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ATTITUDE AND BEHAVIOUR OF MEN TOWARDS MODERN FAMILY PLANNING IN GWAGWALADA AREA COUNCIL, FCT, ABUJA

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ABSTRACT

This research examines the attitudes and behaviours of men towards modern family planning in Gwagwalada area council of Nigeria's Federal Capital Territory by assessing men's knowledge and attitudes to family planning, determining the use of modern family planning methods by men, investigating the extent of involvement of men in family planning choice and use by the couple and evaluating the level of spousal communication in family planning decision making. Quantitative methods were used to collect data from 152 married men residing in four out of the ten wards that make up Gwagwalada area council, while qualitative methods using focused group discussions and in-depth interviews were used to get information from various groups including married men, married women, religious leaders, community leaders and family planning providers. The results showed that majority of the men (53.9%) already had 4 or more children, the mean number of children the respondents had was 3.79 ±1.665SD. Their mean ideal number of children per couple was 5.18± 2.89 SD and some participants noted that only God decides the ideal family size and that it also depends on their financial status. Majority of the men studied were aware of modern family planning methods, however only few of them were currently using a method. Results of focused group discussion and in-depth interviews conducted amongst men in the communities also showed high awareness but low usage with fear of side effects, lack of adequate information and costs as barriers to the use of family planning in the communities. The men had positive attitudes towards modern family planning; however there was poor spousal communication on issues related to family planning. Men were significantly involved in decision making concerning fertility goals and family planning in the community, however they still needed much more enlightenment about its safety so as to dispel the myths surrounding its use. The study therefore recommends that enlightenment campaigns and programmes should be carried out on the benefits of family planning to the members of the community at large; this will enhance acceptability and use of family planning methods in Gwagwalada area council.

INTRODUCTION

This study is necessary because of the crucial role men culturally perform in traditional set ups in African societies, especially at the family units. Culturally, children are regarded as gifts from God. Therefore an attempt to control population could be regarded as an attempt to play the role of God. However the family remains the most crucial unit of population regulation today. This study is an attempt to explore the attitude and behaviour of men towards modern family planning in Gwagwalada area council, Abuja. Nigeria is the most populous country in sub Saharan Africa with a population of over 140 million people in 2006(Official gazette of the Federal Republic of Nigeria, 2009).

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According to reports from the world data sheet, Nigeria's population by mid-2010 was 158 million and therefore the world's seventh highest population and is projected to be 217 million by 2025 and 236 million by 2050 (Population Reference Bureau (PRB), 2010). Nigeria has a high fertility rate (average number of children born by a woman in her lifetime) of 5.7 children and a low contraceptive prevalence rate of 14.6% and 10% for all family planning methods and modern methods respectively (National Population Commission (NPC), 2009). Nigeria's total fertility rate has declined only slightly in the past few decades. UNICEF estimated the total fertility rate at 6.8 in 1990 and 5.4 in 2007.These are in excess of the global average of 2.6. Failing nations, almost without exception, have high population growth rates. Foreign Policy and the Fund for Peace publish an annual ranking of failed states. All of the top ten countries in the 2009 Failed States Index have total fertility rates

substantially higher than the global average. Six of them including Nigeria had total fertility rates of 5.0 or higher. High fertility rates are often associated with high maternal and infant mortality rates. Unhealthy birth spacing is associated with poor health outcomes for mothers and infants, (Igbolo 2014). High population growth rates may make it more difficult for failing states to provide adequate schooling, nutrition, immunization, and other essential services. Population pressures can also lead to environmental degradation, food insecurity, and even conflict (Population Reference Bureau, 2009). The negative impact of uncontrolled population growth is obviously having its toll in Nigeria as evidenced by the poor health indices of high infant and maternal mortalities, poor life expectancy rate, high level of poverty, high prevalence of HIV/AIDS, conflicts and insecurity. In view of these consequences, fertility regulation becomes crucial towards improving the quality of lives of Nigerians. In response to the pattern of the population growth rate and its adverse effect on national development, the Federal Government of Nigeria approved the National Policy on Population for Development on February 4, 1988. Despite the efforts to implement family planning by the Nigerian government and other stake holders, the results obtained and the goal desired remain unachieved as evidenced by high population growth rate, high total fertility rate of 5.7, very low contraceptive prevalence rate of 10% and high rate of unmet needs for family planning (NPC,2009).

The Research Problem

The World Health Organization (1971) defined family planning as the practice that helps individuals or couples to attain certain objectives. These includes avoiding unwanted pregnancies, regulating the interval between pregnancies, controlling the time at which birth occurs in relation to the ages of the parents and determining the number of children in the family. Despite programmes and judicious efforts by several governments at reducing the fertility rate in the country, realization of the recommended maximum of four children per couple still appears difficult. Failure of family planning programmes in many African societies has been attributed to non-recognition of the roles of men in this regard. Most of the family planning programs have paid less attention towards the understanding of men's role in the effective and consistent utilization of contraceptive methods by their wives or the couple. Though women are using contraceptives, the methods that require male involvement, such as condoms, periodic abstinence, withdrawal and vasectomy are less used. Family planning providers in general (governments and private) fail to address men's concerns and fears, which are different from that of women. African men are heads of the house; they are over all responsible for their families. This is also true for the Nigerian families, where the organization of the society is governed by the characteristically male dominant and partrilineal traditions. Sociological factors (culture, religion, etc) are in favor of men as decision-makers both at family levels and community levels. Traditionally, wives in African societies consider their husbands as overall heads. The husbands decide upon most things, and his wife is expected to abide by his spoken decisions or his perceived wishes. This male dominated family structure has great influences in matters of reproduction. Not surprisingly African men generally desire larger families than do their wives (Caldwell & Caldwell, 1990).

Gender inequality in reproductive decision making is a key element of the social context of reproductive health. Speizer (1991) showed that couples often disagree about the desirability of pregnancy and the use of contraceptives. Watkins, Rutenberg and Wilkinson, (1997) argued that when this discordance occurs in a situation of male authority, men's opinions about these issues may over rule women's and the women often must implement the decisions made on these matters. In some cases, husbands fear that if they approve of family planning and allow their wife to use it, they will lose their role as head of the family, their wife may be unfaithful or they may lose face in their community. Blanc (2001) in his work noted that even when men approve of family planning in theory, they may disapprove of their partners' practicing contraception and may be unwilling to use male condoms. As a result, women may sacrifice their own wishes to those of their partners or their perception of their partners' wishes .Alternatively; women may practice contraception covertly, potentially exposing themselves to financial vulnerability or emotional or physical violence if discovered. Conversely, women who have some decision-making power and autonomy often are better able than other women to meet their reproductive health goals (Speizer, Whittel and Carter, 2005). Although pilot programs and initiatives for including men in family planning and other reproductive health services have existed for more than 20 years in a number of countries, few are well-established, and fewer still have been fully integrated into their country's health care system (Gallen, 1986).Program managers and policymakers in many countries have almost automatically assumed that men are not interested in or supportive of family planning and contraceptive use; even though recent research shows that many men are (Ezeh, Seroussi and Raggers, 1996;Wegner, Landry, Wilkinson and Tzanis, 1998). Although studies have been carried out in the country on the attitudes and behaviors of men in family planning, none has been carried out in the Federal Capital territory where government policies emanate from. There is therefore the need to investigate into this phenomenon and discover the instrumentality of men at the family level in population regulation.

Research Objectives

The objectives of the research are:

- To assess the awareness and attitudes of men towards modern family planning.
- To determine the extent of use of modern family planning methods by men in Gwagwalada Area council
- To determine the extent of involvement of men in family planning choice and use by the couple.

Research Hypotheses

The hypotheses of the study are stated in null forms as follows:

H_1: Men in Gwagwalada Area Council are not supportive of family planning services and utilization.

H_2: Men do not have strong influence on family planning decision making in their homes or families in Gwagwalada communities of F.C.T, Abuja.

Literature review

Sub-Saharan Africa is yet to complete its “demographic transition” that is, to shift to low birth and death rates. Sub-

Saharan Africa has the highest fertility rate in the world, averaging 5.2 births per woman. This rate is more than double that of Asia and almost four times that of Europe. The birth rates are so high that even in the face of high AIDS mortality in some countries, the region's mid-2010 population of 865 million is projected to increase to 1.2 billion by 2025. A big factor underlying high birth rates is the low use of modern contraception: only 17% of married women in sub-Saharan Africa use modern methods of family planning compared with 60% in Asia and 69% in Western Europe (Population Reference Bureau, 2010). Factors associated with the failure to meet the family planning need vary from country to country. While access to affordable modern methods of contraception is sometimes a problem, many women reported other reasons for not using family planning which includes amongst others insufficient knowledge of family planning to make informed choices, fears that modern contraceptive methods could cause health problems and opposition to family planning by husbands or themselves for religious or cultural reasons (Ashford, 2003).

Family planning programmes in Nigeria

In response to the pattern of the population growth rate and its adverse effect on national development, the Federal Government of Nigeria approved the National Policy on Population for Development on February 4, 1988. Over the years, emerging issues such as HIV/AIDS, poverty, gender inequality, among others, gained wider recognition. This necessitated a review of the 1988 National Population Policy, giving way to the National Policy on Population for Sustainable Development launched in February 2005 by the then President of Nigeria, Chief Olusegun Obasanjo. The policy recognizes that population factors, social and economic development, as well as environmental issues are irrevocably interconnected and are critical to the achievement of sustainable development in Nigeria. The overall goal of the National Policy on Population for Sustainable Development is to improve the quality of life and standard of living for the Nigerian population(NPC),2009).This is to be achieved through the attainment of a number of specific goals that include:

- Achievement of sustainable economic growth, protection and preservation of the environment, poverty eradication, and provision of quality social services.
- Achievement of a balance between the rate of population growth, available resources, and social and economic development of the country.
- Progress towards a complete demographic transition to a reasonable growth in birth rates and a low death rate.
- Improvement in the reproductive health of all Nigerians at every stage of the life circle.
- Acceleration of a strong and immediate response to the HIV/AIDS pandemic and other related infectious diseases.
- Progress in achieving balance and integrated urban and rural development.

The National Policy on Population for Sustainable Development operates on the principle that achieving a higher quality of life for people today should not jeopardize the ability of future generations to meet their own needs. To guide policy, programme planning, and implementation, the following targets were set:

- Reduce the national population growth rate to 2 percent or lower by 2015.
- Reduce the total fertility rate by at least 0.6 children every five years by encouraging child spacing through the use of family planning.
- Increase the contraceptive prevalence rate for modern methods by at least two percentage points per year through the use of family planning.
- Reduce the infant mortality rate to 35 per 1,000 live births by 2015.
- Reduce the child mortality rate to 45 per 1,000 live births by 2010.
- Reduce the maternal mortality ratio to 125 per 100,000 live births by 2010 and to 75 by 2015.
- Achieve sustainable universal basic education as soon as possible before 2015.
- Eliminate the gap between males and females in school enrolment at all levels and in vocational and technical education by 2015.
- Eliminate illiteracy by 2020.
- Achieve at least a 25 percent reduction in HIV/AIDS adult prevalence every five years.

Even though the time set for achievement of these targets is close by, the challenges towards their realization are obvious as evidenced by the Nations current health and population indices.

Family planning programme implementation strategies in Nigeria

The comprehensive healthcare delivery system in Nigeria through which the family planning programme is implemented is achieved through all levels of health care particularly the primary health centres. Although various Nigeria's policies and frameworks allow and encourage family planning for health and National Development, this is not matched by political will and financial commitment. As at December 2010, all of Nigeria's Public sector family planning commodities are donated through UNFPA. Moreover, there is a huge gap between demand and availability and recently UNFPA has not been able to meet the commodity requirement of the country. In spite of this gap, the Nigerian government has not as at December 2010 any appropriated funds for commodity procurement. As a result of which there are still many unwanted, high risk pregnancies and unsafe abortions thus compounding the already high maternal mortality ratio in the country. Nearly all public sector commodity procurement is donor driven in the country. This is not only an unhealthy situation but also shows lack of leadership commitment to addressing this basic strategy for the reduction of maternal mortality in the country. Following pressures and continued advocacy by stake holders, the Nigerian government in early 2011 heeded to the many advocacy initiatives in the country and declared family planning free for all who wish to use. Unfortunately, this commitment has not been backed by financial commitment to ensure implementation (Goliber, Sanders and John, 2010). Men can be involved in family planning in two ways as decision makers with their wives about a female controlled method, or as users of a male method. In the latter case, few options are available. Apart from rhythm and withdrawal, which are among the least reliable family planning methods, condoms and vasectomy are the only choices. Men's involvement will therefore become

very imperative at addressing the above issues raised .This is because they comprise over 70% of the nation's work force and also about 85% of Nigeria's policy makers at all levels of government.

Men and family planning decision making and utilization

In spite of the introduction of family planning services as means of curbing fertility rate, the population still rises because of the attitudes of the people involved. This is noticed especially in men and the role they play in reproduction. Male involvement in family planning (FP) means more than increasing the number of men using condoms and having vasectomies; male involvement also includes the number of men who encourage and support their partner and their peers to use family planning and who influence the policy environment to be more conducive to developing male-related programs. In this context "male involvement" should be understood in a much broader sense than male contraception, and should refer to all organizational activities aimed at men as a discrete group which have the objective of increasing the acceptability and prevalence of family-planning practice of' either sex (Toure,1996). In the past, family-planning programs have focused attention primarily on women, because of the need to free women from excessive child-bearing, and to reduce maternal and infant mortality through the use of modern methods of contraception. Most of the family-planning services were offered within maternal and child health (MCH) centers, most research and information campaigns focused on women. This focus on women has reinforced the belief that family planning is largely a woman's business, with the man playing a very peripheral role. Involving men and obtaining their support and commitment to family planning is of crucial importance in the Africa region, given their elevated position in the African society. Most decisions that affect family life are made by men. Most decisions that affect political life are made by men. Men hold positions of leadership and influence from the family unit right through the national level.

The involvement of men in family planning would therefore not only ease the responsibility borne by women in terms of decision-making for family-planning matters, but would also accelerate the understanding and practice of family planning in general (International Planned Parenthood Federation (IPPF), 1984). Men's support or opposition to their partners' practice of family planning has a strong impact on contraceptive use in many parts of the world, including Africa. Men typically have more say than women in the decision to use contraception and in the number of children that the couple will have. For example, according to the 1984 Zimbabwe Reproductive Health Survey, 42 percent of married women stated that it was the husband's responsibility to decide whether his wife should use family planning methods. Focus groups conducted by Zimbabwe National Family Planning Council (ZNFPC) and a private research agency suggested "that men were the ultimate decision makers on family size and family planning matters in Zimbabwe."(Piotrow *et al.,*1992). In Ghana, "despite the independent nature of some marital relationships, recent evidence indicates that men have the primary decision-making power in matters of family planning." Both demographic health survey data and focus-group research reveal that the husband is usually the effective decision-maker about fertility. Furthermore, husbands' family-planning attitudes and fertility goals usually are not influenced by those of their wives. And, when partners disagree on whether to use family planning, the man's preference usually dominates (Population Reports, 1994). Also, "There is a reason to suspect that men comprehend family planning messages differently than women do. Men felt that financial considerations were the primary motivation for family planning use, whereas women reported that health and the need for women to 'rest' were the primary motivations for use". According to an analysis from DHS surveys, the mean ideal family size for currently married men is higher than for married women. This difference is significant in West Africa, ranging from about two children in Burkina Faso to more than four children in Niger and Senegal (exception is Ghana, 0.6). In East and North Africa, no significant difference in fertility desire was found. This shows the importance of targeting men with family planning programs (Ezeh, Seroussi and Raggers, 1996).

The husband's support is found to be a good predictor of future practice and continued use. There are studies done in the Philippines which indicate that the continuation rate among women whose husbands support their contraceptive practice is much higher than those whose husbands do not give support to their wives (IPPF, 1984).In South Korea researchers found that 71 percent of women whose husbands approved family planning had used contraception at some time, compared with 23 percent of women whose husbands did not approve (Population Reports, 1994). In Madagascar, Norplant continuation rates were higher after one year among couples in which the husband had been involved in the decision-making process, and among these couples both wives and husbands were more satisfied with Norplant than those in which only the wife was counseled (Tapsoba *et al.,*1993). According to Demographic Health Survey data from 15 countries most in Africa, it was observed that more men are more likely than women in the same country to report knowledge and use of contraception or if not, using, that they intend to do so . It was also indicated that most family planning methods and program efforts are focused on women and men often feel uncomfortable and unwelcome in family planning clinics that are oriented to women (USAID Population Reports, 1999). It is assumed in the African context that women do not have control over their own reproductive behavior. In Nigeria, the family unit is essentially patriarchal and partrilineal, this makes all the important decisions to be 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 (UNDP/UNFPA/WHO/World Bank Special Programme of Research, 1994). Most studies carried out in Nigeria and other African countries have all asserted the domineering position of men on reproductive health matters (Oni, G.A. and MacCarthy, 1991; Isiugo-Abanihe, 1994; Roudi and Ashford, 1996; Donovan,1995). According to the results of these studies, men are dominant decision makers within the family. They also gain socially and economically from having large numbers of children, and that men reproductive preferences and motivation influence their wives reproductive outcome. In contrast to these findings a recent report by Ijadunola *et al.,* (2010) in southwest Nigeria showed male involvement in family planning decision making to be poor. Orji, Ojofeitmi and Olanrewaju (2007) in another study in the same region discovered that most men believed that a decision about family planning should be made jointly by the spouses. According to Hatcher, Ward, Blackburn and Geller (1997), family planning is now seen as human right basic to human dignity. People and governments around the world understand this. However, most available works still point to emphasis being placed on the

women fold at the detriment of the men counterpart (Olawepo, 2003). As it is often assumed in the cultural ethics in Nigeria, a large proportion of the men folks feel less concerned about family planning. However, the emergence of responsible parenthood, and the need to protect men folk's sexuality have improved this awareness among them. Studies have shown that overwhelming reliance on female methods has led to the assumption on the part of many women and men that contraception is only for women. This resulted in women being the most family planning providers and they do not involve men because of another perception or belief that men want large families to prove their virility (Danforth, 1999). It is often wrongly assumed that men are either not interested or concerned about family planning or are opposed to it. Olawepo and Okedare (2006) in their work noted that men were really interested, not only allowing their wives but actually participating in its practice. Increasing programs focusing more on men and addressing their interests and needs will encourage women's use of contraception, and improved continuation rates among men. Male involvement helps not only in accepting a contraceptive but also in its effective use and continuation (Khan and Patel, 1997).

Spousal communication and family planning

Spousal communication makes possible the reaching of agreement on intentions for child spacing and family size, perhaps leading to consensus regarding the goal of a small-sized family. It is helpful for transforming attitudes into the physical act of using contraceptives. Communication regarding desired family size may enable a couple to reach agreement about limiting fertility (Beckman, 1983). Additional communication may enable husbands and wives to exchange practical information about contraceptive methods. Once contraceptives are obtained, close communication may help sexual partners use them effectively and consistently (Cynthia, 2011). Spousal communication may lower the "psychic costs" of contraceptive use. Psychic costs are the social-psychological forces that bring about negative judgment of contraceptives, causing emotional stress and thus discouraging contraceptive use. Individuals who are inclined to use contraception may not do so if they perceive disapproval from spouses, their extended family, or society. Spousal communication may reduce these psychic costs if one partner conveys a favorable attitude toward contraception, reinforcing that its practice is a socially acceptable behavior (Beckman, 1983). Spouse communication is positively associated with contraceptive use: Demographic health survey data from seven African countries (Botswana, Burundi, Ghana, Kenya, Senegal, Sudan, and Togo) show that the percentage of women using modern contraceptives is consistently higher in the group that had discussed family planning with their husbands in the year before the interview than in the group that had not. (Johns Hopkins Population Communication Services/ Population Information Program, 1994). Spousal communication is also reported to be important in deciding family size and contraceptive practices. Commonly, the husband is the predominant decision-making power on contraceptive use within couples, although methods controlled by women such as injectables are popularly used in developing countries. One factor that impedes women's contraceptive use is their husband's opposition to fertility control (Mason, and Smith, 2000). Studies in sub-Saharan Africa suggests that communication between couples is necessary to initiate conversation on an intimate topic, reach agreements on fertility preference, and achieve their reproductive goals through making decision on contraceptive use(Hogan, Berhanu andHailemariam,1999). A study conducted in Ghana by Bawah (2002) also revealed a strong association between spousal communication and contraceptive use even when other factors are controlled in the model. The study also found a causal relationship that spousal communication has a positive impact on contraceptive use, but not the reverse.

Benefits of Family Planning

Recent research is shedding light on how family planning increases survival, improves the health of millions of people, and helps achieve national goals. Considered a "best buy" among health investments, family planning is one of the most cost-effective, high-yield interventions that exist today. Countries that invest in family planning can reap immediate health benefits investment savings in the health and education sectors, and social and environmental benefits that extend well beyond a single generation.(Smith ,Ashford ,Gribble &Clifton ,2009).Family planning could prevent many more deaths—particularly in the poorest countries—if we put current knowledge into practice:

- **Family planning saves women's lives:** Family planning could prevent as many as one in every three maternal deaths by allowing women to delay motherhood, space births, avoid unintended pregnancies and abortions, and stop childbearing when they have reached their desired family size.
- **Family planning saves children's lives:** After giving birth, family planning can help women wait at least two years before trying to become pregnant again, thereby reducing newborn, infant, and child deaths significantly.
- **Family planning saves adolescents' lives:** Teen pregnancies pose health risks not only for the babies but also for the young mothers, particularly those under age 18. Family planning can help young women avoid having children during this high-risk time and also avoid the social and economic consequences of early childbearing.
- **Family planning reduces deaths from AIDS:** The consistent and correct use of condoms can significantly reduce the rate of new HIV infections. Many HIV-positive women and couples want to avoid becoming pregnant and many effective methods are available to assist them.

By averting unintended and high-risk pregnancies, family planning reduces mother-to-child transmission of HIV and the number of AIDS orphans, whose life chances are seriously diminished because they have lost a parent, particularly the mother.

Family planning and economic development

While the relationship between fertility and economic development is complex and often reciprocal, research in developing countries has shown that reducing fertility can yield economic benefits at both the household and national levels. For example, a "demographic bonus" occurs when the family size falls rapidly and there are relatively more people of working age and fewer dependent children. Some Asian countries have successfully taken advantage of their

demographic bonus. In these countries, having fewer young dependents to cater for allowed the governments to invest in health, extend education, and train people for modern jobs. A healthier, better educated and skilled workforce benefited the economies of these countries and made them more competitive globally (World Health Organization, 2010). Family planning is essential in achieving three of the United Nations' Sustainable Development Goals: reducing child mortality, improving maternal health, and promoting gender equality. Family planning also supports achievement of the goals of eradicating extreme poverty and hunger, achieving universal primary education, combating HIV/AIDS, and ensuring environmental sustainability, since population growth exacerbates pollution and threatens fragile ecosystems.

Theoretical frameworks

The theoretical frameworks applicable to this study include the theory of gender and power and the social learning theory. A detailed description of each theory, along with its potential application to the role of men in family planning decision making is presented below.

Theory of Gender and Power

In 1987, R.W Connell developed a collection of writings on the theories of sexual inequality and gender and power imbalances (Connell, 1987). The Theory of Gender and Power is a social structural model that seeks to understand women's risk as a consequence of different social structures (Wingood and Di-Clemente, 2000). According to this theory, three major structures characterize gendered relationships between men and women: The sexual division of labor, the sexual division of power, and the structure of cathexis. These three overlapping structures serve to explain how and why many people assume gender roles. These structures exist at the societal level and at the level of social institutions like, schools, work sites/industries, families, relationships, religious institutions, the medical system, and the media. The three social structures are maintained within institutions through social mechanisms such as unequal pay for comparable work, discriminatory practices at school and work, the imbalance of control within relationships and at work sites. The presence of these and other social mechanisms constrains women's daily lifestyle practices by producing gender-based inequities in women's economic potential, women's control of resources, and gender-based expectations of women's role in society.

In applying the theory of gender and power, it is assumed that gender-based inequities and disparities in cultural expectations that arise from each of the three structural components produce differing risk factors that interact to cause an adverse impact on women's (and men's) health. In the issue of discourse, the organization of the African society is governed by the characteristically male dominant and partrilineal traditions. Sociological factors (culture, religion, etc) are in favor of men as decision-makers both at family levels and community levels. Traditionally, wives in African societies consider their husbands as overall heads. The husbands decide upon most things, and his wife is expected to abide by his spoken decisions or his perceived wishes. This male dominated family structure has great influences in matters of reproduction (Berhane *et al.,* 1999). A woman's ability to control her own fertility is strongly affected by social constructs of gender roles and expectations. Gender inequality, for example, may determine who has access to family planning information, who holds the power to negotiate contraceptive use or to withhold sex, who decides on family size, and who controls the economic resources to obtain family planning related health services. These hurdles vary from culture to culture, yet they exist throughout the world and can often lead to negative family planning health outcomes (Boender, 2004).

Social Learning Theory

Social Learning Theory posits that behavior is the result of "reciprocal determinism" the continuing interaction between a person, the behavior of that person, and the environment within which the behavior is performed. The constant interaction between these factors is such that a change in one has implications for the others. Behavior can result from the characteristics of a person or an environment, and it can be used to change that person or environment as well. Behavior is viewed not in isolation, but rather as the outcome of the dynamic interaction of personal and environmental variables (Brindis, Sattley and Mamo, 2005). The two most important variables that social learning theory takes into account are self-efficacy and modeling. Self-efficacy or the confidence in one's ability to successfully perform a specific type of action, is considered by Bandura (the "father" of Social Learning Theory) to be the single most important aspect of the sense of self that determines one's effort to change behavior. Modeling or imitation which is a basic premise of this framework implies that people learn not only from their own experience, but from the actions and reactions of others as well (Bandura A, 1977a).Results from a study in Ghana shows that encouragement received by men from their social networks significantly increases the likelihood of subsequent contraceptive use by their wives but this effect operates primarily by galvanizing spousal communication on reproductive matters (Avogo and Agadjanian, 2008). In the context of family planning, husbands or wives may model their behavior through the views of the community or experiences from neighbors. For example, several myths and misconceptions surround the use of family planning in some communities. The negative effect of myths and misinformation passed from one person to the other on family planning behaviors is well documented (De Clerque *et al.,* 1986; Orji and Onwudiegwu, 2002). Other important variables include knowledge, skill, problem-solving, expectations, self-control, emotional coping, attitudes, beliefs, intent, and motivation. The term "personal variable" refers to an objective notion of all the factors that can affect an individual's behavior that are physically internal to that individual. "Environmental variables" include observational learning (modeling), reinforcement, family members, peers, friends, opportunities and norms in short, all the factors that can affect a person's behavior that are physically external to that person (Bandura, 1977a). These theoretical frameworks interact at different levels to shape the issue of family planning in our communities.

MATERIALS AND METHODS

The study was an exploratory one, with a cross sectional survey involving married men residing at Gwagwalada area council of Abuja in the Federal Capital Territory of Nigeria. The study was conducted in Gwagwalada area council in Nigeria's Federal capital territory. Abuja is located between latitudes 8◦25′ and 9◦ 25′ north of the equator and longitudes

6◦45′ and 7◦ 45′ east of Greenwich. The territory covers an area of 8,000 square kilometres (Dawam, 2000). Abuja had a projected population of 1,406,239 inhabitants in the year 2006[1]. Gwagwalada Area Council is one of the six area councils in the FCT and was created on the 15th October, 1984 and falls within the Nok culture. It has an estimated population of 157,770 at the 2006 census (NPC, 2009). Before its creation, Gwagwalada and its environs were under Kwali District of former Abuja emirate now Suleja emirate. Gwagwalada Area Council is strategically located on the Suleja – Lokoja highway and is bordered in the south by Kwali, Bwari in the North, while sharing its eastern borders with Kuje and Abuja municipal area councils. The area council covers a very vast land, rich in cultural and historical heritages, that is a ready resource for archeologist and sociologist. Gwagwalada area council is conceived in the Abuja master plan as its industrial zone. It stands out as the second most cosmopolitan city of the FCT after the capital city with various social amenities including schools, banks, hospital, markets and offices. Gwagwalada Area council is mostly inhabited by the original settlers namely, The Gwari, Koro, Bassa, Gede and the Hausa-Fulani, as well as the immigrant population of other Nigerians and expatriates. The area council is made up of ten (10) wards namely: Gwagwalada central, Zuba, Quarters, Kutunku, Tungan -maje, Dobi, Paiko, Ibwa, Ikwa and Gwarko. The first five wards are urban while the latter five wards are rural settlements. Gwagwalada central ward is the most developed and has located in it several federal government agencies including the University of Abuja and The University teaching hospital which is a tertiary hospital that serves the Federal capital territory and surrounding states.

The study population was comprised of married men residing in Gwagwalada area council. It was a mixture of rural and urban dwellers in Gwagwalada communities. Men who refused to give consent, widowers or not currently married men were excluded from the study. A close-ended, pre-tested structured questionnaire was administered to the respondents by interviewer method after obtaining a verbal informed consent. The multistage sampling technique was used. In the first stage, there was a random selection of two (2) urban and two (2) rural wards out of the ten (10) wards in the area council. In the second stage, thirty eight (38) households were selected from each ward by convenience sampling. Thus a total of 152 households were sampled in the four (4) wards. The questionnaire was comprised of sections covering **s**ocio-demographic data, knowledge about contraceptives, attitude to the use of contraceptives, men's use of contraceptive methods, men's involvement in decision making and spousal communication relating to family planning.

The findings from the quantitative data were subjected to analysis using Statistical Package for Social Science (SPSS) statistical soft ware version 16.0. Proportions were compared using Chi-square. Statistical significance was set at P value < 0.05. The analysis of the focus group discussions was done manually using content analysis, an approach that was preferred to available electronic software because it allows proper handling of some expressions that may be difficult with computer analysis. The taped version of the discussions were transcribed, the product was then carefully compared with the notes taken during the discussions and a final comprehensive list of issues raised by various participants in each discussion group to the leading questions was prepared. The data was then coded according to the following thematic areas:

- Ideal family size
- Decision making on family planning
- Men's support for family planning in the community
- Perceptions of the community about family planning
- Availability of family planning services in the community

These views were analyzed and some striking expressions were pulled out for verbatim reporting.

DATA PRESENTATION AND DISCUSSION

The age distribution of men in the study ranged between 20 and 59 years, with two- third of them in their third and fourth decades of life. One hundred and twenty four (81.6%) of the men were in monogamous unions while the rest were in polygynous unions. Majority of the participants had at least primary level of education (85.5%).The remaining did not have any formal education. About one third of the men were farmers while the remaining two-thirds had their occupation almost evenly distributed in the public employment, private employment and business/trading sectors respectively. Sixty four of the men were of the Islamic religion (42.1%) while eighty two (53.9%) where Christians. The remaining six (4%) were of the traditional religion.

Table 1. Table showing knowledge about family planning methods that can be used by men

Awareness on family planning methods that can be used by men = 152	Frequency	%
Condom	122	80.2
Normal injections	-	-
Oral pills	14	9.2
Intra uterine contraceptive device	-	-
Implants	-	-
Female sterilization	9	6.0
Male sterilization	7	4.6
Spermicides	-	-
Total	152	100.0

Source: Field survey, 2016

Awareness of Modern Family Planning Methods

Majority of the respondents (79.6%) were aware of modern contraceptives, 13.2% were not aware while the remaining 7.2% of respondents had no opinion. Condom was the commonest modern contraceptive known by 115(75.7%) of the respondents. This was followed by hormonal injections and oral pills which were known by 42.8% and 29.6% of respondents respectively. Only 4.6% of men knew of male sterilization. Concerning modern contraceptive options available for use by men only, 121(79.6%) of respondents correctly identified condom as an option while 14(9.2%) knew of male sterilization, 7(4.6%) were aware of spermicides and 9(5.9%) wrongly thought that men could use hormonal injections for contraceptives. Majority of the men became aware of family planning through a health facility, this was so in 64(42.1%) of the study population. This was followed closely by awareness gotten from the electronic media and the respondents spouses in 51(33.6%) and 17(11.1%) respectively. The print media was the source of information in 15(9.9%), while neighbors and community agents were equally the source in 1.7%.The remaining 0.7% of men got information

about family planning from their friends. From the table above, it is evident that the use of condom is the commonest form of modern family planning as 80.2% of the respondents agrees with its use, 9.2% respondents agrees with the use of oral pills, 6.0% accepts female sterilization while 4.6% respondent knew of male sterilization. It should be noted that more than one method were mentioned by some respondents.

Table 2. Table showing source of awareness about family planning

Source of Awareness	Frequency	%
Electronic media	64	42.1
Health facility	51	33.6
Print media	15	9.9
Wife	17	11.1
Friends	1	0.7
Neigbours	2	1.3
Community agent	2	1.3
Total	152	1.00.0

Source: Field survey, 2016

From the table above, majority of men became aware of family planning through electronic media, this was so in 64 (42.1%) of the study population. This was followed closely by awareness gotten from health facility and respondents spouses in 51 (33.6%) and 17 (11.1%) respectively. The print media was the source of information in 15 (9.9%), while neighbour and community agents were equally the source in 1.3%. The remaining 0.7% of men got information about family planning from their friends.

Men's Attitudes to Family Planning

Table 3. Table showing respondent's approval of the use of family planning method

Response	Frequency	%
Yes, I approve	124	81.6
No, I disapprove	28	18.4
Total	152	100.0

Source: Field survey, 2016

Majority of the participants in the study 124 (81.6%) approve the use of family planning methods while 28 (18.4) of the respondent disapprove the method.

Table 4. Table showing respondent's approval of the use of family planning by their wife

Response	Frequency	%
Yes, I approve	116	76.3
No, I disapprove	36	23.7
Total	152	100.0

Source: Field survey, 2016

As indicated in the table above 116 (76.3%) of the respondent approves the use of family planning by their wife while 36 (23.7%) of the respondents disapprove its use.

Use of Family Planning Method

From the below table more men had used family planning method before compared to those that had never used (51.3% vs 48.7%). However only 42 (27.6%) were current users of male contraceptive methods as against majority, 110 (72.4%) who were not using any form of male contraceptives. Amongst the 42 current users, 38 of them (90.5%) use condom while the remaining 4 (9.5%) use the withdrawal method. There was no use of vasectomy or other male family planning method. The main reasons for non use of family planning methods by the men were desire to have more children (35.5%), lack of knowledge about family planning 928.2%) and fear of side effects (24.5%).

Table 5. Table showing reasons for non use of family planning methods by the men

Reasons for non use of Family planning methods by men, N=110	Frequency	%
Desire to have more children	39	35.5
Disapproves of family planning	2	1.8
Fear of side effects	27	24.5
Religious prohibition	19	9.1
Inadequate knowledge about FP	31	28.2
Fear of loss of headship of house hold	1	0.9
Total	152	100.0

Source: Field Work, 2015

Table 6. Table showing reasons for non use of family planning methods by the wives of respondents

Respondents reasons for non use of family planning methods by their wives , N=107	Frequency	%
Desire to have more children	37	34.6
Disapproves of family planning	4	3.7
Fear of side effects	19	17.8
Religious prohibition	25	23.4
Inadequate knowledge about FP	7	6.5
Health concerns	-	-
Total	152	100.0

Source: Field survey, 2016

From the above table majority of the men (57.6%) confirmed that their wives were not using any family planning method while 29.6% confirmed the use of family planning methods by their wives, the remaining 12.2% didn't know if their wives were using Family planning methods. Amongst the 45 current women users, hormonal injections was the most commonly used in 27 of them (60.0%),implants were used by 6(13.3%) followed by IUCD, pills and female sterilization in 5(11.1%),4 (8.9%) and 3(6.7%) respectively.

Spousal Communication

Table 7. Table showing maker of decision when to have another child

Who makes Decisions	Frequency	Percentage %
Husband	43	28.3
Wife	3	2.0
Both husband and wife	49	32.2
God decides	40	26.3
No opinion	17	11.2
Total	152	100.0

Source: Field survey, 2016

From the above table, decision on when to have another child was taken by both couple in 49(32.2%) of respondents. Husband alone took the decision in 43(28.3%) of the cases. Forty (26.3%) depended on God and thus did not take the decision themselves, 17(11.2%) didn't have an opinion. Only 3 women decided by themselves alone when to have another child. This is shown in Table 10 below. From the below, decision on method of contraceptives to be used by the couple was made together in 34.9% of the study population with equal number of participants not having an opinion on this issue. However, 14(9.2%) of men made the decision alone while

12(9.1%) of women took the decision without input from their husbands. Twenty participants did not respond to the question.

Table 8. Table showing maker of decision on family planning method to be used by couple

Maker of Decision	Frequency	%
Husband	14	9.2
Wife	12	7.9
Both husband and wife	53	34.9
No opinion	53	34.9
Non responses	20	13.2
Total	152	100.0

Source: Field survey, 2016

Table 9.Table showing initiator of discussion about use of family planning method

Initiator	Frequency	%
Husband	90	74.4
Wife	31	25.6
Total	121	100.0

Source: Field survey, 2016

From the above table, amongst 121 participants who responded to the question on who initiated the discussion about when to achieve the next pregnancy, the husband was the initiator in 74.4% of cases, while the wife initiated the discussion in 25.6% of the cases.

DISCUSSION OF FINDINGS

The family unit remains a fundamental component of the society that cannot be ignored in the course of designing strategies for National and International development as it has potentials for initiating a cascade of behavioral practices which can shape the society positively. Family planning has tremendous benefits to the family and the Nation at large. Therefore efforts geared at integrating the male partner towards harnessing these benefits are highly advocated. Findings from this study shows that majority of the male inhabitants of Gwagwalada area council had attained at least the primary level of education with its positive impact on approval and use of family planning by their wives .This is evidenced by the statistically significant associations between husbands educational level and their approval of family planning and its utilization by their wives. Husband's education is vital for behavioral change and decision making on issues related to family planning especially in the use of male controlled methods. These have been proven by previous researchers on the role of men in family planning decision making (Gubhuju, 2009).

Although majority of the participants already had four or more children, they were still desirous of more children. This findings support earlier submission by Caldwell and Caldwell (1990), that African men are desirous of large families, as more children further enhance his status as a man in society. Other reasons that have been advanced for Nigerian men placing high value on children as reported by Isiugo -Abanihe (1994) were that children provided tangible and emotional benefits, a high sense of satisfaction and success even if the man was poor, and support in old age. Sons provided continuity of the family name, which encouraged polygamy and large families. Findings from the focused group discussion in both men and women groups supported an average of five children which shows a desire for high fertility in the community. The mean ideal number of children of 5.3 found in this study was higher than that reported in a study by Campbell and Campbell (1997) in Botswana but lower than 8.5 and 6.7 children reported amongst married men and women respectively in Nigeria's 2008 Demographic health survey (NPC,2009). The dependence on God to determine the number of children in 14.5% of the men in the study is a matter of great concern as the men in this group have the tendency for "continuous procreation "with the adverse consequences of unplanned families such as increased morbidity and mortality for the women, decreased child survival and poor quality of life for members of the family. Enlightenment campaigns on the benefits of family planning and the place of the couple in taking decision concerning their health and general well being will be of tremendous benefit to this group of people. The awareness of men about modern methods of family planning in this study is high and is comparable to findings from other studies (Ijadunola *et al.,* 2010;Lawoyin *et al.,* 2002; Obionu, 1998;Odimegwu, 1999). Condom was the commonest modern method of family planning known by the respondents as was the case in similar studies. (NPC, 2009; Ijadunola *et al.,* 2010; Orji, Ojofeitmi and Olanrewaju, 2007). A study on condom use in a monogamous setting by Oyediran, (2003), reported that although prevention of pregnancy is a major motivation for condom use, many men would use a condom for protection against sexually transmitted infections and prevention of pregnancy simultaneously. The strengthened HIV/AIDS programme interventions on its dual function of preventing transmission of HIV/AIDS as well as pregnancy prevention may have contributed to the higher awareness on condom compared to the other methods.

Vasectomy, or male surgical sterilization, involves the division or occlusion of the lumen of the vas deferens leading to disruption of the passage of sperm from the testes (Ebeigbe, Igberase and Eigbefoh, 2011). Awareness about this safe, reliable, effective and cheap male method of family planning is poor and is comparable to findings from another study by Akpamu *et al.,* (2010) in Ekpoma, Edo State where knowledge and acceptability was poor. It is however lower than what was reported among Resident Doctors in Obstetrics and Gynaecology in the same region, (Ebiegbe, Igberase and Eigbefoh, 2011). The result from the latter study was not surprising as the participants were almost specialists in that field. There is need for further research in this area of male family planning method in Nigeria to find out possible reasons for the low level of knowledge and acceptability. Men had supportive attitude towards family planning as 65.1% would accompany their wives to the family planning clinics, 86.8% were still desirous of having more information about family planning, 81.6% of men would approve the use of family planning methods and 76.3% would approve their use by their wives. The focus group discussion also alluded to men's support for family planning in the community. This is quite commendable and in contrast to opinions that men were not supportive of family planning (Fakaye and Babaniyi, 1989; Odu *et al.,* 2006). The study showed that the high knowledge and support for family planning by the respondents did not translate into a high rate of use of family planning methods by them or their wives mainly due to desire for more children, fear of side effects and lack of adequate information on family planning. The latter two reasons were why some women in the focused group discussions in the rural area resorted to unfamiliar traditional methods like use of herbal medications

and highly concentrated salt solution to prevent unwanted pregnancy. These practices certainly have high failure rates and therefore counterproductive. High level of awareness with a low level of practice of family planning by men have been reported previously by Lawoyin *et al.,* (2002). Religious prohibition was not a major barrier to family planning use as was reported by Odu *et al.,* (2006). Spousal communication in the communities surveyed in Gwagwalada area council was poor. This is similar to findings by Ijadunola *et al*. (2010). Previous studies have documented that family planning communication between husbands and wives was a prerequisite for better and responsible reproductive health behavior and that couples could make better reproductive decisions if they discuss family planning matters more openly and frequently (Becker, 1996; De Silva,1994). Whether to practice family planning or not, which methods to choose, when to start contraception, and the choices regarding the number and timing of children are all outcomes of inter-spousal communication (Oyediran, Ishola and Feyisetan, 2002a).

Islam (2008) in a multi level analysis of male involvement in reproductive health in Bangladesh noted that couples who discuss family planning matters were likely to discuss and understand the potential advantages and disadvantages of different contraceptive methods and that the frequency of inter-spousal communication is sometimes regarded as an indicator of safe family planning practice, where couples practice contraception appropriately and consistently without experiencing any side effects. Poor level of spousal communication in Gwagwalada community may have been responsible for poor use of modern family planning methods by the men and their wives and may also have hampered continued use in those who had used any method in the past especially when they noticed a side effect associated with the method. Spousal communication provides opportunities for the couple to take responsibility for their reproductive health actions rather than leaving it solely for God to deicide as was seen in almost a quarter of the study population. Husbands were greatly involved in decision making concerning the issue of fertility goals of the family as they were the main initiators, sole decision makers in almost one third of situations and contributors in another one third of discussions on when to have the next child. Quantitative and qualitative data from this study reveal that men are major stakeholders on decision making regarding family planning and demand important attention just as their wives in all governments' effort towards achieving a fertility decline in Nigeria.

Available studies show that in many developing countries males often dominate in making important decisions in the family, including those concerned with reproduction, family size, and contraceptive use (Isiugo-Abanihe, 1994; Bruce, 1994). Male involvements help not only in accepting a contraceptive but also in its effective use and continuation (Khan and Patel, 1997). The level of joint decision making on when to have another child as well as family planning methods to be used found in this study is poor and comparable to findings by Ogunjuigbe *et al.,* (2009) in south western Nigeria. This level of joint spousal communication may have been more than what was reported by these men as previous studies have shown that men under report spousal communication compared to women as the men desire to boost their ego and show that they are in control even when such issues were discussed with their wives (Isiugo-Abanihe, 1994; Ogunjuigbe *et al.,* 2009).

Conclusion

Sub-Saharan Africa has yet to complete its "demographic transition"—that is, to shift to low birth and death rates .An important factor responsible for this trend is the failure of family planning programmes in many African societies which have not recognized the roles of men in this regard. Majority of the men studied where highly aware of modern family planning methods, however only few of them were currently using a method. Results of focused group discussion and in-depth interviews conducted amongst in the communities also showed high knowledge but low usage with fear of side effects, lack of adequate information and costs as barriers to the use of family planning in the communities. The men and women had positive attitudes to family planning; however there was poor spousal communication on issues related to family planning. Men were significantly involved in decision making concerning fertility goals and family planning in the community. Involving men and obtaining their support and commitment towards family planning is of crucial importance in this part of the country as most decisions that affect family planning are made by them. Their involvement would improve spousal communication which could ease the responsibility borne by women in terms of decision-making for family-planning matters thereby improving the understanding and practice of family planning in general.

Recommendations

Observations in this study contribute to the basis for the following recommendations:

- There is need for involvement of the men in the planning and execution of family planning programmes in the community. Men should be used as change agents towards convincing their wives on the need for the couple to practice family planning. Involving men will have a multiplier effect by improving their commitment to realization of other reproductive health goals like the use of ante natal services.
- Enlightenment campaigns and programmes on the benefits of family planning to the members of the community at large should be organized; this will enhance acceptability and practice of family planning in Gwagwalada area council. Stake holders like church leaders and community leaders should be mobilized and involved during these campaigns.
- Education of the men and their wives on the methods of family planning, their safety and correct use towards dispelling the myths and rumors surrounding the use of family planning in the community. This will also encourage spousal communication and its benefits of improving practice of family planning
- The primary health centres should be adequately staffed to provide regular services to the people.
- Family planning commodities should be readily available at little or no cost to the inhabitants of Gwagwalada area council.
- Family planning messages should be sensitive to the cultural and religious beliefs of the people like the use of the term "child spacing'' was preferred to "family planning" in some quarters.

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