) that may act as barriers to contraceptive practice among men and women. Casterline et al. (2001) noted that socio-cultural and religious disapprovals of contraception repeatedly emerge as important obstacles to the use of a contraceptive method. The study also identified a combination of these factors that obstruct contraceptive knowledge, adoption, and use among Hausa women in northern Nigeria. He asserted that few Hausa women have any knowledge of birth control and they consider family planning as the moral agnate of murder. This is because birth is an antidote for bereavement in the cultural idioms of this Islamic society and children are considered a divine benefaction. Children are the desired outcome of any Hausa marriage, and giving birth is traditionally viewed as the greatest fulfillment of being a woman. Such cultural beliefs and sentiments may render the adoption and use of contraceptive methods difficult in many sub-Saharan African communities. (Nangendo, 2012)

- **Adequate information by health officials;** There are different types of family planning methods available such as the pill, barrier methods, Intra-Uterine Contraceptive Device etc. And each has its unique method of application and individual should be well informed on which methods is suitable for him or her. It is therefore the responsibility of health professionals to ascertain that each person who obtains a family planning method has

sufficient information on the proposed method and that this person is competent to make a choice. (Osemwenkha, 2004)

- **Women empowerment;** Empowerment literally means 'to invest with power'. When used in context of women's lives, it often refers to women's increased control over decision-making, economic self-reliance, and legal rights to equal treatment, inheritance and protection against all forms of discrimination. In the context of family planning, the concept of women's empowerment is generally associated with a variety of elements that range from delayed marriage, smaller families, access to accurate information, the ability of married females to discuss freely about their family planning needs with spouses and other members of the household and the community, and being able to make independent decisions on fertility regulation including going out of living boundaries to seek contraceptive supplies .(Osemwenkha, 2004)

- **Social networks**

Individuals do not make decisions in social isolation but with interactions with others. Theoretical analyses of contraceptive choice and fertility dynamics show that social interactions can help to explain changes in patterns of fertility or contraceptive behaviour, as well as more general individual's behaviour. Social networks include the extended family, friends, neighbours, political groups, church group, youth groups, and other formal and informal associations. For many women, informal communication is a primary source of FP information.

The influence of social networks is crucial to informed choice. Most people seek the approval of others and modify their own behaviour to please others or to meet others' expectations. In Nigeria and other West African countries for example, some women said it was difficult for them to use FP because their relatives or friends were not using it. These women were reluctant to be the first in their social group to use FP. People choose contraceptive methods that are commonly used in their community because they know that it is socially acceptable to do so, and they tend to know more about these methods.(Mosha & Ruben, 2013).

The Nigerian study concluded that determinants of reproductive health service use, rest on the individual, household, service and community levels (Moronkola,

Ojediran and Amosu, 2006). Therefore, when considering those influential determinants of use of reproductive health services, the household and community in which the individual lives as well as the characteristics of the health services available in the community must be taken into consideration. Providers should note that women do live in a context where they are not making unilateral decisions about their reproductive health. It is also significant to note that husbands' approval was also rated high as determinant of contraceptive use and this is consistent with literature that men are usually dominant decision makers when birth or fertility control issues are to be determined. One of the frequent reasons women gives for not beginning or continuing to use contraception is their partner's opinions (Moronkola, Ojediran and Amosu, 2006).

- **Individual characteristics**

Several studies have established the influence of religion on the demographic behaviours of individuals. For instance, Doctor, Phillips and Kohler 2009, found that social networks haven significant and substantial effects on contraceptive use and change of parity with the shift from traditional religion to the practice of Christianity and Islam in Ghana. They found that African traditions subordinate individual agency to the traditional family and kindred norms and customs. (Mosha & Ruben, 2013)

- **Spousal communication and power variance between couples**

The effect of spousal communication upon family planning use may also be mediated by the relative power of each spouse in the decision-making process. A study in Uganda suggests that women's social and economic vulnerability inhibits their ability to express and argue for their own interests with their partner, and recommends an explicit consideration of gender inequality as an important component of the study of reproductive outcomes. A study in India found that husbands were the principal decision-makers and initiators of discussions about family planning use. As one group of researchers has noted, power imbalances in marriages favor men, and the husband's opposition to contraception may be sufficient to block use in many cases, but the reverse, the wife's opposition preventing use if the husband is favorably inclined will

occur less often. The researchers conclude, “This asymmetry means that when spouses disagree, women’s family planning aspirations will more often be frustrated than men’s. (Sharan & Valente, 2002)

- **Fear of unknown effect;** Fear of unknown effects is a major factor that militated against the use of modern birth-control methods. However, the perceived fear might have derived more from unfounded rumours relating to the methods and the people’s ignorance of the workings of the methods than from their actual experiences (Nwachukwu & Obasi, 2008).

  Women’s decision about use, non-use or discontinuation of contraceptive methods can be affected by their perceptions of contraceptive risks and benefits, concerns about how side effects may influence their daily lives and assessment of how particular methods may affect relationships with partners or other family members (Moronkola, Ojediran and Amosu, 2006)

- **Religious factors;** Religious beliefs were another factor identified by a relatively significant number of respondents as a barrier to the use of modern birth-control methods. Quite a few research works have reported religious opposition to family planning, with Roman Catholicism said to be the most vehement in this direction. Highlighting the relationship between religion and artificial birth control, a study conducted in Imo noted that Catholicism prohibited all artificial means of birth control but advocated the natural methods. (Nwachukwu & Obasi, 2008)

- **Socio–cultural factors associated with the use of contraceptive methods**

  Husband/partner support has been documented as key in acceptance of contraceptive use. (Michael, 2012). The principal predisposing and enabling factors affecting use of contraceptive methods by women were socioeconomic status, knowledge, and education of the mother. This leads to the conclusion that the main limiting factors to the use of contraceptive methods in the state are poverty, ignorance, and illiteracy.(Michael, 2012)

  Although education was associated with increase in the use of modern family planning methods, a drop was noticed in women with University and higher education. This might partly be explained by the fact that these women start their family life after their education, i.e. at a later age, and try to have the

number of children they wish before their menopause begins,(Ibnouf, van den Borne and Maars 2007). The likelihood of use of contraceptive methods is higher for those with higher parity, literate, (Gizaw and Regassa 2011)

Levels of knowledge of the contraceptive methods as well as communication between spouses regarding family planning issues were significantly associated with contraceptive use (Kessy and Rwabudongo, 2006).

The long-standing forms of African social organization including the high value attached to the perpetuation of the lineage, the importance of children as a means of gaining access to resources (particularly land), the use of kinship networks to share the costs and benefits of children (primarily through child fostering) and the weak nature of conjugal bonds clearly inhibit contraceptive adoption and fertility decline. In the empirical examination of the factors affecting modern contraceptive use, female education emerges as an important determinant of prevalence at the individual, regional, and national levels (National Research Council Working Group, 1993 in Michael, 2012).

2.11 Conceptual Framework

The Precede Framework

This framework outlines and describes the behavioural antecedent factors that influence spousal communication and use of family planning methods among men. These factors are categorized as: Predisposing factors, Enabling factors and Reinforcing factors.

Predisposing factors: These are the antecedents to behaviour that provide rationale for the behaviour. They predisposed men to poor spousal communication about family planning. Some of these factors include knowledge about family planning, beliefs, attitudes, perceptions, and norms, level of education, availability of modern contraceptives, cultural practice, mass media, peer influence, and socio-economic status. Most men are of the opinion that family planning may pose negative side effect in the future to them or their partners and also if their peers got to know that they are using any contraceptive method to delay child bearing, they may mock them. Some even consider cultural demand on men having children as their honour and therefore encourage them to have more. Predisposing factors have the potential to influence the decisions people make about their life and their resultant health behaviour. They do this by either encouraging the behaviour or by inhibiting the behaviour from occurring. Questions such as Q 38, 39, 40,43, 53, 54, 55,59 examined these factors.

Reinforcing Factors: These comprise of the feedback or influence of significant others or people, or media on the continuance or discontinuance of a particular behaviour after it has been initiated or established. Examples of these factors include pressure from peers, familial influence, and availability of modern contraceptive method at perceived lower cost, mass media/television, and other social support groups. They are also factors subsequent to behaviour that provide perpetual rewards or incentives for the behaviour and contribute to its persistence or extraction

Enabling factors: These factors comprise of another set of antecedents to behaviour because they also influence the realization of motives, aspirations and decisions. These include freedom of choice, affordability of modern contraceptive methods, self-efficacy, socio-economic status, accessibility etc. These factors influence the establishment of the behaviour

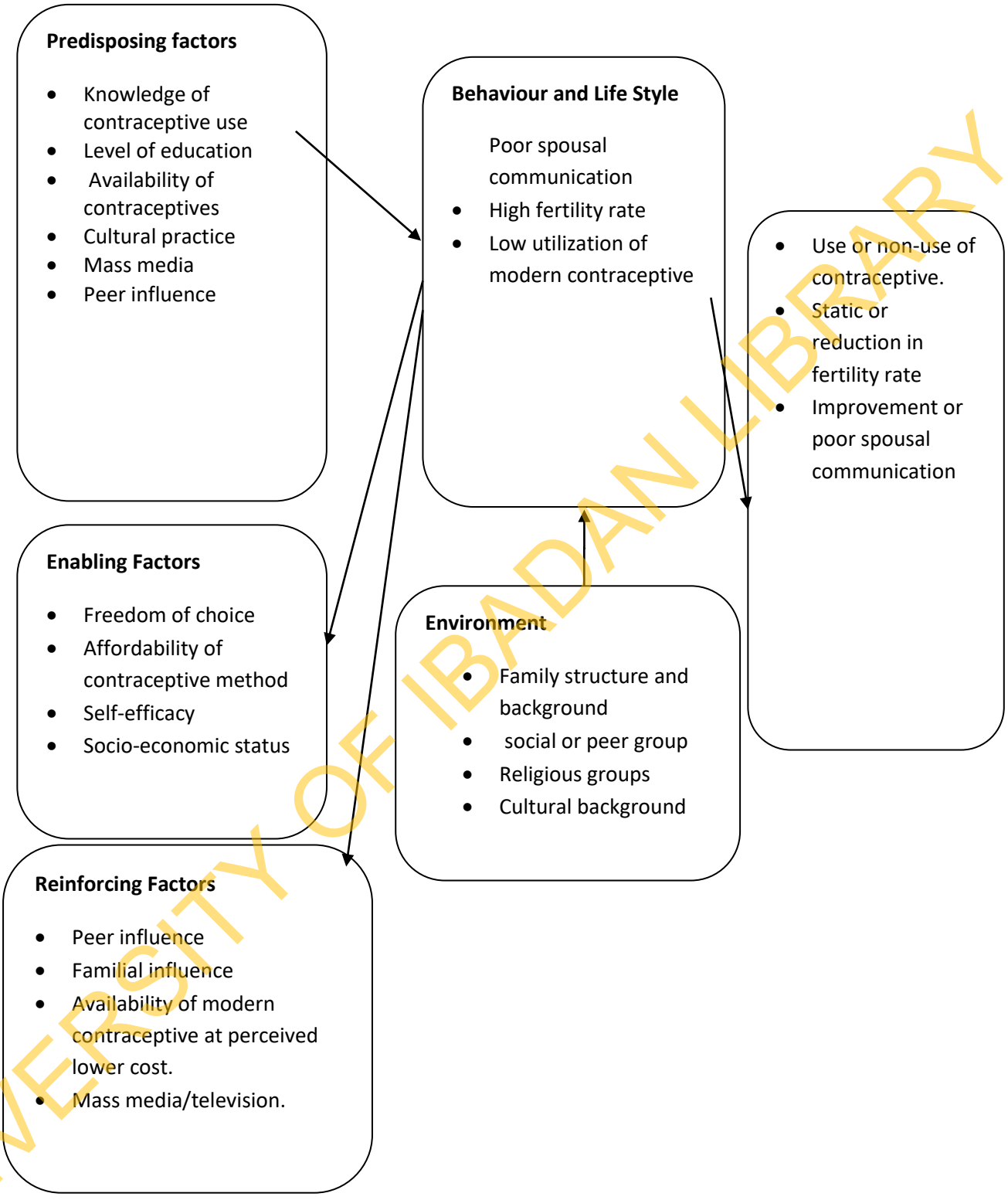

Figure 2.11 Precede Model Concept

In applying this model, the predisposing factors which are capable of influencing the behaviour of men in the adoption of FP contraceptive were taking note of which includes, knowledge, beliefs, attitudes, perceptions, norms, level of education, cultural practice, mass media, peer influence, and socio-economic status. The enabling factors were also noted as well as the reinforcing factors.

The tenets of this model guided the forming of the questions which were used to probe into the knowledge of men on contraceptives as well as the level to which men communicate with their wives on family planning methods. The tenets of this model also guided in setting questions to probe into factors that affect spousal communication between couples and also the pattern of use of contraceptives among couples. The model also enables probing into the factors that hinder and promote use of FP contraceptives among men.

CHAPTER THREE

METHODOLOGY

3.1 Study Design

A descriptive cross sectional study design was used for this study and a well-structured interviewer administered questionnaire and a focus group discussion guide was engaged in the collection of both quantitative and qualitative information appropriate for achieving the objectives of the study.

3.2 Study Location

The study location was Sabo community in Ibadan North local government area of Oyo state.

Sabo community is situated in ward 6 of Ibadan North local government, Oyo state. It is bounded on the North by; Mokola road, west by; Veterinary and Jemibewon Road, south: Adamasigba Staduim Complex, East; Alafia Hospital, Dugbe road.

The population predominantly consists of people from the Northern region of the country. There are also other ethnic groups from different parts of the country and outside the country, who came to reside in Sabo for commercial activities. The major commercial activities in the community are; bureau de change who engage in currency exchange, Suya spot, Tailoring and Embroiding, Okada riding and Cafeterias. it has one primary health center and some other private hospitals as well as pharmacy stores. There are also filling stations and government schools such as Saint Gabriels Secondary School, Sabo as well as private schools like mercy day group of school. Sabo is a community dominated by Muslims but we still have Christians in the community. It has one central mosque and two other mosques and different Islamic schools for both the men and the women including children. We also have churches such as Baptist church and Zion day church.

The population of Sabo was estimated by Frank Salamone 1990, to be 10,000 (Salamone, 1981) however recent information from national population commission reveals that the current population in Sabo is 29,873. The community is divided into different clusters which are according to their respective population. This includes;

Table 3.2 population of Sabo community

Settlements	Total Population
Sabo central	6,188
Turmu sawa	1,947
Gangare	1,638
Saint Lawrence	491
Sabo garage	1,542
Ghana	1,633
Okeisu	9,578
Ile ayo	1,223
Oro compound	941
Alafia hospital area	636
Corn oil area,	742
Saint bridges area	428
Okehausa	1,206
Magirika	1,993
Christus hospital area	628
Total	**29,873**

Source:(National Population Commission, Oyo State, 2015)

The leader of Sabo is the SarkinHausawa of Ibadan who is also recognized by the Olubadan of Ibadan.

3.3 Study Population

The target study population consisted of married men resident in the community during the period of 4th and 12th of October, 2015 when the study was conducted.

3.4 Sample Size

The sample size for this study was estimated from the Leslie Kish formula for single proportion which is as follows;

$$N = \frac{z^2pq}{d^2}$$

N= Minimum sample size required

Z= Standard normal deviation set at 1.96 normal interval

P= the prevalence of use of family planning methods in the South west zone in Nigeria according to NDHS, 2013 is 38% (National Population Commission Federal Republic of Nigeria Abuja, 2013)

Q= proportion of men with poor spousal communication under investigation {Q= (I-P), Q= I-0.38=0.62}

D= degree of accuracy set at 0.05 (precision set at 5%)

Therefore the sample size $N= (1.96)^2 * 0.38*0.62/0.05*0.05$

N= 3.8416*0.2356/0.0025

N=0.908096/0.0025

N=362.032384

This can be approximated to be 362

A non- respondent rate of 10% of 362= 362*10/100=36.2

Therefore, 36 were added to sample size calculated to make the sample size 398 in order to address any possible case of incomplete responses.

3.5 Eligibility Criteria

All married men resident within the five selected strata in the community within the period of 4th to 12th of October.

3.6 Inclusion Criteria

Participants in this study were married men resident within the five selected strata in the community.

3.7 Exclusion Criteria

1. Women (both married and unmarried) were not included in the study

2 All unmarried men were not also included in the study.

3.8 Sampling Technique

A multistage sampling technique was employed in selecting married men in Sabo community in Ibadan north local government.

The study sample was drawn from population of married men resident in the five sub-communities within Sabo community which are; Sabo Gangare, Sabo Oke Hausa, Sabo Oke esu, Sabo Gana and Sabo central.

Stage one: A stratified sampling technique was used to stratify the community into five strata which were ; Sabo Gangari, Sabo Oke Hausa, Sabo Okeesu, Sabo Gana and Sabo central.

Stage two: proportionate sampling technique was used to determine the total number of respondent in each of the selected strata.

Stage three: systematic sampling technique was used to select respondents at an interval of two houses within the community. All married men that were willing to participate were recruited into the study. An estimated number of data to be calculated based on the sample size which was set as a target and made known to all the research assistants. The commercial activities which brought most of the men to the road side during the day was also considered and participants were also recruited among them but in order to identify which of the strata of the community each participant by the road side came from, question 12 was used which stated that which part of Sabo do you live and anyone within the selected strata was recruited if willing. Table 3.8 showed how data were collected in the five selected strata.

Table 3.8 Break down of how data were collected

Name of sub-community	Estimated number of participants (%)	Actual number collected
Sabo gangare	$12 \times \frac{398}{60} = 80$	75
Sabo central	$13 \times \frac{398}{60} = 86$	80
Sabo ghana	$11 \times \frac{398}{60} = 73$	68
Sabo oke esu	$14 \times \frac{398}{60} = 93$	85
Sabo oke Hausa	$10 \times \frac{398}{60} = 66$	62
Total	**398**	**370**

3.9 Instrument for data collection; Both qualitative and quantitative tools were used for the collection of data.

Focus Group Discussion

Focus group discussion guide which was developed by the researcher and approved by the project supervisor was used to collect information used in modifying the questions asked in the quantitative (questionnaire) data collection tool. There were seven major questions in the FGD guide that was used for the discussion and these questions focused on the married men's opinion about family planning, who made decision on number of children to born, who made decision on spacing of children, reasons for having many and few children, who initiate family planning discussion in the family, method of contraceptive commonly used by men and also what could be done to improve discussion of family planning.

The discussions were conducted in a suitable environment. The discussion conducted among the young Muslim married men with marriage age of below 10years was staged in a building used for meetings, while that of the elders with marriage age of above 10years was conducted in another venue that is also serine. The discussion among married Christian men in which they were combined due to their few numbers was conducted in Bishara Baptist Church building. The Islamic married men were interviewed in Hausa language by a colleague who is fluent in Hausa language and was later back-translated to English language. The participants for the young Muslim married men were six in number while the Muslim elderly married men were eight in number and the Christian participants were also six in number. The discussion sessions were all Tape-recorded after taken consent from the participants and pictures were also taken for evidence. Details of the FGD guide can be seen in the appendix IV.

Questionnaire

A semi-structured questionnaire was used as a quantitative tool for data collection, which was developed after evaluation of relevant literature. The questionnaire consisted of six sections as there are five objectives of the study with the inclusion of the socio-demographic information section. The sections are as follows:

Section A: Information on Socio-demographic characteristics such as age of respondents, sex, marital status, ethnicity, occupation, level of education, family unit, the number of years respondent have spent in the community and level of income was obtained.

Section B: This section also looked into the Knowledge of family planning methods among men where information on what men know about family planning methods was obtained

Section C: In this section, the level at which men communicate with their spouse on family planning matters was determined

Section d: this section determined possible factors that affect spousal communication on family planning among men

Section E: The pattern of use of family planning contraceptives among men was determined in this section

Section F: In this section, factors promoting and hindering use of contraceptive was determined.

Details of the questionnaire on English, Yoruba and Hausa language can be found in the appendix I,II and III.

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3.10 Validity of the study

In order to attain accuracy in measurement, the validity of the instrument was ensured through the development of a draft instrument by consulting relevant literature, subjecting the draft to independent peer and expert reviews particularly experts in public health. The validity of the instrument was further ascertained by pre-testing 10% of the sample size which was 22 questionnaires from the initial sample size of 216 in a community with similar characteristics with the actual study population. This was carried out in another Hausa community in Ojoo called Shasha. According to the pretest, majority 13(59.1) understand family planning as a method of limiting childbirth, the condom was the most known type of contraceptive 19(86.4) and on discussion, 12(54.5) of the respondent said they had discussed with their

wives. The validity of the instrument was achieved through a close supervision by the project supervisor.

3.11 Reliability of the study

The reliability of the instrument was ensured as much literature was reviewed to ensure that it is reproducible. The instrument was translated to Hausa and Yoruba language for easy understanding as the study site is dominated by the Hausa speaking people who also speak Yoruba language and then was back-translated to English language for analysis. The research assistants were selected considering the different ethnic groups and languages in the community such as Igbo and Yoruba and were trained using demonstration and return demonstration method of training to master the instrument for data collection. Five research assistants from the community were recruited and trained to join five other volunteered colleagues of health promotion and education who also participated in the data collection for both the qualitative and the quantitative data collection.

Ten percent which was 22 according to the initial sample size for the study of the instrument was pre-tested in a population with similar characteristics as the study population. This was carried out in another hausa community in Ojoo called Shasha. According to the pretest, majority 13(59.1) understand family planning as a method of limiting childbirth, the condom was the most known type of contraceptive 19(86.4) and on discussion, 12(54.5) 0f the respondent said they had discussed with their wives.

The reliability of the instrument was achieved through a close supervision by the project supervisor and to ascertain the reliability, the pretest instruments were analyzed and a reliability coefficient of 0.73 was obtained. After the pretest result was presented, some of the questions were modified such as how do you encouraged your partner about family planning was modified and broke down to have you ever encouraged your spouse about family planning? And it was further split to if YES, How and if No Why to gather more detailed information. Questions on discussion about family planning between couples were also modified as well as questions on use of contraceptive methods.

3.12 Methods of Data Collection

Focus group discussion

Three sessions of focus group discussion was conducted among Muslims and Christians. A session each among Muslim married men with marriage age of 0-9years and married men of marriage age 10years and above and a session among the Christian married men. There were six participants for the young Muslim married men, eight Muslim married men of marriage age 10years and above and 6 participants for the Christian married men. Each of the discussion was tape-recorded and pictures were taken after consent from the participants of each session. The discussion was conducted in a serine environment. The moderator anchored the discussion using the FGD guide with the time keeper guiding the discussion with time. There was no need for a security as the environment was a serine environment and there was no intruder.

The FGD was conducted to collect information used in modifying the questions asked in the quantitative (questionnaire) data collection tool. There were seven major questions in the FGD guide that was used for the discussion and these questions focused on the married men's opinion about family planning, who made decision on number of children to born, who made decision on spacing of children, reasons for having many children, who initiate family planning discussion in the family, method of contraceptive commonly used by men and also and what could be done to improve discussion of family planning.

Administration of questionnaire

An interviewer-administered questionnaire was also used to obtain the necessary information from the respondents in the general population. The questionnaire was developed based on the literature review and the information obtained from the FGD together with input from health promotion specialists in the Faculty of Public Health, University of Ibadan. The questionnaire consisted of both open and close-ended questions and was administered by the research assistant.

3.13 Data Management

Management of Focus group discussions

All the three sessions of FGD for both the Muslims and the Christians which were tape-recorded was well managed. The two sessions conducted in Hausa language which was tape recorded was given to an expert in Hausa language to translate in English language and was transcribed to words for the researcher to analyze. The one conducted in English language in the church was also transcribed into words for analysis. Each of the questions asked was treated separately and respondents' identity was concealed for the purpose of confidentiality and was coded for example as "first respondent, second respondent". The analysis of the focus group discussion was done manually. The responses of the respondents were highlighted for effective discussion. All the discussion session on tape and the transcribed copies are all kept securely in a folder and kept from easy access of people.

Management of questionnaires

The researcher checked all copies of administered questionnaires one after the other for the purpose of completeness and accuracy. Serial numbers was assigned to each questionnaire and question for easy identification and correct entry and analysis. A coding guide was developed to code and enter each question into the computer for analysis. Analysis was done with the use of statistical package for the social sciences; SPSS version 20 after a template was designed.

The data entered into the computer was subjected to analysis using descriptive statistics and chi- square. Knowledge of family planning was categorized to be poor, fair and good among the 370 participants using a 26 point scale drawn from the open ended knowledge questions where the responses was allotted marks. Any correct response was allotted a mark of one while the wrong response was awarded zero mark. Knowledge was categorized as being good, fair and poor based on the scale prepared. Anybody that scored between 0-8 was categorized to have poor knowledge, those that scored between 9-17 were categorized as having fair knowledge while those that scored between 18-26 were categorized as having good knowledge. The questions used to develop the 26 point scales are on "understand of family planning, benefits of family planning, methods of family planning known, reasons for non encouragement

of spouse on FP planning by men and side effect of FP". The detail of this can be seen in figure 4.4.2 in chapter four in the result of this study. The results were displayed on tables and charts. Variables were cross-tabulated. The significant relationship between variables was tested using chi-square. A p-value of less than 0.05 was considered to be statistically significant. The questions were kept away from the reach of an unauthorized person in computer system where they are locked with a password and the papers well kept.

3.14 Ethical Consideration

All interviews were conducted in compliance with the ethics of the health promotion and education profession. Oyo State Ministry of health ethics review committee approved the study before it was implemented (see appendix VII for approval letter). The research assistants were well trained and also made to sign the confidentiality assurance form. Respondents were informed on the purpose of the study and given option to either participate through written or verbal consent (See Appendix VI for consent form) so as to ensure volunteerism and information that was provided by the respondent were also be treated with confidential.

CHAPTER FOUR

RESULTS

4.1.0 Findings from Focus Group Discussion

This section shows the result of findings from the focus group discussions conducted among three different groups where information on family planning was gathered. The first session was conducted among married Muslim men with marriage age of ten years and below and another session with another set of Muslim married men of marriage age of 10 years and above and the last session which took place in a church compound was among married Christian men.

4.1.1 Opinions on family planning

Responses on the opinion on family planning suggests that religion plays a vital role in men's acceptance or rejection of family planning methods despite that it appeared all the respondents are aware of what FP is. Majority of the opinion indicates negative view towards the subject with religion, personal belief, negative side effects and farming as some of the likely reasons for the negative opinion. However few of the respondents see FP to be good and a good means through which the family can be catered for. Evidence of some of these opinions are highlighted below;

"*I am not in support of FP because it is against my belief whatever God gives me or bless me with is what I will use truthfully but I am not in support of FP"* Another respondent among the adult men of marriage age above 10years is of the opinion that *"everybody has their own opinion but as for me I can't do it just like what Islam says, our conscience is in the hands of God and the number of children we would also give birth to is in the hands of God. It is good for us to let God do his thing* one respondent among the Christian body said *family planning is good because it make one to produce the number he or she can cater for."*

Another respondent also said; "*I have heard our clergy talk about it and I have also been among some committee on FP and I was a resource person at the program in Sabo, Shasha and Bodija and the focus is that what one should consider before starting a family. After the organizing committee called that there was positive response on the program*

A respondent also said this; truthfully I don't have anything against FP, me I am from a family of 4 wives and 13 children and I personally I have two wives but one is late and my children are 6 in number and I would like to marry another wife so that we can reproduce and be plentiful so I can't do FP"

One of the respondent said *as* farmers they don't do family planning. Another respondent said it is good because it make one to produce the number he or she can cater for. The rest also spoke about given birth according to your capacity.

4.2.0 Decision about number of children to born

The discussants responses to who decides the number of children to born suggested that there are different deciding factors. Some of the respondents said it is a collective decision of both the husband and wife while others said the wife in some cases demands for another child when she feel the one at hand is already grown up. Another discussant gave hospital bill burden as a major decider question on who do make decision on number of children to born which is part of the number of children to born. Others said the man as the head of the family decides that as well as God. Evidence of these responses are highlighted below;

. One of the adult married Muslim men said this "*what you just said we Muslim don't do FP it is the wife that decides when she wants another child, you see when we sleep with our wives and no pregnancy is coming forth it is the wife that will say our child is almost 4 years now but God has not made mine so. I have 10 children; I have 2 wives and 10 children. Because of theses your wife should be able to say she wants another child but it is God that gives children. Islam did not teach us to use condom or take injection but should be able to release and do withdrawal. That is all that I know. But there are times the wife will come and say she wants child spacing but since we are not the ones that give children it is God, sometimes we would say in 2 years we want another child and in one year she is not even through with breastfeeding you will see she is pregnant again."*

However, Most of the Christian discussants said*: "it is the husband or man who decides being the head of the family and one in particular said: the church cannot decide but can give advice on number of children to give birth to. Another respondent said: it is a collective responsibility of both the husband and wife."*

Another respondent from among the Muslims said this *"my opinion on me and my wife sitting and discussing on the number of children that we should have, just like what my friend here says that the number of children one would have is in the hands of God. I don't have the right nor my wife to say this is what I want or not because it will bring conflict because God has prepared FP for us in ways that it should happen. If we should give birth it will take 3-4 years before giving birth again. My wives are 2 now and they both have 9 children. We are not of the opinion to start saying this is the number of children we want to have it is all in the hands of God to decide the number of children."*

Another adult Muslim participant said this also; "*this matter is for both the man and the woman, the man may say he wants this number of children and the woman may say she wants this number, truly as for me I can't say this is the number of children I want or if it should be a boy or a girl."*

Another respondent said this among the young married Muslims

"What I have to say about it is that there is no one that will tell you or decide for you the number ***of*** *children you should have. There are some cases where the wife goes ahead to do FP without involving her husband. And I know someone that goes to the hospital because the wife refuses to do FP and every day they sleep together without any pregnancy coming forth. So the husband went to the hospital to know what he can do to prevent pregnancy and he was told that he will have to use condom except the wife decides to do FP. You see he is doing everything to ensure that his children do not exceed a particular number but the wife does not want it. You see there is no family that will come and tell your number of children that you should have"*

4.2.1 Decision about Spacing of childbirth

Most narratives suggested that injections used with the intention of spacing child may be held by the child in the womb. Injection for spacing pregnancy was also reported to cause delay in pregnancy after the drug or injection has been stopped for preparation for another pregnancy. The evidence of the discussions is shown below;

"Topic on spacing is not like when you use injection or take drugs it is God that helps in child spacing we have noticed that families that uses contraceptive pills when they give birth to the child, the pills are discovered on the hand of the child that is why I

decided that my two wives by God grace will not use pills. I once have someone that have issues on getting pregnant and when she was about to give birth it did not take her 5 minute to deliver her child, you see there are others that give 2-3 years spacing between their children that is what is happening in this community."

Another participant said this, "*as for me going to receive injection to enable us space our children is not a good option, you see at times after 4 years of receiving the injection she has not gotten pregnant and before the effect of the injection wipes off completely it will take 9 years and she is anxious to get to pregnant again , the injection was for 4 years and now this her 9th year and she has not conceive again and you know we the Hausa we are skeptical on this issue , you know I had my first child in January 1998 and till 2007 before having another you see it was God that helped in spacing my children not family planning."*

4.2.2 Reasons for having many children

The narratives suggest that men have many reasons why they want many children. Some gave birth to many children because they believe the children will be of help in term of farming, defense in time of riot. Another said he desired to have his children in many profession therefore given birth to many children is the answer. Evidence of the response is shown below;

"you see when you have many children they would be able to help you out and do whatever they feel like doing you see I want a situation whereby in all profession like police, soldier, immigration I should be able to say I have a child in this organization but since God did not bless me with much I will give the best I can to them"

A participant from among the Christians said this. "*As farmers you need more children to help you in the farm so you need to give birth to many"*. Another respondent had this to say; " *another reason for having many children is for defense. when you have many children, in time of war, they will be able to defend you and when anybody want to treat you any how if that fellow consider the number of your children he will draw back."*

4.3.0 Factors that affect spousal communication.

Among the factors that discussants mentioned that affect spousal communication are love for pleasure of the present and no consideration for the future, and lack of peace was also mentioned as a factor that affect spousal communication, also mother inlaws and lack of proper guidance from doctors were among the factors mentioned. Evidence of this is highlighted below;

"Because they want to enjoy themselves and also lack of education on the part of some make them not to think of the future but the present alone therefore do not discuss about FP. Another *speaker said lack of peace in the home may also not allow couples to discuss about FP. Also some mother-in-laws can advise the man not to allow his wife to control him so he must never allow such discussion*. Another speaker also talked *about lack of proper guidance of a doctor, so if they don't know the use of a method, they cannot discuss about it. He also talked about the negative implication about FP that couples have heard made them not to discuss it*. Another speaker *said some couples give birth to many because they believe children are wealth so must be produced in large number."*

4.3.1 Contraceptive use

The FGD also explored contraceptive use among men. Findings from the discussion suggested that several methods of contraceptives are known to both men and women. Both modern and traditional methods were mentioned. However it was said that some of the methods expressed negative effects to those that used them. It was also reported that Islamic married women do not like to use contraceptive method for fear of losing the husband because children are the pride of the man and if they use contraceptive methods to prevent pregnancy, the husband may take up a new wife. Competition for children was another factor mentioned. Evidence of these responses is highlighted below;

"Yes I know those that talks more about it are the women who have kids, sometimes when I am at home I do hear some women talking about it thinking that I am asleep and you will hear one saying I inserted ring in my arm and it is affecting her and she has to remove it and there is another that said it was put in her arms when they were about removing it, it became a problem. Also I have heard of the rubber that men wear and there is this thing that a woman said it was inserted into her and it was

really affecting her because she has not done it before and she can't complain to her husband"

Another respondent also said this*; "There is one that I know that men uses to wear like a ring charm when they want to sleep with a woman it is always there, there is also another that they wear around there waist".*

When the respondents were asked which contraceptive method they are using, some asked if men are actually having contraceptives. However one of the participants said this;

"In Islam a woman that is married out of 100% ,99% of the women would not agree with their husband to use condom with them unless if they are not married because for the unmarried are scared of getting pregnant. But those women who are married out of the 100% only 1% will agree with her husband to use condom with her". One other respondent said this*; "1 there is one of my friend that once had a case like this where his friends wife went to do FP where it resulted in conflict and I have also heard where both the man and woman did FP, but due to its side effect when the wife went to collect one injection she said she is no more going back to collect it again. So due to the side effect normally she do see her menstrual flow once a month but after the injection it becomes twice in a month, it changes her body system and you know when a woman is seeing her menstrual flow she does not pray and because of that she told her husband that she does not agree with FP. It got to an extent whereby she has to tell her family members on what is going on and they told her it is not her fault and they asked her to be patient so after that she noticed that every month she gets pregnant and she has to use drugs to terminate the pregnancy and it is forbidden in Islam."*

The Christian body said this; *It is God that give children and he is the one that knows how to stop them.*

Another participant talked about injection which could be two years or three years interval. Another speaker talked about traditional methods such as tying rope on the waist before marriage, he also talked about the withdrawal method. Another also talked about injection which he used on FP. Most of them talked about condom.

One of the Islamic participants said this;

"but from what do cause conflict between us and our wives is not that this women really want to give birth to much children but they are scared their husband will marry another wife who will come and give birth to more children, yes she will begin to feel that the other woman will have more children than her. That is the reason you see our wives quarrelling over who their husband will sleep with at night and you see even if you tell them that you are not going to marry another they know it is a lie because they know the moment we have more money it's for us to get another wife"

Another respondent said this;

"me what I have to say is that just like what honourable said that when a man sleeps with a woman he should be ready to take up the responsibility but you know there are times that we sleep with women and we did not know it will result in pregnancy which will later cause problem that is why I am of the opinion that if you want to sleep with a woman you should make use of condom in that way it will prevent unwanted pregnancy"

On the question, reasons why men may not want to discuss about FP with their wives. A respondent said this;

"The reason is that everything that God does is good just like the situation where a woman went to collect in injection after 4 years she has not given birth it was at the 9th year before she gave birth you see that is what can bring fear among the women will hinder them from going for the method there is one that I know that I know around my place where this women went for FP and it resulted in complications this was not about giving birth. It was about her health now it has resulted in problem you see as for if there are ways that one can do it without using injection or tablet you see after a woman finishes her menstrual flow you calculate the days before going into her and pray at the same time"

4.3.2 Improving discussion on family planning

A way of improving discussion was considered important by the discussants. Most suggested the enlightenment level of couples on FP methods should be intensified. Others suggested that the religious leaders should be used as a tool for improving the discussion and others suggested that wives should be given autonomy to express themselves in reproductive issues. Below are evidences of responses;

"my own opinion is based on your project that you are doing so what I have to say is that you should come around and enlighten us on different methods of FP just like on the issue of polio that was how we were enlightened on how it was prevented and the women were the focus for discussion, so you see it is good you come enlighten us on the benefit and complications attached to FP"

Most of the Christian respondents said *women should be given freedom to initiate discussion on FP and they should be listened to.*

Another Muslim young married man said this;

"What me I have to tell you on this matter is that if you want to encourage people on this issue of FP you should go through religious leader where they would tell people on the benefit of FP and you will have good response"

Results of Quantitative data collection (questionnaire)

4.3.3 Socio-demographic characteristics

A total of 370 respondents participated in the study (table 4.1) the respondents includes married men, widowers as well as men who are separated with their wives. The age range of the respondents was between 20-81 with a mean age of 43.36± 10.247. Majority, 140(37.8%) of the respondents were between the ages of 40-49 years of age, followed by 32(8.6), 107(28.9%) and 58(15.7%) of the respondent were between the age of 20-29, 30-39 and 50-59 years respectively and the remaining few respondents 32(8.6%) were of the age range of 60 years and above.

Majority of the respondent 341(92.2%) were married, 15(4.1%) were divorced and the few remaining respondents 11(3.0%) were separated while 3(.8%) were widowers.

Most of the respondents 360(97.3%) were of the Islamic religion, followed by some of the respondents 9(2.4%) being of the Christian religion while the least 1(.3%) of the respondents were of the Traditional religion.

Also, the majority of the respondents 339(91.6%) were of the Hausa tribe followed by respondents 21(5.7%) which were of the Yoruba tribe and few of the respondents 2(.5%) being from the Igbo tribe and the others 8(2.2%) being from Benin (.3%), Togo (.3%) and Fulani (1.6%) respectively. Majority of the respondents 231(62.4%) had secondary education followed by respondents 75(20.3%) with primary education and 56(1.9%) respondents had tertiary education as their highest level of education while others 3(.8%) of the respondents went to Islamic schools and the remaining 4(.9%) had no formal education.

Some of the respondents 304(82.4%) were business men, 27(7.3%) were civil servants, 27(7.4%) were artisans while others 11(3.0%) were hospital attendant 1(.3%), Islamic priest/lecturers 10(10.3%)

The largest number of the respondents 250(67.5%) are of the monogamous family unit, while the rest 120(32.4%) of the respondents were of polygamous family units. Also, 265(72.2%) of the respondents has children less than 5 in number and 66(18.0%) of the respondents has children numbered between 6-10, while the rest, 36(9.8%) has above 11 number of children.

The results are presented in table 4.3.3

Table 4.3.3a Socio-Demographic Characteristics

Variables	No (%)
Age(years)	
20-29	33 (8.9)
30-39	107(28.9)
40-49	140(37.8)
50-59	58(15.7)
60>	32(8.6)
Marital status	
Married	341(92.2)
Divorced	15(4.1)
Separated	11(3.0)
Others	3(.8)
Religion	
Christianity	9(2.4)
Islam	360(97.3)
Traditional	1(.3)
Ethnicity	
Yoruba	21(5.7)
Igbo	2(.5)
Hausa	339(91.6)
Others	8(2.2)
Level of education	
Primary school	75(20.3)
Secondary	231(62.4)
Tertiary	56(15.2)
Others	7(1.9)
Occupation	
Business man	304(82.4)
Civil servant	27(7.3)
Artisan	27(7.3)
Others	11(3.0)

Table 4.3.3b, Socio-demographic Characteristics

Variables	No (%)
	254(68.6)
Number of wives	89(24.1)
1	22(5.9)
2	4(1.1)
3	
4	265(72.2)
Number of living children	66(18.0)
<5	36(9.8)
6-10	
11>	
	16(4.4)
Years spent in the community	50(13.6)
<10	74(20.2)
11-20	97(26.4)
21-30	87(23.7)
31-40	32(8.7)
41-50	11(3.0
51-60	
61>	

4.4.0 Knowledge on family planning methods

Responses of the respondents to the question **"understanding of family planning"** Majority of the respondents, 200(55.7) responded that family planning is a way of controlling birth, followed by 73(20.3) who said it is a way of reducing, limiting and spacing birth. However, 14(3.9) responded that it is an unIslamic practice to kill and destroy women. Details of this is presented in table 4.4.0b.

On the question "**sources family planning information"** majority 152(36.7) responded that they first heard about family planning from the hospital, followed by the television 95(22.9) and the radio 80(19.3). the details of this report is presented in table 4.4.0a.

About **the benefits of FP"** most of the respondents 282(76.0) said there is no benefit in family planning, some 27(7.3) said family planning will bring about better education for children and good health for the mother, the details are presented in table 4.4.0c

When the respondents were asked the question, **" FP methods known"** Majority 249(45.4) responded that it is condom that is known to them as a method of family planning, 82(14.9) know about withdrawal method, 89(16.2) said they know none of the mentioned family planning methods. Details of the methods known is presented in figure 4.4.0.

The rest about knowledge of family planning is presented in details in table 4.4.0a.

Table 4.4.0a Knowledge of family planning

Sources of FP information (N=414)**	No (%)
Friends	38(9.2)
Hospital	152(36.7)
Television	95(22.9)
Radio	80(19.3)
Internet and print media	13(3.1)
Spouse, community and family members	23(5.6)
School	10(2.4)
Religious organizations	3(.7)
Methods of FP known (N=549)**	
Condom	249(45.4)
Male sterilization	9(1.6)
Abstinence	17(3.1)
Withdrawal method	82(14.9
Safe Period method	11(2.0)
Use of Pills	41(7.5)
Use of injections	41(7.5)
Intrauterine device	89(16.2)
Rings	6(1.1)
ever encouraged spouse to use family planning(N=370)	
Yes	51(13.8)
No	319(86.2)
Way of encouragement (N=51)	
Follow her to the hospital	5(9.8)
I discuss it with her	21(41.2)
I tell her the importance	8(15.7)
Make her understand time is changing	10(19.6)
Abstinence	1(.3)
By using contraceptives	6(11.8

****;** Multiple responses included

Table 4.4.0b Knowledge of family planning

Reasons for no encouragement(N=319)	
It is against my religion	270(84.6)
it will affect the health of my wife	2(.6)
i don't like it	23(7.2)
just got married, need kids	6(1.9)
not yet ready to do it	3(.9)
am not interested in it	10(3.1)
God decides	2(.6)
Create misunderstanding between couples	1(.3)
I want natural method	1(.3)
she went for it herself	1(.3)
Best place for family planning counseling (N=356)	
Hospital/Healthcare	244(68.5)
Religious organization	8(2.2)
None place	104(29.2)
Decision about family planning (N=368)	
Doing it	15(4.1)
Not doing it	52(14.1)
It is good	18(4.9)
It is not good	94(25.5)
Interested in it	22(6.0)
Not interested in it	167(45.4)

****;** Multiple responses included

Table 4.4.0b Understanding Family Planning

	No (%)
What men understand by family planning (N=359)	
A way of reducing, limiting and spacing birth	73(20.3)
A way of controlling birth	200(55.7)
A way of avoiding poverty and planning for the future	45(12.5)
A good practice by parents to prevent unwanted pregnancy	7(1.95)
An unIslamic practice to kill and destroy women	14(3.9)
It is not good	16(4.5)
I don't understand it	4(1.1)
Total	

Table 4.4.0c knowledge of benefits of family planning

Variables	No (%)
The benefits of FP(N=370)	
Improves standard of living/stable economy	15(4.1)
Enables better education for children	14(3.8)
Good health for the woman	6(1.6)
Gives peace and tranquility for both spouse	11(3.0)
Makes life easier	13(3.5)
I don't see any benefit in Family planning	282(76.2)
Makes you give birth to children you can care for	11(3.0)
I don't know	6(1.6)
Enables birth spacing	12(3.2)
Total	370(100)

Table 4.4.0d: knowledge of side effects of using family planning methods

	No (%)
Side effects of using FP methods (N=362)	
Irregular menstrual period, pain, swollen stomach and extensive bleeding	11(3.0)
Difficult in pregnancy affect the health of the woman	142(39.0)
No side effect	59(16.3)
I don't know	6(1.7)
Destroys woman's womb and kills the women generally and cause delay in pregnancy	56(15.5)
No sexual enjoyment	2(0.6)
It is not good and bring curse from God	86(23.8)
Total	362(100)

4.4.1 Categorization of knowledge of family planning among men

A total of 370 respondents were categorized to be having poor, fair and good knowledge based on a 26 point scale drawn for the open ended knowledge questions. Each correct response in the scale attracted a score of one while the wrong responses were scored zero. The respondents that scored between 0-8 were categorized to be having poor knowledge and those that scored between 9-17 were categorized to be having fair knowledge while those that scored between 18-26 were categorized to be having good knowledge. The allotted scores were merged to the knowledge questions in the SPSS and were added up to 26 and then categorized as being poor, fair and good. The result is represented in figure 4.2.1

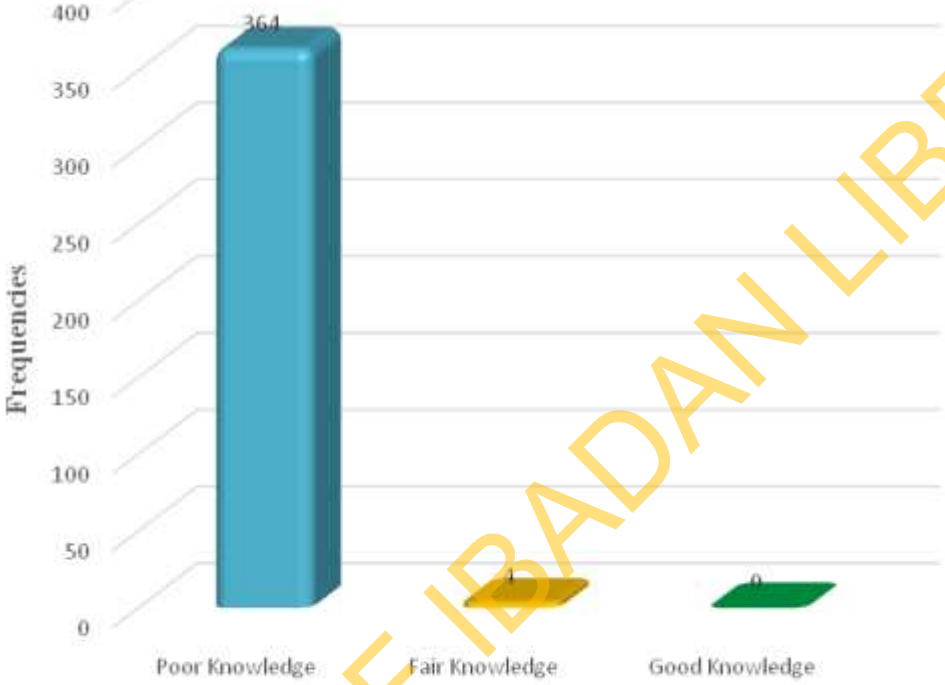

Figure 4.4.1. Categorization of knowledge of family planning

4.4.2 Level of spousal communication

Majority 307(83.2) of the respondents had never discussed about FP with their wives while 62(16.8) had discussed with their wives. The most period that couples discussed about family planning was before marriage 21(33.9) followed by those that discussed immediately after marriage 15(24.2), on who brought up the discussion, men 40(64.5) and women 14(22.6) while some responded that both of them brought up the discussion 8(12.9) and on the convenient time when couples discuss about family planning, the most convenient time of discussion was anytime 43(69.3) followed by evening 15(24.2). some of the respondents 59(16.7) said they have discussed about FP with people apart from their wives while 295(83.3) said they had never discussed with any other person about family planning. And those that discussed with others most discussed with their friends. On who made decision about the number of children to born, men 59(16.9) made decision on numbers to born followed by the response that Allah 42(11.7) made the decision on how many children to born. This is represented in the table and figure 4.4.2.

Table 4.4.2 Level of spousal communication

Period discussion on family planning methods with partner started

	Frequency	%
Before marriage	21	33.9
Immediately after marriage	15	24.2
After our first Child	8	12.9
After second Child	8	12.9
After third Child	2	3.2
After fourth child	6	9.7
After fifth child and above	2	3.2
Total	62	100.0

Initiator of discussion about Family planning between husband and wife

Me	40	64.5
my wife	14	22.6
Both	8	12.9
Total	62	100.0
Convenient period to discuss family planning with wife		
Early in the morning	1	1.6
In the noon	2	3.2
In the evening (night)	15	24.2
Anytime	43	69.4
I don't know	1	1.6
Total	62	100.0
Ever discussed about FP with other apart from spouse		
Yes	59	15.9
No	311	84.1
Total	370	100.0

Others family planning issues was discussed with apart from spouse

My friends	58	98.3
Doctors	1	1.7
Total	59	100.0

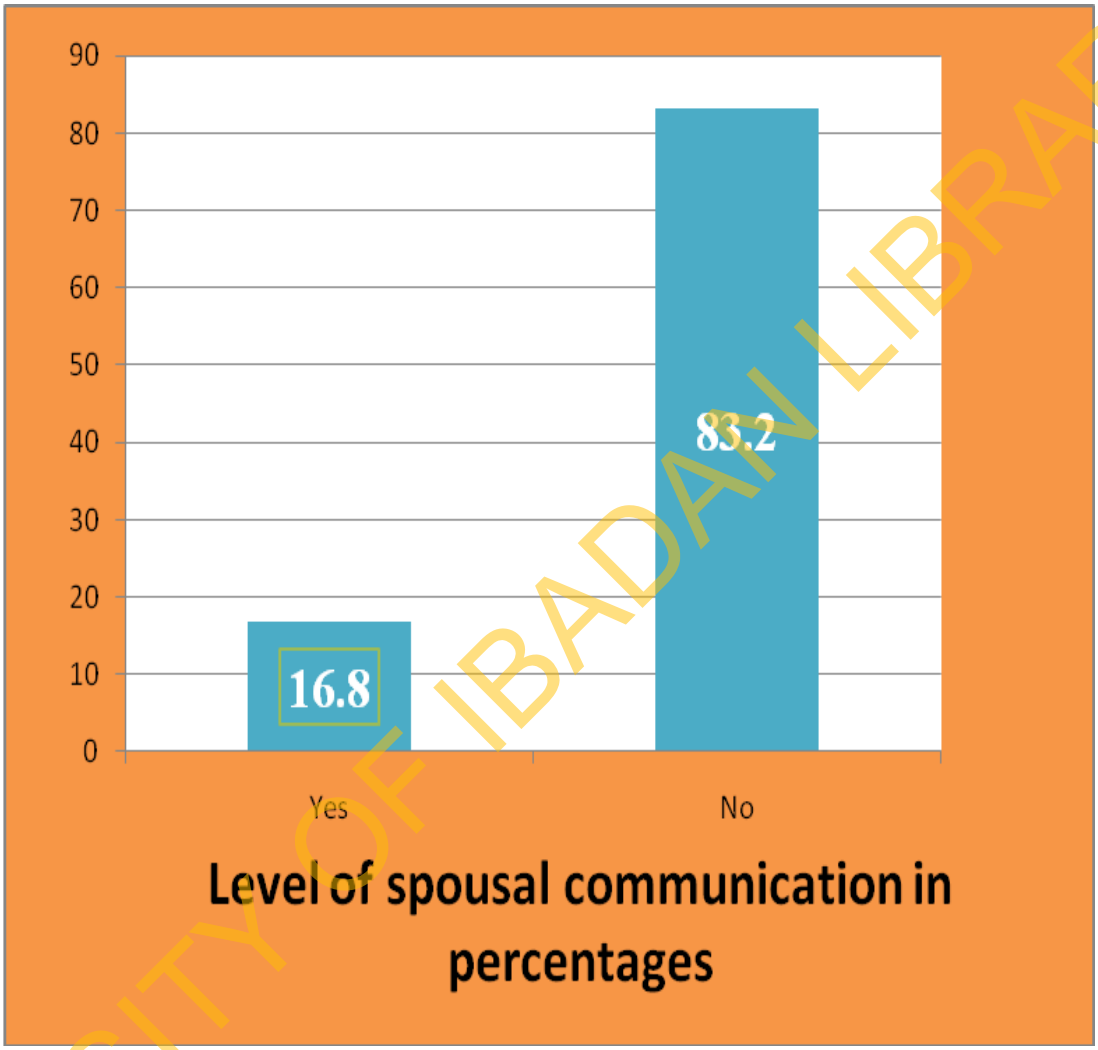

Figure 4.4.2 level of spousal communication in percentages.

Table 4.4.2, spousal communication

Who made the decision about the number of children to have		
Myself	68	18.4
my wife	10	2.7
both of us	14	3.8
Allah/ God	220	59.5
Nobody	42	11.4
Money/finance/funds	16	4.3
Total	370	100.0

Knowing about the number of children wife (yes) desire to have		
YES	46	12.9
NO	311	87.1
Total	357	100.0

Specific number of children wife(yes) desire to have		
1	1	2.0
2	6	11.8
3	10	19.6
4	11	21.6
5	13	25.5
6	3	5.9
7	4	7.8
8	1	2.0
10	2	3.9
Total	51	100.0

Table 4.4.2b Spousal communication		
Ever had any disagreement about family planning with spouse		
YES	7	2.6
NO	261	97.4
Total	268	100.0
How disagreement was resolved		
leave for peace to reign	4	57.1
impose my decision on her	2	28.6
make her understand condition of things	1	14.3
Total	7	100.0
Revisiting family planning discussion that ends in disagreement.		
YES	5	71.4
NO	2	28.6
Total	7	100.0

4.4.3 Factors that affect spousal communication

Few of the respondents 62(16.8) agreed to the statement that knowing about FP will make it interesting for them to discuss it with their partner while majority 297(80.5) disagree to the statement, however, majority 221(59.7) agreed to the statement that the health implication it has caused some women will not allow them to discuss the subject with their partners and to this 47(12.7) disagreed. On the statement when there is plan for more children, family planning discussion is not necessary, majority 292(78.9) agreed while 40(10.8) disagreed. The details of this are presented in the table 4.4.3.

Table 4.4.3 Factors that affect spousal communication

Statement	Agree (%)	Undecided (%)	Disagree (%)
Knowing about FP makes it interesting to discuss about it	62(16.8)	10(2.9)	297(80.5)
The negative health implication it has caused some women will not let me discuss about it with my wife	221(59.7)	101(27.3)	47(12.7)
When there is still plans for more children family planning discussion is not necessary	292(78.9)	38(10.3)	40(10.8)
Lack of personal interest on FP planning on the part of the man makes the discussion difficult	321(86.8)	5(1.4)	44(11.9)
My religious doctrine does not permit family planning so no need to discuss it	318(85.9)	7(1.9)	45(12.2)
You don't expect FP discussion in the house of a man with more than one wives	285(77.0)	48(12.4)	39(10.5)

4.4.4 Pattern of contraceptive use

When the question, have you or your spouse ever used contraceptives, was asked, out of the 370 respondents, 57(15.4) said yes and when the question was reframed that did you use contraceptive in your last sex with an intention of controlling birth, 40(10.8) said they did and the 57(15.7) respondents out of 370 respondents that responded, said their partner agreed with them using contraceptive and the male condom was the most used modern contraceptive 77(17.7) while withdrawal method was the most used traditional family planning method 39(9.0). On current use of modern contraceptives, out of 50 respondents currently using contraceptives, the male condom was the most used with 28(7.6) followed by female condom 10(2.7) and for the current use of traditional methods of family planning, withdrawal method and the safe period were the most currently used, 15(4.1) and 12(3.2) out of a total of 36 respondents. Details of these results are presented in the tables and charts 4.4.4abc.

Table 4.4.4a Pattern of Contraceptive use

Ever use of contraceptives	**No**	**%**
YES	57	15.4
NO	312	84.6
Total	**369**	**100.0**

Use any contraceptive in last sex with the intention of controlling birth		
YES	40	10.8
NO	329	89.2
Total	369	100.0

Partner agree with use of FP contraceptive		%
YES	57	15.7
NO	306	84.3
Total	363	100.0

Modern contraceptive methods used in the last one year		
Male condom	74	76.3
Injection	12	12.4
Pills	5	5.2
Intrauterine device	4	4.1
Male sterilization	2	2.1
Total	97	100.0

Spouse finding modern contraceptive method convenient to use		
YES		
NO	317	85.7
Total	370	100.0

Table 4.4.4b Pattern of contraceptives use

Traditional family planning methods spouses used in the last one year		
	YES	NO
Withdrawal	39	39.4
Safe period/rhythm	31	31.3
Abstinence	27	27.3
Ring	2	2.0
Total	99	100.0

Spouses finding traditional family planning method convenient to use		
YES	53	14.3
NO	317	85.7
Total	370	100.0

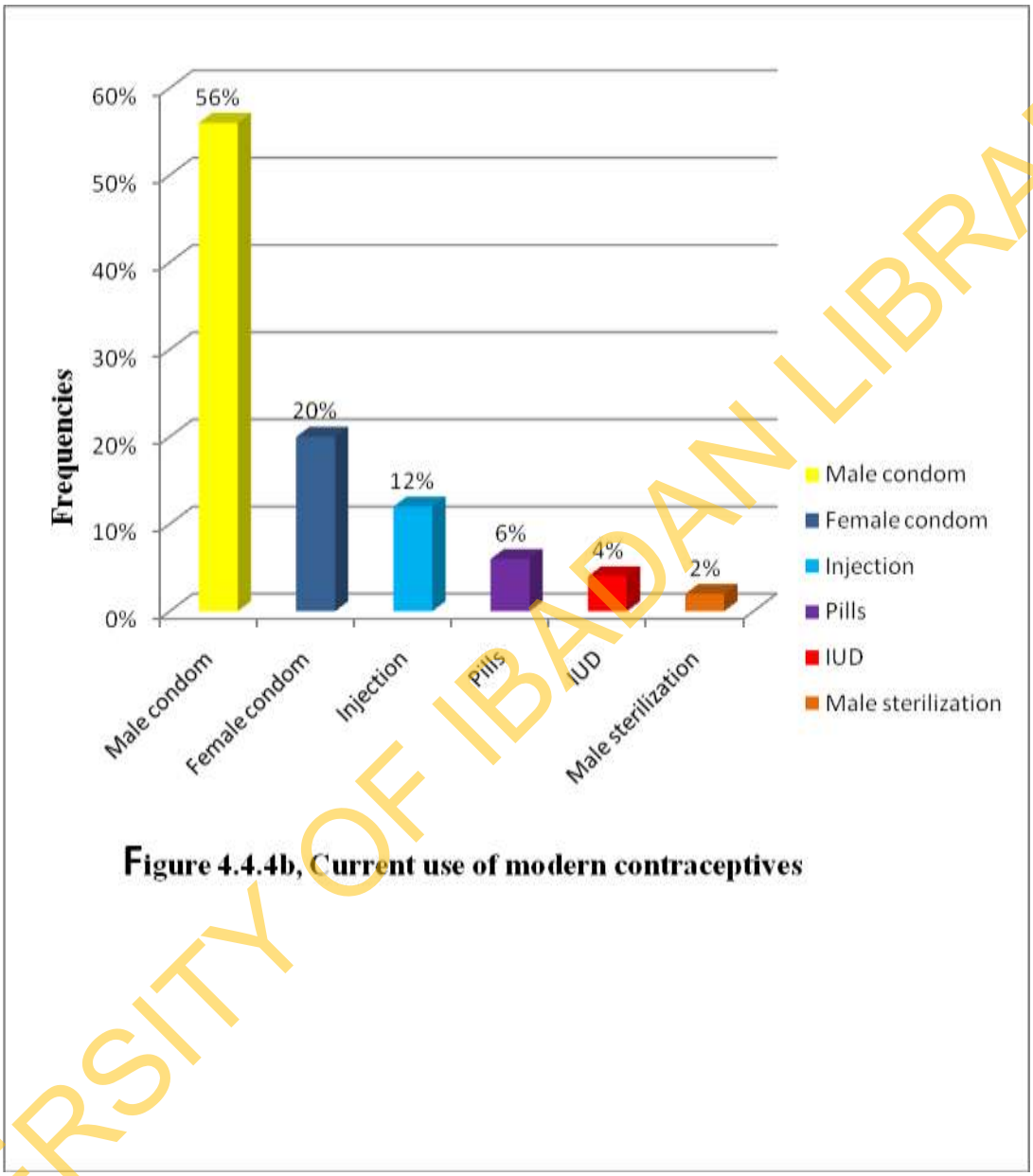

Figure 4.4.4b, Current use of modern contraceptives

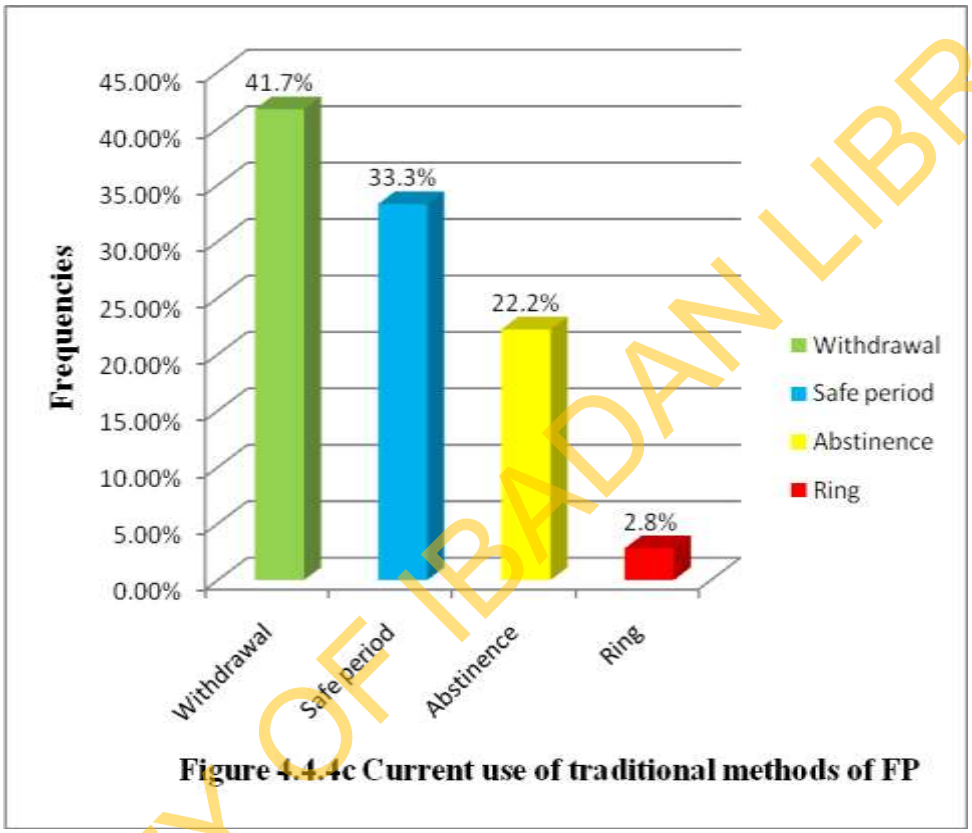

Figure 4.4.4c Current use of traditional methods of FP

4.5.0 Factors that promote and hinder use of contraceptives

Majority of the respondents 306(82.7) disagreed to the statement that information on proper use of contraceptive will enable them use any while 57(15.4) agreed that information on proper use will enable them use contraceptives. Factors such as tradition, culture, desire for more children and fear of friend making jest of them on hearing that they are using contraceptives were some of the reason most men do not agree to the use of contraceptive and some 252(58.1). The result is presented in the table 4.5.0

Figure 4.5.0 Factors that promote and hinder contraceptive use

Statement	Agree (%)	Undecided (%)	Disagree (%)
Information on the proper use of contraceptive will enable me use it	57(15.4)	7(1.9)	306(82.7)
The use of contraceptive is not permitted by my tradition	304(82.)	24(6.5)	42(11.4)
My cultural belief does not permit the use of contraceptive,	309(83.2)	17(4.6)	44(11.9)
Giving birth to many children is the pride of a man in my family	308(83.2)	8(2.2)	54(14.6)
Couples who care for each other will encourage the use of contraceptives	57(15.4)	57(13.5)	263(71.1)
The use of contraceptive will affect the health of my wife negatively in future	252(68.1)	58(15.7)	60(16.2)
My friends may make jest of me if they got to know that am using contraceptive with my wife	43(11.6)	32(3.6)	295(79.7)
Family planning will cause a loss of confidence between a husband and a wife	242(65.4)	48(13.0)	80(21.6)
A family that practice family planning will have conflict in their marriage	268(72.4)	48(13.0)	54(14.6)
It is embarrassing for me to talk about family planning with my spouse	274(74.3)	23(6.2)	72(17.5)
If birth is controlled, children will have a better education	67(18.1)	21(5.7)	281(76.2)
Practicing FP will bring about a happy home	59(15.9)	21(5.7)	286(77.3)
Family planning will improve the standard of living	63(17.0)	21(5.7)	286(77.3)
Where there are more than one wife, the competition for children won't permit the use of contraceptive.	233(63.0)	38(10.3)	99(26.8)

Testing of Hypothesis

4.5.1 Relationship between socio-demographic characteristics and spousal communication.

The first hypothesis stated that there is not significant relation between socio-demographic characteristics of men and spousal communication. The variable tested with spousal communication were age, marital status, religion, level of education, occupation, number of wives and number of living children. Fisher's exert was used to calculate the relationship where there were values less than 5. The result among the age group shows that spousal communication is much among men of age range 40-49 with percentage frequency of 31(50.0%). x^2 = 6.078, df= 4, p-value = 0.188 which shows no association. The result for religion shows that Islamic men Discuss more with their spouse with percentage frequency of 56(90%) x^2 =12.396 df= 2= p-value = 0.001 which indicate that there is an evidence of relationship between religion and spousal communication which can further be elaborated when looking at religion and non spousal communication whose percentage frequency is 303(98.7%) also shows the same association between religion and non spousal communication. The details of the tests are presented in the table 4.5.2.

Table 4.5.1a The Relationship between Socio-demographic characteristics and Spousal communication

	Spousal communication		X^2	df	p-value
Age group	YES (%)	NO (%)			
20-29	5(8.1)	28(9.1)	6.078	4	0.188
30-39	17(27.4)	89(29.0)			
40-49	31(50.0)	109(35.5)			
50-59	7(11.3)	51(16.6)			
60>	2(3.2)	30(9.8)			
Total	62(100.0)	307(100.0)			
Marital status					
Married	58(93.5)	282(91.9)	1.379	3	0.702
Divorced	2(3.2)	13(4.2)			
Separated	1(1.6)	10(3.3)			
Others	1(1.6)	2(0.7)			
Total	62(100.0)	307(100.0)			
Religion					
Christianity	6(9.7)	3(1.0)	12.396	2	0.001
Islam	56(90.3)	303(98.7)			
Traditional	0(0)	1(0.3)			
Total	62(100.0)	307(100.0)			
Level of education					
Primary	7(11.3)	68(22.2)	14.031	3	0.002
Secondary	36(58.1)	194(63.4)			
Tertiary	19(30.6)	37(12.1)			
Others	0(0)	7(2.3)			
Total	62(100.0)	306(100.0)			
Occupation					
Business men	43(69.4)	266(85.3)	11.408	3	0.007
Civil servant	10(16.2)	17(5.4)			
Artisan	5(8.1)	22(7.1)			
Others	4(6.5)	7(2.2)			
Total	62(100.0)	312(100.0)			

Table 4.5.1b The Relationship between Socio-demographic characteristics and Spousal communication

Number of wives					
1	48(77.4)	205(67.0)			
2	12(19.4)	77(25.2)			
3	2(3.2)	20(6.5)			
4	0(0)	4(1.3)	2.349	3	0.467
Total	62(100.0)	306(100.0)			
Number of living children					
<5	52(85.2)	212(69.5)	6.623	2	0.034
6-10	7(11.5)	59(19.3)			
>11	2(3.3)	34(11.1)			
Total	61(100.0)	305(100)			

4.5.2 Relationship between socio-demographic characteristics of men and the use of family planning.

The second hypothesis stated that there will be no relationship between the socio-demographic status of men and the use of family planning methods.

In this study socio-demographic characteristics used to test the use of family planning includes age, marital status, and level of education, religion, occupation, number of wives and number of living children. Respondents within the age group of 40-49 had the highest frequency and percentage of use 29(20.7). Fisher's exert was used to calculate each of the relationships, (x^2 = 5.760, df= 4 p-value = 0.893.)

Followed by respondents within the age group of 30-39 with frequency and percentage use of 92(86). Respondents with tertiary level of education has the highest percentage of use 14(25) while respondent with secondary education had the highest frequency and percentage of not used 197(85.3).

x^2=4.978, df=3 p-value=0.150

Business men had the highest frequency of use of family planning methods 37(12.2) while artisans has the highest frequency of none used 20(74.1)

x^2= 14.375 df= 3 = 0.001

On religion, Islam had the highest frequency of not used 309(85.8) while Christianity had the highest percentage of used 6(66.7). Details of the result is shown in table 4.5.3.

Table 4.5.2a Relationship between socio-demographic characteristics of men and the use of FP Contraceptives.

	Use Of Family Planning Methods		X^2	df	p-value
Age group	YES (%)	NO (%)			
20-29	3(9.1)	30(90.9)	5.760	4	0.893
30-39	15(14.0)	92(85.9)			
40-49	29(20.7)	111(79.3)			
50-59	8(13.8)	50(86.2)			
60>	2(.3)	30(93.75)			
Total	57(100.0)	313(100.0)			
Marital status					
Married	54(93.1)	287(91.7)	2.883	3	0.556
Divorced	2(3.4)	13(4.2)			
Separated	0(0)	11(3.5)			
Others	2(3.4)	2(0.6)			
Total	58(100.0)	313(100.0)			
Religion					
Christianity	6(66.7)	3(33.3)	13.489	2	0.001
Islam	51(14.2)	309(85.8)			
Traditional	0(0.0)	1(100)			
Total	57(100.0)	313(100.0)			
Level of education					
Primary	9(12)	66(88.0)			
Secondary	34(14.7)	197(85.3)	4.978	3	0.150
Tertiary	14(25.0)	44(75.0)			
Others	0(0.0)	1(100)			
Total	57(100.0)	308(100.0)			

4.5.2b Table of Relationship between socio-demographic characteristics of men and the use of FP Contraceptives.

Occupation					
Business men	37(12.2)	267(87.8)	14.375	3	0.001
Civil servant	10(37.0)	17(63.9)			
Artisan	7(25.9)	20(74.1)			
Others	3(27.3)	8(72.7)			
Total	57(100.0)	312(100.0)			
Number of wives					
1	43(75.4)	211(67.6)	1.173	3	0.748
2	11(91.3)	78(25.0)			
3	3(5.3)	19(6.1)			
4	0(0)	4(1.3)			
Total	57(100.0)	312(100.0)			
Number of living children					
<5	48(87.3)	217(69.6)	8.357	2	0.015
6-10	6(10.9)	60(19.2)			
>11	1(1.8)	35(11.2)			
Total	55(100.0)	312(100.0)			

4.5.3 Relationship between spousal communication and use of family planning contraceptives

The third hypothesis stated that there is no significant relationship between spousal communication and the use of family planning contraceptives and the variable tested against current use of FP contraceptives indicated that there is an evidence of significant relationship between spousal communication and use of FP contraceptive. Therefore the null hypothesis was rejected.

X^2=222.145, df = 1, p-value= 0.00. This result is presented in the table below

Table 4.5.3 Relationship between spousal communication and use of contraceptives

Discussion		Current use of contraceptives		Total
		Yes (%)	No (%)	
Discussion about family planning	Yes	40(84.2)	22(4.5)	62
	No	0(15.8)	307(95.5)	307
Total		40	327	369

X^2=222.145, df = 1, p-value= 0.00.

CHAPTER FIVE

DISCUSSION, CONCLUSSION AND RECOMMENDATION

5.1.1 Socio-demographic characteristics

The age of the respondents ranged from 20-81 years of age which is in line with the categorization of age group as used by Ijadunola et al, 2010 in Male Involvement in Family Planning Decision Making in Ile-Ife , Osun State , Nigeria. the mean age of the respondents was 43.36± 10.247. Majority of the respondent were between age 40-49 and 30-39 which also similar to the age group used by Ijadunola et al 2010 in Male Involvement in Family Planning Decision Making in Ile-Ife , Osun State , Nigeria.

Majority of the respondents were of the Hausa ethnic group, and this could be as a result of the fact that the study centre was Sabo Hausa community and the Hausas are the predominant ethnic group. The Islamic religion is also the most populous religious group 360(97.3) in the community. This is similar to the work done by Izugbara et al on Gendered interests and poor spousal contraceptive communication in Islamic northern Nigeria

5.2.0 Knowledge of family planning among men.

This study attempted to determine the knowledge of men about family planning in Sabo Hausa community in Ibadan. The study revealed that majority of the respondents 200(55.7) see family planning as a way of controlling birth while 73(20.3) sees it as a way of reducing birth and few saw it as a way of avoiding unwanted pregnancy. This finding is similar to that of a study conducted by Adelekan, Omoregie, Edoni, 2013 on Male Involvement in Family Planning : Challenges and Way Forward in Olorunda Local Government Area, Osogbo, Nigeria. On the sources of information on family planning, it was documented that 152(36.7) heard about family planning from the hospital, television 95(22.9) and Radio 80(19.3) and this is similar to the report of national demographic health survey 2013. On the type of contraceptive known by men, majority, 249(45.4) knew about Condom while 82(14.9) knew about abstinence which similar to the findings of Berhane et al 2011 on Men ' s Knowledge and Spousal Communication about Modern Family Planning Methods in Ethiopia.

On the issue of benefit, 282(76.0) said there is no benefit in family planning and this might be as a result of the fact that the area is a Muslim dominated community for Islamic religion does not encourage the use of family planning.

27(7.3) said it enhances better education for children and good health for the mother while 26(7.0) said it makes life better.

Most of the respondents had never encouraged their wives on family planning utilization. 319(86.2) of men never encourage their spouse of family planning. This could be traced to the religious stance on family planning contraceptive use and the desire to have more children. About side effect of family planning, most of the respondent said it causes irregular menstrual period and pain, difficulty in pregnancy and affect the health of the woman. This is similar to the study conducted by Duze, and Mohammed 2006 on Male Knowledge, Attitudes, and Family Planning Practices in Northern Nigeria.

Also on the focus group discussion, (FGD) on knowledge of Family Planning, most of the participants said FP is against their belief and that it is it has its repercussion however they all see family planning as a way of reducing and spacing children. Most of the participants said they believe it is God that gives children and that he is the only one that can determine when to give you children, the number to give you and when to give you. This reason can be traced to the fact that the community is a Muslim dominated society and the religion stand on FP is well defined. This is contrary to the findings of Izugbara et al, 2010 on Gendered interests and poor spousal contraceptive communication in Islamic northern Nigeria.

5.2.1 Level of spousal communication

The study attempted to document the level of spousal communication and Majority 307(83.2) of the respondents had never discussed about FP with their wives while 62(16.8) had discussed with their wives. This could be as a result of lack of personal interest in spousal communication or probably desire for more children on the part of the men, religious stand and fear of lost of trust from spouse. The most period that couples discussed about family planning was before marriage 21(33.9) this could suggest that the few that discussed about family planning before marriage actually had plan for the future though successful implementation might be a challenge and this is similar to the finding of ijugbara et al, 2010 on Gendered interests and poor spousal contraceptive communication in Islamic northern Nigeria. It was also reported that the discussion on family planning is mostly initiated by men in this study, 40(64.5) yet the percentage of men who had never discussed about FP with their spouse is on the

increase 295(83.3). This could also be due to lack of personal interest and the mindset by some men that family planning is not men's affairs. However majority of the respondent believed that it is Allah/God that decides on the number of children couples should have. This might be due to the fact that majority of the respondents are Muslims and the Islamic religion is not in support of family planning. Some of the respondent actually discuss about family planning with friends rather than with their wives and this could be that they trust and confide more on friend on the subject of FP than their spouse. This finding is similar to the one conducted by M, Duje, I Mohamed 2006 on Male knowledge, attitudes, and family planning practices in northern Nigeria. Also this finding is similar to that Babalola and John 2012 on Factors Underlying the Use of Long-Acting and Permanent Family Planning Methods in Nigeria: A Qualitative Study.

Most of the respondents for the focus group discussion among both the Christians and the Muslims responded that the discussion of family planning is mostly initiated unanimously though at times the wives do brought it up but they too does. However, on who made decision about number of children to born, they both said the man is the head of the family therefore is vested with the autonomous authority to decide though most of the participant said it is God's to decide. This might be due to the fact that Nigeria and in particular the Hausa society is a patriarchal and patrilineal country and society where most of the decisions are being made by the man. This is similar to the findings of Duze, Mohammed, Mustapha and Ismaila, 2006 in Male knowledge, attitudes, and family planning practices in northern Nigeria.

5.2.2 Pattern of Contraceptive use.

This study tried to document the pattern of contraceptive use and out of the 370 participants, only 57(15.4) had ever used contraceptives. This could be as a result of the fact that the study was conducted in Hausa speaking and Muslim dominated community where contraceptive use is not permitted by the religion. This is similar to the findings of the national demographic health survey 2013. The pattern of current use of both the modern and the traditional method of contraceptive use was also determined and it was reported that the male condom was the most commonly used modern contraceptive 28(56) while withdrawal was the most currently used traditional method of family planning 15(41.7) and this could be as a result of the fact that condom is the most available and affordable modern contraceptive and the withdrawal method is also much easier to practice by men. This finding is somehow in contrast with the findings of Adelekan, Omoregie and Edoni, 2013 on Male Involvement in Family Planning,Challenges and Way Forward in Olorunda Local Government Area, Osogbo, Nigeria. .

This study also tried to document the findings of the focus group discussion on contraceptives use and though some of the respondents were positive about the use of contraceptives but most never supported it. And some of the reason for not supporting contraceptives was the religion stand on contraceptive use and some gave reasons of the health implication suffered by their wives and this is similar to the findings of Babalola and John 2012 on Factors Underlying the Use of Long-Acting and Permanent Family Planning Methods in Nigeria: A Qualitative Study but contrary to the findings of Ijugbara et al, 2010 on Gendered interests and poor spousal contraceptive communication in Islamic northern Nigeria.

5.3.0 Factors that hinder and promote use of Contraceptives among men

The study also attempted to document some factors that hinders and promote the use of contraceptives among men. Majority of the respondents 306(82.7) disagreed to the statement that information on proper use of contraceptive will enable them use any while 57(15.4) agreed that information on proper use will enable them use contraceptives. Factors such as tradition, culture, desire for more children and fear of friend making jest of them on hearing that they are using contraceptives were some of the reason most men do not agree to the use of contraceptive and some 252(58.1) said

the negative health implication on their wives hindered them from using family planning contraceptive.

On the report of the focus group discussion, some of the participants emphatically said anything that Islam do not support should better be left unattended to while some talked about the negative health implication on the woman. Some but some said because they want to sponsor their children to school they can use family planning to regulate birth. This is in line with a qualitative Study of Babalola and John (2012) on Factors Underlying the use of Long-Acting and Permanent Family Planning methods in Nigeria.

5.3.1 Implication for health education

Findings from this study have health promotion and education implication therefore there is the need to apply multiple interventions to tackle these problems.

Awareness and health education: there is the need for more awareness programmes on family planning. Health education on the risk a woman is being put through giving birth to so many children should be made known to the public. The contraceptive prevalence in the south western zone is 38% but the finding in sabo indicates that more efforts should be put in place to enlighten them on the economic factors, child and maternal mortality and the importance of fertility regulation in addressing this health and socio-economic issues. Creating awareness is achievable through organizing health talks in the community health center in which the stakeholders should be well enlightened so as to influence others in the community. Couples should also be well enlightened on the best available methods that they can use in controlling birth. The issue of side effects which had made some not to utilized should also be addressed so that people will not be using that as an excuse for not using family planning methods. Religion is another factor that made people not to use family planning methods, therefore the religious leaders should be involved in public enlightened. Posters, billboard, leaflets, documentaries, jingles to give out information on the importance and the benefits of family planning. This tools will go a long way to modify the behaviour of this people.

Community participation: involving the members of the community is one means through which they can take any project as their own and maintain it. Family planning program implementers should recognize the importance of the community member. When they are not involved the program becomes foreign to them and this might

eventually lead to failure of the program. In this case gender equality should be emphasized and religious leader and other stakeholders should be involved in any family planning program.

Training : More health workers should be recruited and trained to educate couples on the importance of family planning and how to use some of this methods.

Social mobilization should target community leaders, traditional leaders, religious organization and also faith based organization can partner with health facilities in promoting services available and how they can be afforded and utilized.

5.3.2 Conclusion

Findings from this study revealed that most men were not interested in the utilization of family planning methods and the reasons given were lack of personal interest, negative health effect on their wives, cultural and religious beliefs. Based on this, majority of the respondents believed that God decides the number of children couples should have and also men being the head of the family, decide the number of children to give birth to.

The study also revealed that, most of the respondents had never discussed about FP with their wives therefore making the level of utilization of FP contraceptives to be low. However, the condom was the most used modern contraceptive while the withdrawal method was the most practiced traditional method of contraceptives.

5.3.3 Recommendations

Based on the findings of this study, the following recommendations are made.

1. Family planning policy makers and health workers at the Local Government Area (LGA) should create awareness on the economic and educational benefits of family planning.
2. The importance of spousal communication in the effective utilization of FP contraceptive should be emphasized by health workers during family planning counseling
3. Gender inequality in family planning decision making should be addressed by all stakeholders including; religious organizations, FP policy makers, educational institutions and health organizations.
4. Religious and traditional leaders should partner with health workers at the LGA to mobilize community members to endorse the use of FP.

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APPENDIX I

QUESTIONNAIRE

SPOUSAL COMMUNICATION AND USE OF FAMILY PLANNING METHOD AMONG MEN IN SABO COMMUNITY OF IBADAN NORTH LOCAL GOVERNMENT OF OYO STATE

Dear Respondent,

My name is **TOMERE FIYEJUNA BEKEWEI,** a Postgraduate Student of the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan. The purpose of this study is to investigate **Spousal communication and use of family planning methods among men in Sabo community in Ibadan north local government**. The findings from this study will help in the design of programmes and formulation of policies aimed at preventing maternal mortality and improve the economy. Your identity, responses and opinion will be kept strictly confidential and will be used for the purpose of this research only. Please note that you do not have to write your name on this questionnaire, also try and please give honest answers to the questions asked as much as your maximum co-operation will assist in making this research a success.

Would you want to participate in the study? (1) YES { } (2) NO { }

Thank you very much.

Important Instruction(s): Please Do Not Write or Supply Your Name

section a| socio-demographic characteristic

Instructions: In this sections please tick (√) in the appropriate boxes that correspond to your answers or complete the spaces provided below

1. **Age in years** (as at last birthday)……
2. **Marital status** |1.married { } 2.divorced{ } 4.separated{ }
3. **Religion** |1.Christianity { } 2. Islam { } 3.Traditional { } 4.Others ……
4. **Ethnic group** |1. Yoruba { } 2.Igbo { } 3.Hausa { } 4.Others (specify)……
5. **Which state are you originally from**? ……
6. **Level of education** |1. Primary { } 2. Secondary { } 3. Tertiary { }

7. **Occupation** |1. Business man{ } 2. Civil servants{ } 3. Artisan{ } 4. Others (specify)……

8. **Family unit** |1. Polygamy { } 2. Monogamy { } 3. Others……

9. **How many wives do you have**? …….

10. How many living **children** do you have for now?.....

11. How many **years** have you spent in this community? ……

12. Which part of Sabo do you live? 1. Sabo Gangare( ) 2. Sabo Oke Hausa,( ) 3 Sabo Okeesu, ( ) 3.Sabo Gana ( ) 4. Sabo Seriki ( ) 5. Others specify ……

13. What is your weekly income……..

section b: knowledge of family planning methods among men

S/N	**STATEMENT**	**RESPONSE**
14	What do you understand by family planning?	
15	From who or where did you first hear about family planning?	
16	What do you think are the benefits of family planning?	
17	Which of these family planning (FP) methods do you know? *Please tick appropriately (√)* [a] Condom ( ) [b] Male sterilization ( ) [c] Abstinence( ) [d] withdrawal ( ) [e] Safe period (rhythm method) ( ) [f] Pills( ) [g] Injection( ) [h]Use of Ring ( ) [i] Intrauterine device (IUD) ( ) [j] Others specify ……	
18	Have you ever encouraged your spouse to use Family planning?	
19	If **YES**, how?	
20	If **NOT,**why?	
21	Where is the best place you go to for family planning counseling?	
22	What side effects do you think one can suffer from using family planning methods?	
23	What is your decision on family planning?	

Section C: level of spousal communication among men

Please tick the appropriate box (√)

24.Have you ever discussed with your wife on family planning? 1. YES ( ) 2 NO ( )

25. If **NO*please skip to question 30***

26.At what time in your marriage did you start discussion on family planning methods with your partner?*Please tick appropriately* ( ) [a] Before marriage( ) [b] Immediately after marriage ( )[c] After our firstborn ( ) [d] after our second born( )[e] After fourth child ( )[f] Never discussed ( ) [g] don't know ( )

27.Between you and your partner, who do brought up discussion about family planning? .....

28. Around which of the following period do you find it convenient to discuss family planning with your wife[a] Early in the morning, ( ) [b] In the noon ( ) [c] In the evening ( ) [d] Anytime, ( ) [e] I don't know

29. Have you ever discussed about family planning with anybody apart from your spouse? 1. YES ( ) 2 NO ( )

30.If **NO *please skip to question 32***

31. If **YES,** with whom have you discussed family planning issues? ……

32. Who made the decision about the number of children to have? ……

33. Do you know the number of children your wife (ves) desire to have? 1. YES ( ) 2 NO ( )

If **YES,***please specify (First wife…….) (Second wife……..)*

34.Have you and your wife(ves)ever had any disagreement about Family planning? 1. Yes ( ) 2. No ( )

35 .If**NO,***please skip to question 38a*

36. If **YES**, how did you resolve it? ……

37. In a situation whereby your FP discussion ends in disagreement, do you revisit it later? 1. YES

( ) 2 NO ( )

Section D: Factors That Affect Spousal Communication

S/N	STATEMENT	agree	undecided	disagree
38	Knowing about FP makes it interesting to discuss about it			
39	The negative health implication it has caused some women will not let me discuss about it with my wife			
40	When there is still plans for more children family planning discussion is not necessary			
41	Lack of personal interest on FP planning on the part of the man makes the discussion difficult			
42	My religious doctrine does not permit family planning so no need to discuss it			
43	You don't expect FP discussion in the house of a man with more than one wives			

SECTION E: pattern of contraceptive use among men

44. Have you or your spouse ever used any contraceptive 1. YES ( ) 2. NO ( )

45. Did you use any contraceptive in your last sex with an intention of controlling birth?

1. YES ( ) 2. NO ( )

46. Does your partner agree with you using FP contraceptive? 1. YES ( ) 2. NO ( )

47. Which of the following modern contraceptive methods have you or your spouse used in the last one year?[a] male condom ( )[b] female condom ( )[c] male sterilization ( )[d] pills ( )[e] diaphragm ( ) [f] abortion ( ) [g] injection ( ) [h] IUD ( )[i] Others specify…….

48. Which one are you or your wife(ves) currently using? ……

49. Do you or your spouse find this (s) modern method of contraceptive convenient to use? 1. YES ( ) 2. NO ( )

50. Which of the following traditional family planning methods have you or your spouse used in the last one year?[a] abstinence ( ) [b] coitus interrutus (withdrawal) ( )[c] safe period(rhythm) ( )[d] ring( ) [d] others specify ……

51. Which of these methods are you or your spouse currently using?……

52. Do you or your spousefind this traditional method(s) of contraceptive convenient to use? 1. YES ( ) 2.NO( )

Section F: Factors Promoting and Hindering Use of Contraceptives

S/N	Statement	**Agree**	**Undecided**	**Disagree**
53	Information on the proper use of contraceptive will enable me use it			
54	The use of contraceptive is not permitted by my tradition			
55	My cultural belief does not permit the use of contraceptive,			
56	Giving birth to many children is the pride of a man in my family			
57	Couples who care for each other will encourage the use of contraceptives			
58	The use of contraceptive will affect the health of my wife negatively in future			
59	My friends may make jest of me if they got to know that am using contraceptive with my wife			
60	Family planning will cause a loss of confidence between a husband and a wife			
61	A family that practice family planning will have conflict in their marriage			
62	It is embarrassing for me to talk about family planning with my spouse			

63	If birth is controlled, children will have a better education			
64	Practicing FP will bring about a happy home			
65	Family planning will improve the standard of living			
66	Where there are more than one wife, the competition for children won't permit the use of contraceptive.			

APPENDIX II

Ibeere

Ibara Eni Soro Larin Lokolaya Ati Eto Ifetosomobibi Laarin AwỌn Ọkunrin Ni Sabo Awujo Ti Ibadan Ariwa Agbegbe Ijoba Ipinle Oyo

Eyin oludahun,

Orukọ mi ni TOMERE FIYEJUNA BEKEWEI, akeekoagbatiileiweFasititi Ilu Ibadan, niIpinle Oyo, Nigeria

Iwadi ijinleyi ni lati se iwadi Ibaraenisorolarinlokolayaatietoifetosomobibi laarin awọn ọkunrin ni agbegbeSabo ti Ibadan ariwa agbegbe ijoba ipinle Oyo

Awọn awari lati iwadi yi yio mu iranwobaetolatideenaikuawonabiyamo, atilati mu iwuribaoroajeorileedewa. Ìdánimọ rẹ, esi re, atiakosile re yio wan i ipamo, atipato fun iwadiijinleyinikanni. Jọwọ kiyesi pe o ko nilo lati kọ orukọ rẹ siori iwe ibeere yi, ki o si fi idahun ti o ye si awọn ibeereti a beere.Ifowosowopo re yio mu kiiwadiijinleyiyori sir ere.

Ṣe o fẹ lati kopa ninu iwadi? (1) BẸẸNI {} (2) SI {}

O ṣeun pupọ.

Pataki ilana (s) : Jọwọ Ma Ko Kọ oruko re

IPELEA ; -dapo- ibi ti iwa

Awọn ilana : Niipele yi, tokasinu(√) apoti o baidahun re mu, tabiki o se alayesiibiti a tipese:

1. Ojoori : { }
2. Ipo igbeyawo 1.o ti se igbeyawo { } 2.etikorasile { } 3.eti pin ya { }
3. Esin 1.Onigbagbo { } 2.Musulumi { } 3.Esin aba laaye { } 4.others ----------
4. eya ẹgbẹ 1. Yorùbá { } 2.Igbo { } 3.Hausa { } 4.Others (pato) ----------
5. Ipele ti eko 1 oniwemefa { } 2. Oniwemewa { } 3. iwe giga { }
6. Ise re? 1. Olokoowo { } 2.Oniseijoba { } 3. Oniseowo { } 4. Eto to yato, toka ----------
7. Iruebi? 1. Ebialayapupo { } 2.Ebialayakan { } 3. Ebimiran, to ka .....
8. iyawo melon i oni? ..... .
9. Omomelonioti bi bayiti won siwalaaye ?
10. Odun melon i o ti lo niagbegbe Saboyi? .....

11. E lo ni o n wole fun o lose-ose?.....

IPELEB : imo ti ebi igbogun ọna laarin awọn ọkunrin

S / N	Gbólóhùn	Idahun
1	Kini o monipaifetosomobibi?	
2	Niboni o tikokogbonipaifetosomobibi?	
3	Ki niawonohunti o ro wipe o je anfaaniifetosomobibi ?	
4	Ni akokowoganpatoni o baololufe re soronipaifetosomobibi? ?	Jowo ko ami maaki bojumu ( ) [a] ṣaaju igbeyawo ( ) [b] lẹhinomo akọbi ( ) [c] lẹhin tie bi omo ekeji( ) [d] lẹhin ọmọ kẹrin ( ) [e] e kò sọ ri( )
5	Darukoetoifetosomobibimejiti o mo?	
6	Iruetoifetosomobibi won ni e n se amulo?	
7	Bawoni o se gbaololufe re niyanjunipaifetosomobibi?	
8	Nibo ni o daraju fun o latigbaamorannipaifetosomobibi?	
9	Kí ni akobati o le bapadenipaawon liana ifetosomobibi ?	

10	Kí ni ipinnu re lori ifetosomobibi?	

IPELED: ipele ti ibaraẹnisọrọti ore alabasepo laarin awọn ọkunrin

Jowo ko ami maaki sinu apoti o ye ()

14. Nje o baiyawo re soronipaifetosomobibiri? 1. BẸẸNI () 2 BEEKO ()

15. Ǹjẹ o mọ iyeomotiiyawo re felati bi? 1. BẸẸNI () 2 BEEKO ()

16. Bi ọkunrin, njoiwonio n se ipinnu iyeomoti e ma bi? 1. BẸẸNI () 2. BEEKO ()

17. Laarin ati orẹ alabaṣepọ re, tanieniti o ma n da oronipaifetosomobibisile?

.....

18. Njeotibaenikenisoronipaifetosomobibiyatosiiyawore? 1. BẸẸNI () 2 BEEKO ()

Ti o ba je bẹẹni, jọwọ se alaye .....

19. Ṣe o rorun fun o latisooronipaifetosomobibi pẹlu aya rẹ? 1. BẸẸNI () 2.BEEKO ()

20. njeoya e laralatibaaraitasoronipaifetosomobibijuiyawo re lo?1. BẸẸNI () 2. Beeko ()

21. Nje o tibaaya re soronipaifetosomobibi? 1. BẸẸNI () 2 SI ()

22. Nje o nianiyanlati so fun alabasepo re nipaetoifetosomobibi? 1. BẸẸNI () 2. Beeko ()

23. Se ololufe re fowosiawononatia n gbafetosomobibi? 1. BẸẸNI () 2 SI ()

IPELEE : okunfa ibaraẹnisọrọlatiawonalabasepo?

S / N	Gbólóhùn	Bẹẹni	Bẹẹkọ
1	Emi ko mo ohun to n je ifetosomobibi?		
2	Otiyaraju fun mi lati ma soronipaifetosomobibi?		
3	Mo si tun fe lati bi ọmọ si, nitorina emi kò ba alabaṣepọ so ohunkohunnipaifetosomobibi?		

4	Emi ko fẹran etoifetosomobibi, nitorina, n koba alabaṣepọ so ohunkohunnipa re?		
5	Esin mi kofi aye gbaetoifetosomobibi, fun idieyin, n kobaalabasepo mi jiroronipa re?		

IPELEE :Liloogun igbalode fun ifetosomobibi laarin awọn ọkunrin?

S / N	Gbólóhùn	Bẹẹni	Bẹẹkọ
1	Nje o lo ogun igbalode fun ifetosomobibinigbationiibalopo to keyin?		
2	Bawo ni o se maa nloogun igbalode fun ifetosomobibi?		
3	Se alabaṣepọ re gba pẹlu relatilo ogun igbalode fun ifetosomobibi?		
4	Ṣe o riogun igbalode yiniirọrun lati lo?		
5	Mo n lo ogunifetosomobibinigbatialabaṣepọ mi bagba mi laaye?		

IPELEF : okunfa igbega si ati ki o hindering lilo ti contraceptives

S / N	Gbólóhùn	Bẹẹni	Bẹẹkọ
1	Ṣe o ni alaye to dan monran lori lilo ifetosomobibi ?		
2	Ṣe esin re gbaifetosomobibilaaye ?		
3	Ṣe asa re fi aayegbafifialafosaarinomobibi?		
4	Ninuebiwa, ama n bi ọmọpupo?		

5	Nkògbàgbówípéìfètòsómobíbí le sise fun iyawo mi?		
6	Mo lere wipe ifetosomobibiyio pa iyawo mi laralojoiwaju?		
7	Awọn ọrẹ mi le ṣe jest ti mi o ba ti mo ti lọ fun ebi igbogun		
8	Etoifetosomobibiyo mu ifokanbalekurolaarinokoatiiyawo		
9	Ebiti o ba n lo ifetosomobibiyoo ma niasòninuigbeyawo won		
10	O je nkanitiju fun mi lati so nipaetoifetosomobibipelu/aya mi		

APPENDIX III

Tsarin tambayoyi

Abokin aure sadarwa da kuma yin amfani da tsarin iyali Hanyar daga mutãne a sabo al'umma na Ibadan arewa karamar hukumar na Jihar Oyo

Dear weights,

Sunana **TOMERE FIYEJUNA BEKEWEI**, a Postgraduate Student na Ma'aikatar Lafiya gabatarwa da ilimi, Faculty of Public Health, College of Medicine, Jami'ar Ibadan. Dalilin wannan binciken ne gudanar da bincike da abokin aure sadarwa da kuma yin amfani da tsarin iyali hanyoyin mutãne a sabo al'umma a Ibadan arewa karamar hukumar. Da binciken daga wannan binciken zai taimaka a cikin zane na shirye-shirye da kuma halitta na manufofin da nufin hana masu juna biyu mace-mace da kuma inganta tattalin arzikin kasar. Da shaidarka, martani da ra'ayin za a skiyaye tsananin sirri da za a yi amfani ga manufar wannan bincike ne kawai. Lura cewa ba ka da a rubuta sunanka a wannan littafin tambayoyi, kuma kokarin da don Allah ba gaskiya amsoshin tambayoyi tambaye kamar yadda ka m co-aiki zai taimaka a yin wannan bincike wani rabo.

Za ka so su shiga a cikin binciken? (1) YES {} (2) NO {}

Na gode sosai.

Muhimmanci Umarni (s): Don Allah Kada Rubuta ko wadata Your Name

Sashe A. socio-alkaluma da halayyar

Umarnin: A cikin wannan sashe don Allah Tick (√) a cikin dace kwalaye da cewa dace to your amsoshi ko kammala sarari bayar a kasa

1. Age: {}
2. aure hali daban 1.married {} {} 2.divorced 4.separated {}
3. addinin 1.Christianity {} 2. Musulunci {} {} 3.Traditional 4.others ----------
4. Ethnic kungiyar 1. Yoruba {} {} 2.Igbo 3.Hausa {} 4.Others (saka) .....
5. Level ilimi 1. Primary {} 2. Secondary {} 3. Mai zurfi na {}
6. zama 1. kasuwanci mutum {} 2. Civil bayin {} 3. Artisan {} 4. Wasu (saka) ---------- ----------
7. Family naúrar 1. auren mace fiye {} 2. auren mace daya {} 3. Wasu saka .....
8. Ta yaya mata da yawa gare ku? .....

9. Kuma da yawa rai yara kada ka da a yanzu?

10. Ta yaya shekaru masu yawa nan ka kashe a sabo .....

11. Mene ne ka mako-mako samun kudin shiga

Sashe B : sanin tsarin iyali hanyoyin daga maza

S / N	sanarwa mayar	da martani
1	Me ka fahinta daga tsarin iyali hanyoyin ?	
2	Daga ina kuka farko ji game da tsarin iyali hanyoyin ?	
3	Me kuka gani ne amfanin tsarin iyali hanyoyin ?	
4	A abin da matakin ba ka fara tattaunawa tsarin iyali hanyoyin da abokin tarayya ?	Don Allah Tick ayi kasafi () [a] kafin aure () [b] bayan mu dan farin () [c] bayan mu biyu haife () [d bãyan hudu yaro () [e] ba tattauna ()
5	ambaci biyu tsarin iyali hanyoyin da ka sani?	
6	Wanne hanyoyin da tsarin iyali kuke yin amfani ?	
7	Yaya ka karfafa ka da abokin tarayya game da tsarin iyali hanyoyin ?	
8	A ina ne wuri ka je ga tsarin iyali shawara ?	
9	Abin da sakamako masu illa da kake tunani wanda zai iya fama da yin amfani da tsarin iyali hanyoyin ?	
10	Mene ne hukuncin a kan tsarin iyali ?	

Sashe C: matakin abokin aure sadarwa a tsakanin maza

Don Allah Tick da ya dace akwatin ()

14. Shin, ka taba tattauna da matarka a kan tsarin iyali? 1. YES () 2 NO ()

15. Shin, ka san yawan yara da mata so a yi? 1. YES () 2 NO ()

16. Kamar yadda wani mutum ne kai da wanda ya yanke shawara yawan yara su haifi? 1. YES () 2. NO ()

17. Tsakanin ku da abokin tarayya (wadanda) bã kawo tattaunawa game da tsarin iyali? .....

18. Shin, ka taba tattauna game da tsarin iyali da wani baya ga mijinki? 1. YES () 2 NO ()

Idan a, don Allah saka .....

19. Kuna jin dadi tattauna game da tsarin iyali da matarka? 1. YES () 2 NO ()

20. Shin, ba ka fi son tattauna tsarin iyali da mai zuwa na baya zuwa matarka? 1. YES () 2 NO ()

21. Shin, ba ka taba tattauna tsarin iyali tare da mata? 1. YES () 2 NO ()

22. Kuna da wani niyya ta tattauna tsarin iyali tare da mata? 1. YES () 2 NO ()

23. Shin mijinki amince da tsarin iyali hanyoyin? 1. YES () 2 NO

Sashe D : abubuwan da zai shafi abokin aure sadarwa

S / N	Sanarwa	YES	NO
1	Ba na ma san abin da iyalinsa shirin ya		
2	Yana da ma da wuri a gare ni domin tattauna tsarin iyali		
3	I har yanzu nufin samun karin yara don haka sai na ba sa so su tattauna FP da ta abokin tarayya		
4	Ba na son tsarin iyali don haka sai na ba sa so su tattauna shi da abokin tarayya ta		
5	My addini ba yarda FP haka ba za mu tattauna shi da abokin tarayya ta		

Sashe E : juna da maganin hana haifuwa amfani daga maza

S / N	Sanarwa	YES	NO
1	Shin, u amfani da wani maganin hana haifuwa a cikin last		

	jima'i ?		
2	Ta yaya sau da yawa ba ka yi amfani da tsarin iyali maganin hana haifuwa ?		
3	Shin, ka da abokin tarayya yarda da ku ta yin amfani da tsarin iyali maganin hana haifuwa ?		
4	Ka ga zamani maganin hana haifuwa hanyoyin dace a yi amfani da		
5	Na yi amfani da maganin hana haifuwa kawai idan na abokin tarayya yarda da shi		

Sashe F : dalilai inganta da kuma hana yin amfani da contraceptives

S / N	**Sanarwa**	**YES**	**NO**
1	Kuna da isasshen bayani a kan dace na amfani da tsarin iyali ?		
2	Shin addininku yarda tsarin iyali ?		
3	Shin, ka al'adu karfafa yaro jerawa ,		
4	A cikin iyali mu ba ta haifi 'ya'ya da yawa		
5	I bã su yin ĩmãni tsarin iyali za su yi aiki don mãtãta		
6	Ina jin shi yana iya shafar lafiyar mata ta barnatar da daga baya a nan gaba		
7	Abokai iya yin izgili da ni idan na je ga tsarin iyali		
8	Family shiryawa zai sa a asarar amincewa tsakanin miji da mata		
9	A iyali cewa yi tsarin iyali sunã da rikicin a cikin aure		
10	Kuma lalle ne m gare ni in magana game da tsarin iyali da na mata		

APPENDIX IV

FOCUS GROUP GUIDE

Selection criteria: Married Christian and Muslims men resident in Sabo community.

Copies of informed consent and confidentiality forms will be provided to each participant and read aloud for the benefit of those who cannot read. Participants will be provided an opportunity to ask any questions. Verbal agreement will be taped. The recording will be on audio tape.

Here is the guide. All the questions below will be asked in the order given, and efforts will be put in place to maintain a flow of the discussion.

participation of all group members will be encouraged in the conversation.

The discussion will start with an explanation of ground rules as follows**:**

Before we start I would like to remind you that there are no right or wrong answers in this discussion. We are interested in knowing what each of you think, so please feel free to share your point of view, regardless of whether you agree or disagree with what you hear. It is very important that we hear all your opinions. You probably prefer that your comments not be repeated to people outside this group. Please treat others in the group as you want to be treated by not telling anyone about what you hear in this discussion today.

Let's start by going around the circle and having each person introduce himself.

(Members of the research team will also introduce themselves and describe each of their roles.)

1. What is your opinion about family planning?

2. In this our community households, who makes the decisions about the number of children in the family? (we will Probe as indicated: Husbands? Mother-in-laws? Religious or community leaders? Co-wives? Others?)

- Who makes decisions about the spacing of births?
- How are these decisions made?

3. What are the reasons for:

• Having many children?

• Having few children?

4. Between men and women who do usually come up with discussion on FP in the home.

We will probe into,' if men, what are the reasons behind the discussion,

Same question for women too.

5. In your own opinion, what are the likely reasons why couples may not want to discuss family planning with each other?

6. What have you heard about contraceptives methods?

- Can we please mention the contraceptives methods we know?
- Which ones among these contraceptives is commonly being used among men and women?
- What are the reasons for using them?
- What are the likely reasons why men may not want to use these contraceptives with their wives?

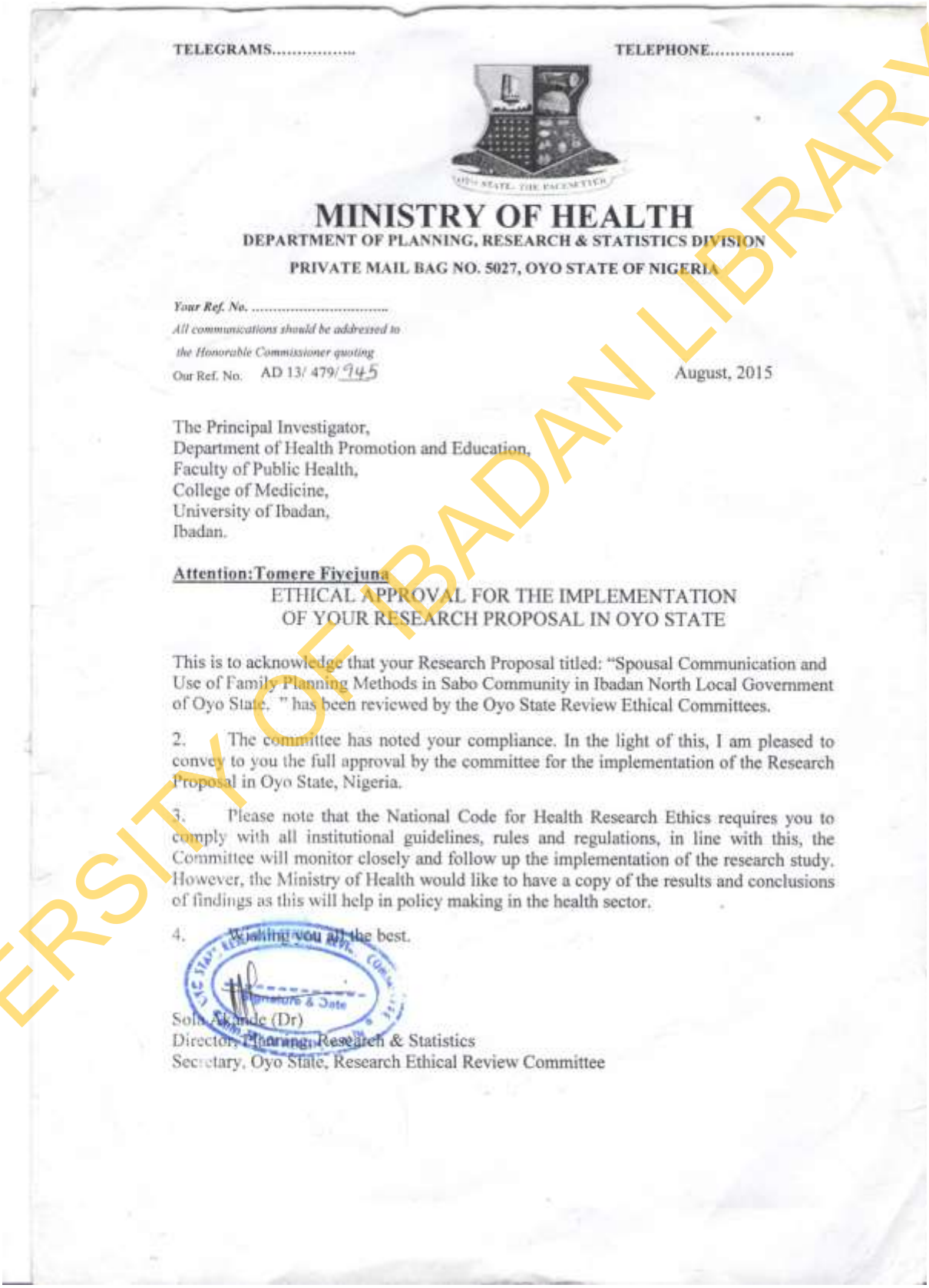
7. What do you think can be done to improve discussion on FP among couples

8. Do you have any questions?

Thank you for taking the time to talk to us!!

Appendix V

Ethical approval letter



TELEGRAMS..... TELEPHONE.....

MINISTRY OF HEALTH
DEPARTMENT OF PLANNING, RESEARCH & STATISTICS DIVISION
PRIVATE MAIL BAG NO. 5027, OYO STATE OF NIGERIA

Your Ref. No. .....
All communications should be addressed to the Honorable Commissioner quoting
Our Ref. No. AD 13/ 479/945 August, 2015

The Principal Investigator,
Department of Health Promotion and Education,
Faculty of Public Health,
College of Medicine,
University of Ibadan,
Ibadan.

Attention: Tomere Fiyejuna

ETHICAL APPROVAL FOR THE IMPLEMENTATION OF YOUR RESEARCH PROPOSAL IN OYO STATE

This is to acknowledge that your Research Proposal titled: "Spousal Communication and Use of Family Planning Methods in Sabo Community in Ibadan North Local Government of Oyo State. " has been reviewed by the Oyo State Review Ethical Committees.

2. The committee has noted your compliance. In the light of this, I am pleased to convey to you the full approval by the committee for the implementation of the Research Proposal in Oyo State, Nigeria.

3. Please note that the National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations, in line with this, the Committee will monitor closely and follow up the implementation of the research study. However, the Ministry of Health would like to have a copy of the results and conclusions of findings as this will help in policy making in the health sector.

4. Wishing you all the best.

Signature & Date

Sola Akinde (Dr)
Director, Planning, Research & Statistics
Secretary, Oyo State, Research Ethical Review Committee

APPENDIX VI

INFORMED CONSENT FORM

IRB Research approval number:

This approval will elapse on: dd/mm/yyyy

Title of the research: Spousal Communication and Use of Family Planning Methods Among Men in Sabo community in Ibadan North Local Government in Oyo State.

Name and affiliation(s) of researcher(s) of application(s): This study is being conducted by TOMERE FiyejunaBekewei, Department of Health Promotion and Education, University of Ibadan.

Purpose(s) of research: The purpose of this research is to investigate spousal communication and use of family planning methods among men in sabo community in ibadan north local government.

Procedure of the research, what shall be required of each participant and approximate total number of participants that would be involved in the research: Selected participants will be well informed about the purpose of the discussion before the commencement of the discussion.

Expected duration of research and of participant(s)' involvement: You are expected to be involved in this discussion for about 45minutes. You will be required to give correct information during the discussion.

Risk(s): You will be exposed to no risk whatsoever during your participation in this discussion.

Cost(s) to the participants, if any, of joining the research: Your participation in this discussion will not cost you anything. It will only take your time.

Benefit(s): This is to help policy makers know how to formulate policies on family planning that will be of benefit to the whole nation.

Confidentiality: All information given in this discussion will be given code numbers and no name will be recorded. This cannot be linked to you in anyway and your name or any identifier will not be used in any publication or reports from this study.

Voluntarism: Your participation in this research is entirely voluntary.

Due inducement(s): You will not be paid any fees for participating in this research.

Modality of providing treatments and action(s) to be taken in case of injury or adverse event(s): No injury or adverse events whatsoever are envisaged in this study.

Statement of person obtaining informed consent: I have fully explained this research to _____ and have given sufficient information, including about risks and benefits, to make an informed decision.

DATE:…… SIGNATURE:…….

NAME:……
…….

Statement of person giving consent: I have read the description of the research or have had it translated into language I understand. I understand that my participation is voluntary. I have enough about the purpose, methods, risks and benefits of the research study to judge that I want to take part in it. I understand that I may freely stop being part of this study at any time. I have received a copy of this consent form and additional information sheet to keep for myself.

DATE: _____ SIGNATURE:
_____

S/N_____

In addition, if you have any question about your participation in this research, you can contact the principal investigator, Name: TOMERE FiyejunaBekewei of the department of Health Promotion and Education, Phone: 07055382415 and E-mail: tomfitambek@yahoo.com