

Original Research Article

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3 **Men's Perception and Practice of Family Planning in Ede South Local Government**

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Area Osun State, Nigeria5 **ABSTRACT**

6 **Background:** Majority of men in Sub-Saharan Africa have been observed to have poor
7 family planning (FP) behaviour. The study was carried out to determine the awareness,
8 perception and practice of family planning among men in Ede South Local Government Area
9 (LGA), Osun State, Nigeria.

10 **Methods:** The study, carried out between October and December 2010 among men in Ede
11 South LGA, employed a cross-sectional descriptive design. A pre-tested, self-administered,
12 semi-structured questionnaire was used to elicit information from 340 men who were
13 recruited by multi-stage sampling method. The data were analyzed using SPSS version 17.

14 **Result:** Ninety-nine percent were aware of family planning. Male condom was the most
15 commonly known while vasectomy was the least known; 89.5% had good perception of FP
16 while 66.1% had good practice. The most commonly used methods were condom (49.5%),
17 withdrawal (22.5%) and oral contraceptives (19.8%). Religion, educational and occupational
18 status significantly predicted perception while religion and educational status significantly
19 predicted practice ($P < .05$).

20 **Conclusion:** Men in Ede-South LGA were largely aware of and majority had good
21 perception of FP. However a fewer proportion had good practice of family planning. There is
22 a need to bridge the gap between awareness, perception and practice of family planning.

23 **Keywords:** *Men, family planning, perception, practice, behaviour, Nigeria*

24 **1. INTRODUCTION**

25 Family planning services are defined as “educational, comprehensive medical or social
26 activities which enable individuals to determine freely the number and spacing of their
27 children and to select the means by which this may be achieved” [1].

28 Men are important stakeholders in family planning. As the traditional head of households in
29 our society, they have tremendous influence in decision making as regards reproductive
30 health behaviors such as contraceptive use and utilization of health facilities for reproductive
31 health needs. Their approval, support and actual involvement in family planning is therefore
32 critical in achieving good reproductive health of the entire family [2,3].

33 Though men play a pivotal role in family planning issues, they have not been too involved. In
34 most developing countries, women carry the burden of responsibility on contraceptive use
35 often with little or no support and sometimes with great resistance from their male partners
36 [4,5,6]. Men’s support or opposition to their partner’s practice of family planning has a strong
37 impact on contraceptive use in many parts of the world including Africa. For example,
38 according to Zimbabwe reproductive health survey done in 1984, 42% of married women
39 stated that it was the husband’s responsibility to decide whether his wife should use family
40 planning method or not [7]. Also in Ethiopia, women at risk of unplanned pregnancies were
41 not using contraceptive methods because of male opposition [8,9]. As a result, there are still
42 so many unplanned, ill-spaced and unwanted pregnancies with the attendant high risks of
43 maternal, infant and child mortalities and increasing poverty [10,11].

44 Men in Africa resist the use of contraceptives, even among partners, for a variety of reasons
45 of which the major ones are based on cultural, socioeconomic, religious and health issues
46 [12].

47 Some of the male controlled family planning contraceptive methods include natural methods
48 (periodic abstinence and withdrawal), condoms and vasectomy. While natural methods are

49 well known to some men and condoms are a bit popular, vasectomy is the least known and
50 least accepted among men in in developing countries [3,13].

51 The ICPD (1994) in Cairo recommended that “special research should be undertaken in
52 factors inhibiting male participation in family planning”[14]. The Programme of Action
53 (POA) also stated that innovative programmes must be developed to make information,
54 counseling and services for reproductive health accessible to adolescent and adult males [14].

55 The actualization of this POA is still inadequate in Nigeria. Also, even though the Nigerian
56 Reproductive Health Policy concluded that the inclusion of males in family planning
57 programmes in Nigeria will enhance overall programme effectiveness and so recommended
58 that special attention must be focused on them with respect to reproductive health matters;
59 men are still being neglected in these matters [15,16]. If the needs of men concerning
60 reproductive health education and services are not met then progress towards better health for
61 the entire family cannot be achieved and the present total fertility rate (TFR) of 5.7 and
62 population growth rate of 2.8% cannot be reduced to acceptable levels [17,18,19].

63 Apart from the fact that most researches conducted about family planning in Nigeria focused
64 on women, there is paucity of studies about family planning in Ede South LGA of Osun State
65 in particular. This study was therefore conducted to determine men’s awareness, perception
66 and practice of family planning in the Local Government Area.

67 **2. METHODOLOGY**

68 *Study setting*

69 Ede South Local Government Area (LGA) is one of the 30 LGAs in Osun State. It is made up of ten
70 wards and covers a land area of about 424 square kilometres. The LGA is made up of both urban
71 and rural areas and comprises of six major towns with its administrative headquarters at Oke-Iresi,

72 Ede, Osun State. It is bounded in the North and South by Ede North, Ife North and Ayedade LGAs
73 and bounded on the West by Egbedore, Ejigbo and Ayedire LGAs.

74 The total number of people in Ede South LGA is 76,035 [20]. The people are predominantly
75 Yorubas but other ethnic groups such as Igbos and Hausas also reside in the LGA. The majority of
76 the people are farmers while a few are traders and artisans. There are many public and private
77 primary and secondary schools and two tertiary institutions within the LGA. The major religions of
78 the inhabitants are Islam and Christianity.

79 This was a descriptive cross-sectional survey conducted among men between the ages of 18 and 70.
80 Assuming a 95% level of confidence, proportion of men using contraceptives of 27% (from a
81 previous study) and a level of significance 5%, the formula for calculating single proportions by
82 Abramson and Gahlinger was used to obtain a minimum sample size of 302 [21,22]. In order to
83 compensate for improperly completed questionnaires, the calculated sample size was increased by
84 5% but a total of 340 respondents were eventually interviewed.

85 Respondents were recruited into the study using multistage sampling technique. There were 10
86 wards in the LGA; simple random sampling was used to select 50% out of these. From each of
87 the selected wards, 5 streets were selected by balloting. From each of the selected streets,
88 systematic random sampling was used to select 7 houses. From each selected house, an eligible
89 respondent who consented was interviewed.

90 A pre-tested, semi-structured questionnaire, developed in English language and back translated
91 into Yoruba in order to ensure the content validity was used. The questionnaire was pre-tested
92 in Olorunda LGA which was not utilized for this study. It elicited information about the socio-
93 demographic characteristics, awareness, perception and practice of family planning among
94 men. Data were collected through guided self-administration by literate respondents and by
95 interview of non-literate respondents by trained research assistants.

96 Data was analyzed using the Statistical Package for Social Sciences (SPSS) version 15. In
 97 determining the perception of family planning, an 11 -point question was used. Each correct
 98 response was scored one while a non- or wrong response was scored zero. Respondents who
 99 scored 6-11 were categorized as having good perception; those that scored 0-5 were
 100 categorized as having poor perception. In determining practice, a three-point question was
 101 used. Each correct response was scored one while a non- or wrong response was scored zero.
 102 Respondents who scored 2-3 were categorized as having good practice; those that scored 0-1
 103 were categorized as having poor practice.

104 Ethical clearance was obtained from LAUTECH College of Medicine Ethics and Research
 105 Committee. Permission to conduct the survey was obtained from the LGA authorities.
 106 Informed consent was obtained from the respondents, the questionnaires were filled
 107 anonymously and confidentiality of information collected was ensured by the researchers.

108 **3. RESULTS**

109 Of the 340 questionnaires distributed, 333 were filled correctly giving a response rate of
 110 97.9%.

111 Table 1: Most of the respondents were aged 18 to 54 years with a mean age of 35.3 ± 11.7
 112 years. Sixty percent of the respondents were married, 61.9% were Muslims, 82.8% had at
 113 least secondary education, 45.0% were skilled workers and 89.5% were Yorubas.

114 **Table 1: Socio-demographic characteristics of respondents (n = 333)**

Variable	Frequency	Percentage
Age in years		
18-24	43	12.9
25- 34	160	45.0
35-44	71	21.3
45-54	34	10.2
≥55	35	10.5
Marital Status		
Single	120	36
Married	199	59.8

Divorced/separated/ Widowed	14	4.2
Religion		
Christianity	122	36.6
Islam	206	61.9
Traditional/ others	5	1.5
Educational status		
None	17	5.1
Primary	40	12.0
Secondary	127	38.1
Tertiary	149	44.7
Occupational Status		
Unemployed	45	13.5
Unskilled	60	18.0
Skilled	150	45.0
Professional	78	23.4
Ethnicity		
Yoruba	298	89.5
Igbo	23	6.9
Hausa	7	2.1
Others	5	1.5

115

116 **3.1 Awareness and sources of information**

117 Three hundred and thirty two (99.7%) of the respondents were aware of family planning. The
 118 major sources of information about family planning were the radio 180(54.2%), school
 119 42(12.7%) and friends/relations 38(11.4%). (Table 2)

120

121 **Table 2: Awareness of and sources of information about family planning among**
 122 **respondents**

Awareness	Frequency	Percentage
Aware	332	99.7
Not aware	1	0.3
Total	333	100.0
Sources of information		
Radio	188	56.6
School	42	12.7
Friends/Relations	38	11.4
TV	35	10.5
Place of Work	17	5.1
Hospital	12	3.6

123	Total	332	100.0
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124 **3.2 Perception**

125 Majority of respondents agreed that both sexes should determine what type of family
 126 planning to be adopted (87.7%), family planning should be joint decision of men and their
 127 partners (85.3%) and it is not against their moral and cultural beliefs (82.9%) while 33.9%
 128 and 18.6% respectively agreed that condom doesn't reduce sexual satisfaction and vasectomy
 129 is a desirable practice. Overall, about ninety percent of the respondents had good perception
 130 while 10% had poor perception. (Table 3)

131
 132 **Table 3: Respondents' perception about family planning (n = 333)**
 133

Perception	Disagree	Not Sure	Agree
Both sexes should determine what type of family planning to be adopted	23(6.9)	18(5.4)	292 (87.7)
Family planning should be joint decision of men and their partners	33 (9.9)	16(4.8)	284 (85.3)
It is not against my moral and cultural beliefs	38(11.4)	19(5.7)	276 (82.9)
Modern methods are better than traditional methods	32(9.6)	30(9.0)	271 (81.4)
Family planning is for both sexes	56 (16.8)	18(5.4)	259 (77.7)
Abstinence can be a safe method of family planning	57(17.1)	25(7.5)	251 (75.4)
My religion supports family planning	64 (19.2)	37(11.1)	232 (69.7)
Men should use contraceptives	133 (39.9)	32(9.6)	168 (50.5)
Family planning is not a foreign practice with destructive effect	91(27.3)	81(24.3)	161(48.3)
Condom doesn't reduce sexual satisfaction	163 (48.9)	57(17.1)	113 (33.9)
Vasectomy is a desirable practice	180 (54.1)	91(27.3)	62 (18.6)

134

135 **3.3 Practice**

136 Only 190(57.1%) of the respondents or their wives were currently using a family planning
137 method. The commonest method currently used by the respondents were male condom
138 165(49.5%), withdrawal 75(22.5%) and oral contraceptive pill 66(19.8%) while the least
139 were implants 2(0.6%) and vasectomy 2(0.6%). Overall, 66.1% of the respondents had good
140 practice while 33.9% had poor practice of family planning.

141 **3.4 Relationship between socio-demographic characteristics and perception of family**
142 **planning**

143 Religion, educational level and occupation significantly predicted respondents' overall
144 perception of family planning. When compared, respondents that were Christians, who had
145 higher education and were professionals had better perception of family planning than those
146 who were non-Christians, uneducated and unskilled ($p < 0.05$) (Table 4)

147

148 **3.5 Relationship between socio-demographic characteristics and practice of family**
149 **planning**

150 Religion and educational level significantly predicted respondents' overall practice of family
151 planning. When compared, respondents that were Christians and who had higher education
152 had better practice than those who were non-Christians, uneducated and unskilled ($p < 0.05$;
153 Table 5)

154

155 **Table 4: Relationship between socio-demographic characteristics and respondents'**
 156 **perception of family planning.**

Socio-demographic characteristics	Perception		X ²	P-value
	Poor (%)	Good (%)		
Age (years)				
19 and below	0(0.0)	5(100)	*7.60	.050
20-29	8(6.8)	109(93.2)		
30-39	9(8.5)	97(91.5)		
40 and above	18(17.1)	87(82.9)		
Marital status				
Single	7(5.8)	113(94.2)	4.38	.110
Married	26(31.1)	173(86.9)		
Divorced/separated/widowed	2(14.2)	12(85.8)		
Religion				
Christianity	2(1.6)	120(98.4)	16.21	.000
Islam	32(15.5)	174(84.5)		
Traditional/Others	1(20.0)	4 (80.0)		
Educational status				
No formal education	8(47.1)	9(52.9)	*54.04	.000
Primary	13(32.5)	27(67.5)		
Secondary	13(10.2)	114(89.8)		
Tertiary	1(0.7)	148(99.3)		
Occupational status				
Unemployed	2(4.4)	43(95.6)	*29.96	.000
Unskilled	15(25.0)	45(75.0)		
Skilled	18(12.0)	132(88.0)		
Professional	0(0.0)	78(100)		
Ethnicity				
Yoruba	35(11.7)	263(88.3)		**,298
Igbo	0(0)	23(100)		
Hausa	0(0)	7(100)		
Others	0(0)	5(100)		

157 ***Likelihood Ratio Chi-square ** Fisher's Exact test**

158

159

160 Table 5: Relationship between socio-demographic characteristics and respondents' practice
 161 of family planning

Socio-demographic characteristics	Practice		X ²	P-value
	Poor (%)	Good (%)		
Age (years)				
19 and below	4(80.0)	1 (20.0)	*9.11	.020
20-29	37 (31.6)	80 (68.4)		
30-39	29 (27.4)	77 (72.6)		
40 and above	43 (41.0)	62 (59.0)		
Marital status				
Single	41 (34.2)	79 (65.8)	1.76	.420
Married	65 (32.7)	134(67.3)		
Divorced/separated/ widowed	7 (50.0)	7 (50.0))		
Religion				
Christianity	26 (21.3)	96 (78.7)	*17.47	.000
Islam	83 (40.3)	123 (59.7)		
Traditional/others	4 (80.0)	1 (20.0)		
Educational status				
No formal education	11 (64.7)	6 (35.3)	13.80	.030
Primary	19 (47.5)	21 (52.5)		
Secondary	43 (33.9)	84 (66.1)		
Tertiary	40 (26.8)	109 (73.2)		
Occupational status				
Unemployed	13 (28.9)	32 (71.1)	7.20	.059
Unskilled	25 (41.7)	35 (58.3)		
Skilled	57 (38.0)	93 (62.0)		
Professional	18 (23.1)	60 (76.9)		
Ethnicity				
Yoruba	104 (34.9)	194 (65.1)	2.26	.521
Igbo	6 (26.1)	17 (73.9)		
Hausa	1 (14.3)	6 (85.7)		
Others	2 (40.0)	3 (60.0)		

162 *Likelihood Ratio Chi-square

163 4. DISCUSSION

164 This study assessed the awareness, perception and practice of family planning among men in
 165 Ede South LGA, Nigeria. Awareness of family planning was almost universal among the
 166 respondents. This is in keeping with the reports of some other studies conducted both within
 167 and outside Nigeria in which about 99% of the men were aware of family planning [3,23].
 168 However some studies reported a lower percentage of awareness [24]. The most popular

169 sources of information about family planning were the radio, the school and friends while the
170 least was the hospital. Likewise, the most popular source of information about family
171 planning in most other studies was the radio. In these studies however, the other popular
172 sources reported differed from those recorded here and also differed from study to study
173 [3,23].

174 In Nigeria and in some other developing countries, the radio is a very effective means of
175 communication for all and sundry. There are now a lot of radio stations in most cities and
176 towns which transmit numerous educational programs in different local languages to their
177 listeners. In addition, people across different wealth quintiles are able to afford transistor
178 radios some of which are now attached to cellular phones; such that people have access to
179 vital information even as they go about their daily duties. Health managers and policy makers
180 should key into the widespread availability of the radio even in the remotest places to further
181 enlighten, educate and teach people about health related matters and particularly the men,
182 about family planning issues [19,25].

183 The commonest methods known were condoms, oral contraceptive pills and withdrawal. This
184 is similar to the reports of studies conducted in Ife and Olorunda LGAs in which condom
185 and oral pills were the most popularly known [3,4].

186 A high proportion of the respondents in this study had good perception about family
187 planning. About eight out of ten of the respondents were of the perception that family
188 planning is not against their moral and cultural beliefs; modern methods are better than
189 traditional methods and the decision to use family planning and the method to be adopted
190 should be a joint one between men and their partners. About seven out of ten stated that it
191 was not against their religion. However, about half of the respondents felt that condom
192 reduces sexual satisfaction and vasectomy is not a desirable practice. The respondents view
193 about the condom is corroborated by the reports of some studies conducted in Western Kenya

194 and Malawi in which respondents felt that condoms were an issue in contraception because
195 they interfere with sexual pleasure, they are not really accepted within marriage but good for
196 extramarital affairs, and could be left in the woman's body. Condom use was considered a
197 'double loss' of both possible conception and pleasure [12,13].

198 The perception of most of the respondents that decision making about family planning use
199 and method adopted should be a joint one contrasts with the reports of studies conducted in
200 Nigeria, Uganda and India. While some felt that family planning and fertility issues are
201 entirely in the woman's domain; do not really concern men and as such they need not worry
202 about it; some felt that discussing topics such as contraception is unnecessary and is a waste
203 of precious time [4,23,26]. In a South African study on the other hand, men felt that decisions
204 about the number of children to have is solely that of men and so should not be discussed
205 with women who have limited decision-making powers [9].

206 Overall, about nine out of ten respondents had good perception. This is higher than the
207 finding in a Nigerian study in which just about two-thirds of the respondents had a positive
208 perception [4]. It would have been wonderful if this high perception of family planning can
209 translate into high practice but it is often not the case as seen in this study and previous other
210 researches where high perception, knowledge or approval does not translate into practice
211 [3,27].

212 Though majority of the respondents felt that family planning should be a joint decision of
213 both sexes; only four out of ten of them ever discussed family planning with their wives. This
214 is similar to that reported among men in Ife but slightly lower than that reported in Olorunda
215 [3,4]. Communication about family planning is important as inter-spousal communication is a
216 crucial matter that has a strong positive effect on the continuous use of family planning [3,4].
217 In this study, about seven out of ten respondents had ever used a family planning method.
218 The most commonly used were male condom, withdrawal and oral contraceptive pills while

219 the least ever used was vasectomy. This is lower than that of the Ife study but higher than that
220 reported in the Ilorin and Olorunda studies [3,4,27].

221 Slightly over half of the respondents or their wives were currently using a family planning
222 method. The commonest methods currently used by the respondents were the same as those
223 ever used by them ie male condom, withdrawal and oral contraceptive pill but a lower
224 proportion of respondents were using them as at the time of the study ie some people that
225 were previously on these methods had stopped or changed to other methods as the case may
226 be. This finding is similar to the Ife, Ethiopian and Indian studies in which slightly over half
227 and about three-fifth of the respondents were current users [3,24,28] but higher than those of
228 the Ilorin and Olorunda studies in which less than a fifth of the men were currently using
229 contraceptives [4,27]. In most of these studies (with exception of Olorunda), condom was the
230 commonest method being used while vasectomy was the least. Overall, about two-thirds of
231 the respondents had good practice.

232 Religion and educational status significantly predicted respondent's perception and practice
233 of family planning. When compared, respondents that were Christians and who had higher
234 education had better perception and practice of FP than those that were non-Christians, and
235 uneducated. Religion as a predictor of respondents' perception and practice of family
236 planning as found in this study is corroborated by studies conducted in Ghana, Senegal,
237 Pakistan and the United States of America [25,29,30,31]. Though the Quran does not prohibit
238 birth spacing or limiting the number of pregnancies, some Muslims feel that family planning
239 is infanticide, others feel that the larger the number of Muslims and their population, the
240 larger their power, while yet others view it as a practice imposed by the West to reduce their
241 number [29,30]. It may not be the religious affiliation per se that brings about the poor
242 perception and practice of family planning; rather, it may be how fundamental and
243 conservative people's religious identifications are. People who are more conservative

244 generally display lower support for family planning irrespective of their religion as some
245 conservative Christians have also been found to have poor perception of family planning, but
246 for different reasons [31].

247 Education also significantly predicted respondents' perception and practice of family
248 planning. More respondents with tertiary education had better perception and practice of
249 family planning than those with other levels of education or no education at all. This findings
250 is also corroborated by studies conducted in Tanzania, Turkey, Ghana, North Central Nigeria
251 and Uganda [25,27,32,33,34]. Those who were educated in this study could have been more
252 exposed to family planning education than the rest and were therefore in a better position to
253 overcome the forces of ignorance and tradition which tends to make peoples' perception and
254 practice of family planning poor. It has also been documented that education contributes to
255 the reduction of child mortality and therefore fertility; since people no longer feel the need to
256 have additional children as an insurance against child death and therefore practice family
257 planning better.

258 **5. CONCLUSION**

259 Almost all the men in Ede South LGA, Osun State Nigeria, were aware of and majority of
260 them had a good perception and practice of family planning. However, there were gaps
261 between their awareness, perception and practice. The factors which significantly predicted
262 their perception were religion, education and occupation while the factors which significantly
263 predicted their practice were religion and education. Public enlightenment and other forms of
264 advocacy about family planning targeted at men should be intensified in order to bridge the
265 gap between their awareness, perception and practice.

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