KNOWLEDGE, ATTITUDES AND FAMILY PLANNING BEHAVIOURS OF MEN IN OLUKU COMMUNITY, OVIA NORTH EAST LOCAL GOVERNMENT, BENIN CITY.

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CERTIFICATION

We, the undersigned certify that this work was carried out by Eniebiat Udoh DANIEL in the Department of Health, Safety and Environmental Education, University of Benin.

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DEDICATION

This research work is dedicated to God who is my helper, sustainer and strength and giver of grace to complete this work amidst all odds.

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Without mincing words, the researcher is immensely indebted to God Almighty who made it possible for him to initiate progress and accomplish this research work despite all odds.

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ABSTRACT

This study was carried out to ascertained the knowledge, attitudes and family planning behaviours of men in Oluku community Ovia North East LGA, Benin City. To guide the study, five (5) research questions were raised and three (3) hypotheses were formulated. Relevant literatures related to the study were reviewed with maximum attention to the relationship with the subject of interest.

The study was a descriptive research which adopted a survey research design with the population of five thousand, two hundred and sixty (5,260.) men in Oluku community, while 263respondents made up the sample size carefully selected using simple random sampling technique. A self- constructed questionnaire, whose reliability was determined using test-retest method, was validated by the supervisor and used to collect relevant data necessary for the study. The data were further analyzed using simple percentage, frequency counts, Pearson's Product Moment Correlation Coefficient (PPMC) and Chi-square statistical methods. The results were presented, interpreted and discussed by the researcher and findings were drawn.

Following the findings, majority of the respondents (men in Oluku) have high knowledge of family planning. Furthermore, majority of the respondents had negative attitudes which were significantly related to their negative family planning behaviours. These were associated with low socio-economic status and religious factor which were proven to influence family planning behaviours of men. Hence, the researcher recommended that the government and relevant stakeholders should provide for functional institutions and health system which guarantees child survival and an improvement in the general level of education in the community as some men, especially in the rural areas, are scared of, and believe that non-use of family planning could help them to still have many children in case of child-mortality. This is key to enhancing knowledge, attitudes and family planning behaviours of men.

CHAPTER ONE

INTRODUCTION

Background of the Study

The practice of family planning has called for global attention because of its importance in decision making on population growth and issues of development. Childbearing and the use of family planning methods are some of the most important decisions on reproduction that could be taken by couples to curtail the number of children they want to have. Therefore, the issue of family planning and its methods has led many married men to either accept family planning or reject it (National Family Survey, 2000). The World Health Organization (WHO, 1971), cited in Shaw (2010), defined family planning as the practice that helps individuals or couples to attain certain objectives, such as avoiding unwanted 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. It refers to the methods or means by which individuals or married couples space the process of conception, pregnancy and childbirth which is mutually determined by both partners in order to have the number of children that they can care for. It also involves teaching men and women about their bodies and teaching them how to prevent births usually with contraceptives but sometimes also with abortion or sterilization. This means men and women need to know more about their bodies and how to prevent unwanted pregnancy, which could only by implementing any form of family planning. In a nutshell, family planning is the process whereby individuals or couples decide to have children by choice not merely by chance.

Family planning services are important because, as educational, comprehensive medical or social activities, they enable individuals to determine freely the number and spacing of their children and to select the means by which these may be achieved. They also could be effective in reducing complications associated with frequent pregnancies. Family planning methods could be helpful in reducing the risk of unintended pregnancies in women living with HIV (Human Immunodeficiency Virus) and reduce the risk of contracting STIs (Sexually transmitted Infections). Family planning may enable individuals to make informed decisions about their reproductive health (such as the prevention of unsafe abortion), improvement of socio-economic status and in turn instrumental in population control.

Despite offering enormous benefits, family planning has been faced with several challenges. Over the years, there have been a lot of campaigns on the use of family planning and reduction of population in several countries, including Nigeria. Even at that, a study by National Population Commission (NPC, 2009) indicates that contraceptive use is still low in many developing countries. This can be attributed to some challenges such as culture, poverty and poor access which have been widely understood as militating against its use (USAID, 2008; & NPC, 2009). The United States Agency for International Development (USAID) and the NPC noted that studies presenting men's self-related barriers towards family planning are relatively few, as much attention is either given to women or on eliciting clients' knowledge and utilization gaps regarding family planning methods, but specific attention to eliciting their knowledge gaps regarding the benefits of family planning

is often deficient. Yet, identifying men's self-reported barriers and benefits is central to any family planning intervention which could further promote their knowledge, attitude and behaviours toward decision making on the number of children couples want to have by using different methods to achieve that, ranging from contraceptives to use of condoms, male and female sterilization among others. Conclusively, factors such as culture, low education, poverty and poor access to information on family planning are among other numerous reasons that have been identified by scholars to militate against the use of family planning methods.

Men are important stakeholders in family planning. As the traditional heads of households in our society, they have tremendous influence on decision-making as regards reproductive health behaviours (such as use of family planning methods or contraceptives) and utilization of health facilities for reproductive health needs. As a result, their knowledge and attitude influence their approval, support and actual involvement (behaviour) in family planning which is critical in achieving good reproductive health of the entire family.

Though men play a pivotal role in family planning issues, obviously, they may not have been adequately involved. It is believed that in most developing countries, women carry the burden/responsibility of contraceptive use often with little or no support and sometimes with great resistance from their male partners. Men's support or opposition to their partner's practice of family planning has a strong impact on contraceptive use in many parts of the world including Africa.

Apparently, although men play a pivotal role in family planning issues, they may not have been adequately involved. In most developing countries, women carry the burden/responsibility of contraceptive use often with little or no support and sometimes with great resistance from their male partners. Men's support or opposition to their partner's practice of family planning has a strong impact on contraceptive use in many parts of the world including Africa. At present, a number of men in Africa still resist the use of contraceptives (or family planning methods) for a variety of reasons which border majorly on cultural, socioeconomic, religious and health issues. These issues translate into a number of many unplanned, ill-spaced and unwanted pregnancies with attendant high risks of maternal, infant and child mortalities and an increasing level of poverty.

A substantial number of issues mentioned earlier may be averted by men through adequate knowledge of, attitude and behaviour towards the adoption of male family planning/contraceptive methods. Such methods include natural family planning methods (i.e., periodic abstinence and withdrawal), condom use and vasectomy. While natural methods are well known to some men and condoms are a bit popular, vasectomy is the rarely known and least accepted among men in developing countries (WHO, 2010).

The International Conference on Population and Development (ICPD) held in Cairo in 1994 recommended that special research should be undertaken in factors inhibiting male participation in family planning. Its Programme of Action (POA) further stated that innovative programmes must be developed to make information, counselling and services for reproductive health accessible to adolescents and adult males. The actualization of this

POA is perceived as still inadequate in Nigeria (Federal Ministry of Health, FMOH, 2019). This is because despite the conclusion of the Nigerian Reproductive Health Policy that the inclusion of males in family planning programmes in Nigeria will enhance overall programme effectiveness and so recommended that special attention must be focused on them with respect to reproductive health matters; men are still being neglected in these matters. If the needs of men concerning reproductive health education and services are not met, then progress towards better health for the entire family may not be achieved and population growth rate will be difficult to reduce to acceptable levels.

Apart from the fact that most researches conducted on family planning in Nigeria are believed to focus on women, there appears to be a paucity of studies on family planning and men in Ovia North East Local Government Area (LGA), Benin City, Edo State in particular. Hence, this study will, therefore, be conducted to determine the knowledge, attitude and family planning behaviours of men in Oluku community, Ovia North East LGA, Edo State.

Statement of Problem

Family planning has attracted global attention due to its importance in determining the number and the spacing of children, reduction of maternal mortality as well as complications due to frequent pregnancies, and above all essential in decision making about population growth and development issues. Despite the campaign on the usefulness of family planning in having smaller and healthier family, studies by NPC (2009); and Adeleye, Akoria, Shuaib and Ogholoh, (2010) indicate that the use of contraceptives and other family

planning methods is still low in many developing countries, including Nigeria. The result is an obvious population increase which may be associated with several challenges such as low standard of living, unemployment, congestion in schools, over-utilization of Primary Health Care (PHC) facilities and thus difficulty to meet the primary health needs of members of the community.

While Adeleye et al (2010) outlined culture, poverty and poor access as some of the factors militating against the use and acceptance of family planning, several other scholars argue that very little achievement recorded in family planning in developing countries is due to too many researches focusing more on women and neglecting the reproductive health needs of men in a patriarchal and patrimonial setting, such as Nigeria. They believe that African men play important roles in the decisions about family life, including fertility and family planning. However, fertility and family planning research and programmes have ignored their roles in the past, focusing more on women's behaviours. Since the 1994 International Conference on Population and Development (ICPD), interest in men's involvement in reproductive health has increased. Unfortunately, data on their knowledge, attitudes and family planning behaviours are generally scanty. Thus, data which would help to make decisions and embark on programmes to sensitize men and influence their acceptance, knowledge, attitudes and behaviours toward involvement in family planning in Nigeria have become a contentious problem. This pitfall or gap may have allowed most men to see family planning as the “women’s business” and further exhibit negative attitudes and behaviours

toward it, thereby, making married women to give birth to too many children neglecting the benefits of family planning.

In the light of the solution, the International Conference on Population and Development (ICPD) held in Cairo in 1994, cited in Amu, Odu, Aduayi, Deji, Emmanuel and Owoeye (2017) recommended that "special research should be undertaken in factors inhibiting male participation in family planning". It concluded that "innovative programmes must be developed to make information, counselling and services for reproductive health accessible to adolescent and adult males", as this will be essential in the inclusion of men, and overall enhancement of family planning programmes. Hence, this study ascertained knowledge, attitudes and family planning behaviours of men in Oluku community, Ovia-North East LGA, Benin City, Edo State.

Research Questions:

The following Research questions were raised to guide the study.

1. Are men in Oluku community knowledgeable about Family Planning?
2. What are the attitudes of men in Oluku community toward family planning?
3. What are the family planning behaviours of men in Oluku community?
4. What are the family planning methods used by married men in Oluku community?
5. What are the factors affecting the family planning behaviours of men in Oluku?
6. Do men in Oluku Community discuss family planning with their wives?

Research Hypothesis

The following hypothesis were formulated to guide the study

I. There is no significant relationship between knowledge and family planning behaviours of men in Oluku Community.
II. There is no significant relationship relationship between attitudes and family planning behaviours of men in Oluku community.
III. Socio-economic status is significantly related to family planning behaviours of men in Oluku community.

Purpose of the Study

The purpose of the study was to ascertain the knowledge, attitudes and family planning behaviours of men in Oluku community, Ovia-North East LGA, Benin City, Edo State. More specifically, the study seeks to:

i. Find out if men in Oluku community are knowledgeable about family planning.
ii. Examine the attitudes of men in Oluku community toward family planning.
iii. Determine the family planning behaviours of men in Oluku community.
iv. Determine the family planning methods used by men in Oluku community.
v. Examine the factors which affect the family planning behaviours of men in Oluku.
vi. Ascertain whether men discuss family planning with their wives.

Significance of the Study

The study on knowledge, attitudes and family planning behaviours of men in Oluku community, Ovia-North East LGA, Benin City, Edo State bridges the gap existing in the data on knowledge, attitudes and family planning behaviours of men and their involvement in family planning programme and services, as this key to promoting family planning effectiveness and efficiency. Specifically, this study provides relevant information to men, members of the public, health practitioners, policy-makers and even the government in the following ways:

1. Men are provided with helpful information on family planning methods available for men. The information further enhances the knowledge and attitudes of men toward family planning and as well forestalls positive family planning behaviours in men.
2. Members of the public are intimated with useful information on the current level of knowledge, attitudes and family planning behaviours of men, as well as, offered necessary information on the family planning methods available for men and how to utilize them. E.g., male condom and the proper way of using it, etc.
3. Researchers are provided with current information which augments the paucity of data that exist on knowledge, attitudes and family planning behaviours of men. Thus, the study serves as a foundation for further related studies.
4. Health practitioners such as family planning experts, health educators, policy makers, etc., are provided with relevant information from the findings of the study. This serves as basis for programme appraisal, planning, policy making, implementations and

programmes of intervention, seminars, programme development and evaluation with a view to improving knowledge, attitudes and family planning behaviours of men around the globe.

5. Governments at various levels are not left out, since this study abreasts them with findings that are important in budgeting and execution of plan of action in the direction of achieving their National Population Goals, using family planning as a tool – not only for stabilizing the population but – as a basis for engendering economic development.

Scope and Delimitation

This study covered knowledge, attitudes and family planning behaviours of men, as well as, their reproductive health, meaning, benefits, challenges, history and methods of family planning,. However, it was delimited to men in Oluku Community in Ovia North East L.G.A., Benin City, Edo State.

Operational Definition of Terms

The following definitions are given, to make clear the meaning of relevant terms as were used in the study:

1. **Behaviour**: a recurrent or consistent way of thinking, feeling and acting towards a given situation or event.
2. **Men**: adult males who are married or of marriable age, however, having a female partner.
3. **Family Planning**: methods, means or practices used to decide the number and spacing of children to have and when to have them.

4. **Contraception**: this is defined as the intentional prevention of pregnancy as a consequence of sexual intercourse using either traditional or modern methods - devices, sexual practices, chemicals/drugs and/or surgical procedures.
5. **Contraceptives**: can be defined as any device or act whose purpose is to prevent a woman from becoming pregnant. This was also used interchangeable with birth-control or family planning methods or services in this study.
6. **Intercourse**: can be defined as physical sexual contact between individuals that involves the genitalia of at least one person.
7. **Outercourse**: can be defined as other sexual activities besides vaginal sex. Examples include kissing, massage, masturbating, using sex toys on each other, dry humping (grinding), and talking about your fantasies.
8. **S.T.Is**: STIs stand for Sexually-Transmitted Infections, which can be defined as infections (caused by bacteria, viruses or parasites) but transmitted through sexual contact between persons. Examples include HIV/AIDS, gonorhoea, candida, etc.
9. **Attitude**: can be defined as a learned predisposition, opinion, tendency or feeling which makes an individual to act in a particular way towards an object, thing, event or situation.
10. **Knowledge**: can be defined as facts, information or skills acquired through experience or education.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

Literature related to knowledge, attitudes and family planning behaviours of men in Oluku community, Ovia North East LGA, Benin City – were reviewed under the following sub headings:

1. Concept of Family Planning.
2. Historical Overview of Family Planning.
3. Benefits of family planning.
4. Family Planning Methods, Advantages and Disadvantages.
5. Family Planning Methods available for Men only.
6. Factors affecting Knowledge, Attitudes and Family Planning Behaviours of Men.
7. Knowledge of men on family planning.
8. Attitudes of Men towards Family Planning.
9. Family Planning Behaviours of Men, and Relationship with Knowledge and Attitudes.
    a) Men's role in decision-making in the family planning matters.
    b) Men's involvement in family planning practice, etc.
    c) Discussions on family planning between men and their wives.
    d) Men attending family planning clinics with their wives, etc.
10. Theoretical Framework
11. Summary.

Concept of Family Planning:

The concept of family planning has been x-rayed by several authors. These, hold substantive interpretations of what the notion of family planning is, as well as, the various methods or options which can be adequately utilized to achieve set goals with respect to procreation and population control at large.

The World Health Organization (W.H.O. 1971), cited in Shaw (2010), opined that family planning allows individuals and couples to anticipate and achieve their desired number of children and the spacing and timing of their births. Family planning may be sometimes used as synonym for access to and use of contraception. However, it often involves methods and practices in addition to contraception. Thus, family planning can be achieved through the use of contraceptive methods and the treatment of involuntary infertility (Stith, Butler & Wright, 2009). Importantly, many might wish to use contraception but are not necessarily planning a family (e.g., unmarried adolescents or young married couples delaying childbearing while building a career, etc). Hence, family planning may involve consideration of the number of children a woman wishes to have, including the choice to have no children and the age at which she wishes to have them. These concerns may be influenced by some perceived external factors such as marital situation, career considerations, financial position and any disabilities that may affect their ability to have children and raise them.

Agbonifoh and Onobumen (2018), referred family planning to fertility control - a means by which individuals and married couples space the process of conception, pregnancy and childbirth, mutually determined by both partners in order to have the number of children

that they can conveniently provide and care for. She opined that family planning is the process whereby individuals and married couples decide to have children by choice and not merely by chance. That is so say, family planning, being the use of fertility control methods or modern contraception methods, should be mutually agreed on (based on conscious and deliberate decision reached by both partners) to effectively and efficiently control birth, with an intent to regulating timing, spacing and the number of births in the family and nation at large. No wonder Shaw (2010) earlier opined that family planning is voluntary and available methods of contraception (previously referred to as birth-control) which can be customized to individual needs with a range of methods that acceptable to all and are effective if used correctly.

Elgamel (2013) believed that family planning implies that married couples discuss when and how many children they can have so that they can give the utmost care to the child, financially, psychologically and socially. Simply put, family planning involves planning the number, frequency and timing of pregnancy. In other words, it is a programme to regulate the number and spacing of children in a family through the practice of contraception or other methods of birth-control. Therefore, family planning methods would include every measure that can be taken so as to give a couple their required freedom to determine when they want to have their children and what the time-gap should be if planning for more than one child.

Family planning is defined as having the freedom and responsibility of all the couples and the individuals to decide the number of children they desire and having the knowledge,

education and tools for this purpose (Nazli, Yasemin, Selcuk, Mehmet, Canan & Bilge, 2018). In other words, family planning is a preventive service that allows married couples achieve their desired number of children and decide the spacing of pregnancies according to their economic opportunities and personal wishes, and to ensure that the births are at appropriate intervals for the mother and child health. Family planning does not mean limiting the number of people in a family. Rather, its goal is to prevent pregnancy-related health risks in women and reducing the need for unsafe abortion and infant mortality. From the above family planning can result in higher levels of education, better employment opportunities, higher socioeconomic status and empowerment. As part of focus, family planning services, are to prevent unwanted pregnancies and related maternal and infant mortalities, to provide help and counseling to every family whenever they want and to have as many children as they want. Family planning services improve the abilities of family members in decision-making and recognize the freedom to make free decision about having a child. Family planning services have an important role within the scope of "Primary Health Care", which must be presented to the public (Federal Ministry of Health and Social Services, 2019).

Lately, the notion of family planning has become a catch-all phrase, especially for much of the studies undertaken in this realm (i.e., within the scope of family planning). While, contemporary notion of family planning tends to put a woman at the centre of the discussion, notwithstanding, family planning is usually applied to female – male couple who wish to limit the number of children they have and as well control pregnancy timing (also known as

spacing birth/children). Little wonder Nazli et al (2018) agreed that family is defined as having the freedom and responsibility of all the couples and the individuals to decide the number of children they desire and having the knowledge, education and tools for this purpose. In other words, family planning is a preventive service that allows married couples to achieve their desired number of children and decide on the spacing of pregnancies according to their economic opportunities and personal wishes, and to ensure that the births are at appropriate intervals for the mother and the child, and the family at large. Simply put, family planning services are defined as educational, comprehensive medical or social activities which enable individuals to determine freely the number and spacing of their children and to select the means by which this may be achieved.

Key Points on Concept of Family Planning:

i. Family planning is when both the husband and wife together discuss and mutually decide how many children they would like to have and when, so that they can give sufficient love, care, attention and good education to each of their children.
ii. Family planning is achieved through the use of contraceptive methods and the treatment of infertility (inability to have children).
iii. Planning when and how many children to have is the couple's responsibility, not just the man's or woman's role.
iv. Family planning is just as important for newly married couples as it is for those who already have one or more children. It enables young people to delay their first child till they are prepared to take up the responsibilities of raising a child.

Historical Overview of Family Planning

The history of family planning dates back to the earliest days of humankind. There has never been a time when women and girls did not want to have control over whether, when, and how many children they would have.

In 1912, the modern birth-control movement began in New York with Margaret Sanger - a public health nurse who was concerned about the adverse health effects of frequent childbirth, miscarriages, and abortion, initiated efforts to circulate information about and provide access to contraception (Wardell & Sanger, 1980; Kim, Tikhonov, Merjanian & Balica, 2017). In 1916, Sanger challenged the laws that suppressed the distribution of birth control information by opening in Brooklyn, New York, the first family planning clinic. No wonder Michel (2013) defended that the first voluntary movements of birth planning, initially private initiatives, appeared in the United States and in England at the beginning of the 20th century, with activist women, most notably Margaret and Ethel Sanger, and Marie Stopes, who installed the first clinics promoting birth control in New York City (1916) and in London (1921) respectively.

Notably, it is argued that family Planning was set up in 1936 in New Zealand, during when it was first known as the “Sex Hygiene and Birth Regulation Society” (Dawson, Meny & Ridley, 1980). At that time, contraception was basic and unreliable. It was common at that time for women to die from illegal abortions. A Government inquiry (The McMillan Inquiry) in 1937 found that at least one pregnancy in five ended in abortion, and that the majority of

women dying from illegal abortions were married with four or more children. Thus, the benefits of contraception began to be promoted.

Remarkably, in 1952, India developed its first national family planning policy (World Health Organization, WHO, 2008). Having launched its National Programme for Family Planning, India became the first country in the world to initiate a milestone in family planning, with such historic initiative in 1952. The Family Planning Programme has undergone transformation in terms of policy and actual programme implementation ever since. Around the same time, the International Planned Parenthood Foundation and the Population Council were established, thus marking what is arguably suggested as the start of the modern family planning movement.

In Africa: In the 1970s, access to modern contraception was extremely limited, except for pilot program activities (National Research Council, 1993) and the early efforts of International Planned Parenthood affiliates and other nongovernmental organizations (NGOs), which operated mainly in urban areas. African policy makers did not experience the absolute numbers and the high population density that characterized the Asian context. Consequently, they expressed little support for population control, which was the stimulus for the first family planning programs in India in the 1950s and in much of the rest of Asia and Latin America in the 1960s. Furthermore, policy makers tended to shy away from family planning, which was controversial in the sociocultural setting in much of Africa. This was especially true in Francophone West Africa, which was strongly influenced by conservative French laws. At the Bucharest World Population Conference in 1974, African

leaders joined others from the developing world in voicing support for socioeconomic development and "a new world order," rather than a more demographically oriented approach to Third World problems (National Research Council, 1993; Rosenfield & Schwartz 2005).

The period 1970–1990 marked the golden era of family planning during which reproductive revolution occurred worldwide except in SSA. However, by the early 1990s, changes had begun to occur leading some experts to suggest that population and family planning programmes started in the late 1960s in developing countries constituted one of the most important public health success stories of the twentieth century (Rosenfield & Schwartz, 2005).

During the 1980s, considerable change occurred in the African policy climate. The climate became increasingly favorable for population policies and family planning programs as governments documented and grew more concerned about high population growth rates. In 1984, African leaders endorsed the Kilimanjaro Programme of Action for African Population and Self-Reliant Development, formulated in Tanzania, which called for the provision of family planning services and their integration into Maternal and Child Health (MCH) programs (National Research Council, 1993).

In contrast with other context, such as Asian, where family planning services were often developed independently from health services in special vertical programs supported by economic and demographic rationales, African policy makers opted for a health rationale, an emphasis on spacing (rather than limiting) of births, and the delivery of family planning and

reproductive health services within integrated health programs. In Africa, the health approach was considered both culturally and politically more appropriate than a demographic orientation for dealing with the interconnected problems associated with reproductive health, rapid population growth, and economic development. At the International Conference on Population and Development, ICPD in 1994, the world endorsed integrated reproductive health programs more in line with the ideal (but infrequently realized) African models than with the earlier vertical Asian models.

During the governmental programmes in clinic settings in most African countries in the 1990s, the vast majority of women received modern family planning methods from governmental sources, rather than from nongovernmental agencies, pharmacies, or private practitioners. Among users of modern methods, the proportions receiving them from governmental sources range from 95% in Botswana and 71% in Kenya (two of the most successful programs) to a low of 43% in Ghana (Ross, Mauldin, & Miller, 1993). These governmental sources were most frequently health facilities rather than Community-Based Distribution (CBD) systems, which have been implemented on a much smaller scale in Africa than in the 1970s and 1980s (Phillips & Greene, 1993). A wide range of health facilities - hospitals, clinics, and health posts - are still the major source of supply of modern family planning methods in Africa today.

The clinic-based service - delivery system in Africa has been a major focus of African policy makers and the donor community. However, recent developments - ICPD and the worsening of the HIV/AIDS pandemic in the region - have resulted in still greater emphasis

on the clinic-based system. In response, Ministries of Health (MOHs) and the donor community are increasing efforts to test potential strategies for some of the most important and relevant ICPD components. Particular emphasis is being placed on the integration of family planning with the prevention and treatment of STIs, including HIV/AIDS (Maggwa & Askew, 1997).

Views on the effectiveness of the clinic-based approach to family planning programs in Africa have changed substantially in the last decade. Pertinent to this, Caldwell (1977) referred to "...the complete failure of African family planning programs to reduce fertility", as a mirage. However, the decade since that comment was made has seen dramatic declines in fertility in several African countries with active family planning programs (such as Kenya, Zimbabwe, and Botswana), along significant changes in education, family economics, urbanization, and other factors. Guha (2001) concluded that "an assessment of fertility trends has uncovered evidence of initial fertility decline in two-thirds of the countries of Sub-Saharan Africa that had conducted a Demographic and Health Survey (DHS) before mid-1995, but within a group of countries in East and Southern Africa – where the fertility transition is now well-established and progressing at a rapid pace. Moreover, Guha indicated that "contraceptive use", is by far the most important factor accounting for across country differences (in fertility).

In Africa, few family planning programs existed in the 1970s, and those that did (or were subsequently initiated in the 1980s) generally suffered from very serious weakness as program effort scores were universally weak in 1982 (Ross, Mauldin, & Miller, 1993), and

contraceptive prevalence rates were universally low. However, whether low contraceptive prevalence rates were due to poorly functioning programs, lack of demand for family planning, or both was controversial (Van de Walle & Foster, 1990; & Pritchett, 1994).

Commenting on the increasing change in experience and perspectives that pervaded Africa in the mid-1990s, Fisher & Miller (1996) noted that until recently, conventional wisdom suggests that regardless of how effective African family planning programs are in making services available and accessible, the use of family planning services in Africa will remain low because the demand for these services is very low. However, he pointed to three new sources of data that challenge this "weak demand" hypothesis. Demographic Health surveys conducted throughout Africa indicate that demand for family planning - especially for purposes of spacing births - exists, often at levels far higher than expected. Furthermore, the Situation Analysis studies that form the basis for this volume reveal that in every country where these studies have been conducted, significant weaknesses in the supply of services affect the ability of programs to satisfy demand and operational studies completed throughout the continent demonstrate that "when supply side weaknesses are corrected, when services are made more available, easily accessible, and of higher quality, the use of family planning increases substantially and rapidly (Fisher, 1993). In short, there is demand for family planning services, there are severe service delivery weaknesses, and numerous operational research studies clearly demonstrate the potential to satisfy the demand when those weaknesses are corrected.

NIGERIA is by far the most populous country in Africa (United Nations, 2019). Serious governmental attention to family planning services did not begin until 1983, when substantial donor support became available, and a national population policy was adopted in 1988. The effect of this attention can be seen in a steep rise in program effort scores between 1982 and 1989 (Miller, Robert, Ian, Marjorie, Horn & Lewis, 1998). According to Kate et al (1998), however, the Total Fertility Rate (TFR.) in Nigeria has consistently remained at about 6.5, and the low Contraceptive Prevalent Rate (CPR., 8%) showed no change between 1981 and 1990, but in more recent years, the TFR has been less than 15% (National Population Commission, 2018).

The history of family planning in Nigeria is different and has been marked by several major handicaps: lack of political commitment and recurrent political instability; on social grounds, strong resistance from traditional and religious authorities, especially Muslims in the north and Catholics in the south, as well as sexual taboos, rumors and frontal opposition to certain methods of contraception from selected groups; at organizational level, poor organization and mismanagement of the program, and in particular low reliance on community activities.

In 1988, in response to the rapid rate of population growth and its adverse implications for development, the federal government of Nigeria approved the National Policy on Population and Development, Unity, Progress and Self-Reliance (Federal Republic of Nigeria, 1989). At the inception of the 1988 national policy, the Total Fertility Rate (TFR) was 6.3 children per woman, the infant mortality rate was 87 per 1,000 live births, and the maternal mortality rate was reported to be among the highest in Africa (Pearce, 2001). The targets for the

policy were modest but realistic, such as a Total Fertility Rate of 4 per woman (Pearce, 2001).

According to Pearce the 1988 policy acknowledged that the laissez-faire (careless or nonchalant) approach hitherto adopted on population issues was not effective in lowering population growth, with adverse consequences on the welfare of the citizens and on the socio-economic development of the country. Furthermore, it was believed that the living conditions of the people would improve if the rate of population growth could be reduced to achieve the primary objective of slowing down the rate of population growth; the policy highlighted the need to:

i. reduce the proportion of women who marry before age 18 years by 50 percent by 1995 and by 80 percent by the year 2000;
ii. educe pregnancy to mothers below 18 years and above 35 years of age by 50 percent by 1995 and by 80 percent by the year 2000;
iii. reduce the total fertility rate, over 6 in 1988 to 4 by the year 2000 and reduce the rate of growth that then was estimated at about 3.3 percent to 2 percent by year 2000; and
iv. extend the coverage of family planning services to 50 percent of women of child-bearing age by 1995 and 80 percent by the year 2000.

Over the years, emerging issues such as HIV/AIDS, poverty, and gender inequality, among others, necessitated a review of the 1988 National Population Policy and the launching of the National Policy on Population for Sustainable Development in 2004. The policy

recognizes that population factors, social and economic development, and environmental issues are interconnected and critical to the achievement of sustainable development in Nigeria. The overall goal of the policy was to improve the quality of life and standard of living for the Nigerian population through the attainment of a number of specific goals (National Population Commission, 2009).

In an attempt to reflect the new realities and trends in the national health situation, the National Health Policy and Strategy to Achieve Health for All Nigerians was promulgated in 1988, the first comprehensive national health policy. It was formulated within the context of:

i. the Health Strategy of the New Partnership for Africa's Development (NEPAD), a pledge by African leaders based on a common vision and a firm conviction that they have a pressing duty to eradicate poverty and place their countries individually and collectively on a path of sustainable growth and development; the United Nations Millennium Development Goals (MDG) that Nigeria, like other countries, has committed to achieve;
ii. the New Economic Empowerment and Development Strategy (NEEDS), which is aimed at re-orienting the values of Nigerians, reforming government and institutions, growing the role of the private sector, and enshrining a social charter on human development with the people of Nigeria; and
iii. Development of a comprehensive health sector reform programme as an integral part of the NEEDS.

The current understanding of reproductive health policy in Nigeria emanates from the landmark International Conference on Population and Development (ICPD) held in Cairo in 1994. Already well documented, the ICPD Program of Action (PoA) clearly showed a paradigm shift from implementing individual vertical programs addressing maternal and child health issues to a more comprehensive and expanded understanding and approach to the provision of reproductive health services. The ICPD also anchored this new focus within the context that reproductive health and rights are integral to achieving sustainable development. Since the 1994 ICPD, the Nigerian government, acting through the Federal Ministry of Health (FMoH), has made substantial efforts aimed at improving the policy environment for the implementation of reproductive health programs such as family planning. Hence, the Nigeria Family Planning Blueprint was created in 2014 as a result of the commitments made by the Federal Government of Nigeria (FGN) at the 2012 London Summit on Family Planning to increase funding by an additional $8.35 million annually to bridge identified gaps in Family Planning (FP) and Reproductive Health (R.H.) needs. This scale-up plan is undergoing implementation so as to achieve the set objectives to:

i. provide accurate and comprehensive knowledge of FP methods to every segment of the population through easily accessible channels to generate demand and change behaviour.
ii. Ensure that every State in Nigeria contributes at least 50 percent of the funds it requires for adequate FP service delivery every year.

iii. Ensure that every health facility (including PHCs and private and faith-based clinics) has an adequate number and category of trained staff - according to national guidelines - to provide LARC services throughout the country.

iv. Strengthen contraceptive logistics management systems to ensure continuous contraceptive availability at all health facilities.

v. improved routine data management (including collection, collation, reporting, and use) at all levels of the healthcare delivery system in the country to allow for smooth tracking of family planning progress.

Conclusively, the history of family planning in Nigeria is unique and has been marked by several major handicaps: lack of political commitment and recurrent political instability; on social grounds, strong resistance from traditional and religious authorities, especially Muslims in the north and Catholics in the south, as well as sexual taboos, rumors and frontal opposition to certain methods of contraception from selected groups; at organizational level, poor organization and mismanagement of the program, and in particular low reliance on community activities. However, family planning had started early, in 1962, with the creation of an association (Family Planning Council of Nigeria), but later, a population policy was adopted in 1989 (National Population Policy for Development, Unity, Progress, and Self-Reliance), followed by an awareness campaign (1992), but they were not successful and did not have an impact as in Ghana, although an ambitious goal of four children per woman has been recently adopted. The family planning program was reactivated in 2004, then in 2012,

but so far had only modest effects in rural areas (Caldwell & Ware, 1977; Odimegwu, 1999; & Monjok, Smesny, Ekabua & Essien, 2010).

Benefits of Family Planning

Undoubtedly, family planning is of great importance to couples, families and the nation at large. This is of no difference with the stance of numerous scholars and the prominent WHO (2008) who affirm that family planning affords couples several benefits which include:

1. Improving maternal health and child survival. Family planning helps couples to prevent pregnancies that are too often, too early or too late. It further reduces global rates of maternal mortality and rates of infants, as well as, child mortality. Family planning enables the mother to regain her health after delivery and further gives her enough time for treatment and recovery when suffering from illness. Additionally, healthy mothers produce healthy children. This is because, family planning affords couples, especially mothers to ensure their optimal health and prepare for pregnancies so as to have healthy babies.
2. A study by Yeaky, Muntifering, Ramachandran, Myint, Creanga and Tsui (2009) showed that family planning promotes small family size, improves child survival and reduces sibling competition for scarce family and maternal resources. Furthermore, when correctly and consistently used, family planning in developing countries have been shown to decrease the number of maternal deaths and also prevent more than half of all maternal deaths if full demand of birth control is met (Yeaky et al, 2009)).

Another study found that spacing children can reduce mortality among under-fives by 10% and among pregnant mothers by 32% (United Nations Family Planning Agency [UNFPA], n.d).

3. Reducing the number of abortions, especially, unsafe abortions. Effective and efficient utilization of family planning methods helps to prevent unintended pregnancies and inturn unsafe and frequent abortions among women and adolescents. This is because effectiveness in family planning services helps to close the gap in the unmet need for contraceptives and maximum achievement of reproductive health goals.
4. Prevention of Sexually Transmitted Infections (STIs), including HIV/AIDS. Improved access to condoms, both male and females, reduces the rate at which STIs, including HIV are spread. Moreover, to the extent that HIV-positive women are better able to prevent unplanned pregnancies and births, family planning services are also helpful in reducing the rate of new HIV infections. Resultantly, family planning is expedient in reducing the rate of infertility by addressing the problem of STIs and thus overall improvement in maternal and child health and nation at large.
5. Empowering women. Women who can control the number and timing of their children can take better advantage of educational, economic and career opportunities, improving their own future and that of their families by accumulating assets and investing more in their children's health and wellbeing. Apparently, this is possibly due to the time family planning affords them.

6. Promoting social and economic development and security. Family planning services and programmes help to reduce high population growth and promote countries' economic development in the face of competing resources. This is because expanding population would compete for limited resources such as food, housing, schools, jobs, etc. Hence, family planning allows couples to realize their full potentials, and the woman can better fulfill her roles as a wife, mother, wage earner and community member. While the man can better expand his roles as husband, father and family caregiver. All these go a long way in curtailing population explosion, reduce dependency ratio (youth), better the health indices for the country and improve socio-economic conditions. This will also assist Africa to make progress in achieving all the sustainable development goals (SDGs).
7. Protecting the environment. Family planning services help to slow the population growth rate, since rapidly growing population exacerbates environmental degradation and strains the world's resources.
8. It is worthy to mention, here, that there are a variety of health benefits that are associated with the use of individual family Planning commodities; for instance, pills, injectable and implants have been associated with protection the internal environment of women against uterine and ovarian cancers, benign cysts of the breast or ovaries and Pelvic Inflammatory Diseases (PIDs). Pills can also reduce menstrual flow and dysmenorrhea and decreased prevalence of iron deficiency

anaemia in women and in turn save men the economic cost of ensuring optimal health of the family.

Conclusively, the place of family planning in the health promotion of couples, families and development of nations' economies cannot be overstated. This is evident in the opportunities it affords couples to time/space pregnancies, determine the number of children to have and cater for, prevention of STIs and as well allowing for the preparation of optimal future health of the members of the family.

Challenges Faced by Family Planning

Despites the efforts made by government to control the world's population and improve the standard of living of their citizens through family planning services, a number of obstacles still limit the progress made in family planning in Nigeria and around the globe. According to Ouma, Turyasima, & Awor (2016) in African Medical Journal, these obstacles include:

1. Fear of the occurrence and management of side effects of family planning.
2. Fear of children dying less than five (5) years.
3. Lack of men's and community leaders' participation in family planning.
4. Lack of knowledge about family planning methods and use.
5. Myths and misconceptions about family planning methods.
6. Poor /inaccessible to and cost of utilizing family planning methods or services to mention but a few.

A number of men and even their spouses might be skeptical about the possible outcome of family planning methods with respect to the side effects such may present. This uncertainty may further cause fear and threat to the reproductive health of couples especially in developing countries where the survival and optimal health of mothers and infants/children are yet to be guaranteed. Such fear could be associated with poor knowledge, attitudes and low involvement of men in family planning programmes in the African region. These challenges could be a as a result of some unfounded traditional/regious misconceptions and beliefs surrounding family planning and further compounded by cost of accessing its services by members of the community, thus, impeding the effectiveness and efficiency of family planning services in Nigeria and African region at large.

According to Alhaji (2018), the following are highlighted as challenges to family planning in Africa:

i. Data collection and analysis are still problems coupled with weakened and dysfunctional health-care systems in virtually all countries across Africa. This makes monitoring and evaluation of programmes a challenging task.
ii. Persuading national governments to adjust their budgetary priorities to meet health requirements is one of the biggest challenges.
iii. Till date, there is still huge funding gaps as the health sector is heavily underfunded.
iv. There is a need for broader attention to ever-increasing reproductive health needs, including family planning of women especially the cohort of women coming into motherhood or childbearing age.

v. Studies in Sub-Sahara Africa and around the world reveal a near universal knowledge on contraceptive methods, yet the practice has shown the contrary. So, addressing all or some of these barriers responsible will significantly influence service uptake.

vi. Expanding family planning services in a variety of "right mix" of contraceptive commodity availability to the rural folk and hard-to-reach areas has still persisted and needs to be addressed.

vii. There is a need to link population pressure on both the built and natural environments to reproductive health interventions as a national policy to family planning service utilization.

viii. More research is needed on family planning: most studies are based on cross-sectional designs that cannot establish temporal sequence of cause and effect. Researches based on longitudinal data analysis methods or experiment or randomized control trial designs are needed to generate quality evidence that underscore important causal linkages between factors of interest and adolescent, maternal, child, family and population outcomes.

Conclusively, the challenges to family planning programmes are many, varied and require attention at the highest policy level in order to realize the huge demographic, socio-economic and development dividends of low fertility levels. This will also make Sustainable Development Goals (SDGs) achievable. Importantly, continued political will and support are prerequisite for sustainability and acceptance of family planning programme.

Family Planning Methods

Family planning methods or contraceptive are by definition, preventive methods to assist women avoid unwanted pregnancies. The last few decades have witnessed a contraceptive revolution, and advances in medical science have shown how to interfere with physiology of the reproduction-ovulation cycle.

According to the World Health Organization (2008), United States Agency for International Development (2019) and New Zealand Family Planning Agency (n.d.), the following classification and explanations of family planning methods and/or contraceptive are drawn. Thus, the methods of family planning can be categorized into:

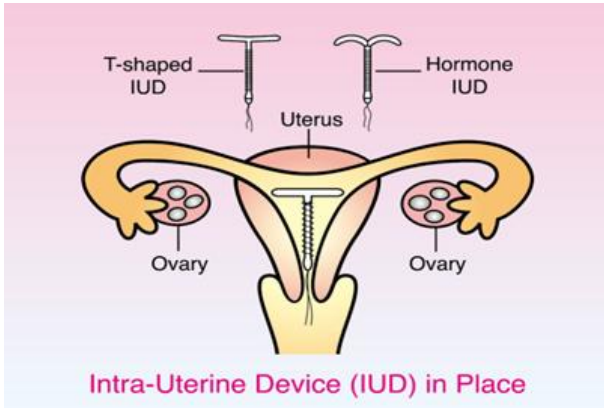
1. Long-Acting Reversible Contraception (LARC)-the implant or intra uterine device (IUD).
2. Hormonal Contraception - the pill or the Depo Provera injection.
3. Barrier Methods – Condoms (both male and female).
4. Emergency Contraception.
5. Fertility Awareness.
6. Permanent Contraception - Vasectomy and Tubal ligation.

1. **Long-Acting Reversible Contraception** (LARC): Long-acting reversible contraception method lasts for a long time.

Two Types of L.A.R.C.

(a). **The Intra Uterine Device**: The IUCD is a small device placed inside the uterus to prevent pregnancy. The commonly used IUCD are made of plastic wound with copper wire,

often in the shape of a T. There are also other types made of plastic alone, stainless steel alone, or hormone-releasing models which lasts for three, five or ten years.



I.U.C.D.

The hormones or the copper stop the sperm from reaching the egg. Sometimes, sperm does reach the egg (fertilization) so the IUD stops the egg from attaching to the wall of the uterus.

Advantages:

i. Long acting – it lasts for between 3 and 10 years depending on the type of IUD.

ii. Reversible – client (women) can choose to have it taken out at any time. After that, a woman will be able to get pregnant.

iii. High effectiveness – that is, it works very well.

iv. One does not a need a client to think about contraception every day.

v. Does not affect breastfeeding.

vi. Does not get in the way of sex.

vii. The copper IUD does not contain any hormones.

viii. The copper IUD can also be used as emergency contraception.

ix. The hormonal IUD has a very small amount of hormones and most people have no side effects from this.

x. The Mirena (a hormonal IUD) can help with period bleeding and pain, and most people will have light bleeding or no periods at all.

Disadvantages:

i. Some women may feel pain, cramps or dizziness when the IUD is put in or taken out. That is, there are some risks from having an IUD put in or inserted.

ii. There may be a small risk of infection when an IUD is put in.

iii. There is a very small risk of damage to the uterus (about 1 in 1000 people).

iv. A copper IUD might give you more bleeding and cramping during your period, but this usually gets better over time.

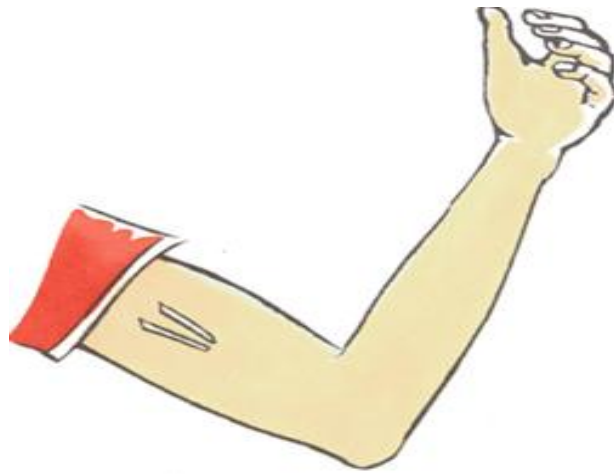
v. The copper IUD can cause an allergic reaction, but this is very rare.

vi. The hormonal IUD might give you irregular or light bleeding.

vii. The IUD can sometimes come out by itself (about 5% of all IUDs). You can check the threads are still in the right place at any time.

(b).**The implant**: The implant, also known as 'the rods', is a type of long-acting reversible contraception (L.A.R.C.) which lasts for five years. Once LARC has been inserted, an individual does need to take contraceptive every day or every month.

The implant is made up of two small rods the size of a matchstick. The rods are put under the skin in the inside of woman's arm by a family planning expert. They slowly release a hormone called progestogen which works for up to five years. A woman can have them taken out whenever she wants. The implant is shown below.



The Implant

Advantages

i. Long action – it lasts for up to five years.
ii. Reversible – one can choose to have it taken out at any time. After that, you will be able to get pregnant again.
iii. It is very effective –i.e., it works very well.
iv. A woman does not need to think about contraception every day.

Disadvantages

i. Implants might cause irregular periods or periods that last longer. This is quite common in the first 6 months but it can last as long as the implant is used. This can be annoying, but it is not harmful and the implant will still work. If the bleeding is a problem, an expert may recommend pills to help.

ii. A woman might have a sore or bruised arm after the implant is put in or taken out. There is a small risk of infection.

iii. Sometimes it is not easy for the nurse or doctor to find the implant in the woman.

LARCs are the most effective types of contraceptive. They are more than 99% effective at preventing pregnancy (New Zealand Family Planning Agency, n.d.).

2. **Hormonal Contraceptions**: These are contraceptives that use hormones to prevent pregnancy. Hormonal contraceptives include:

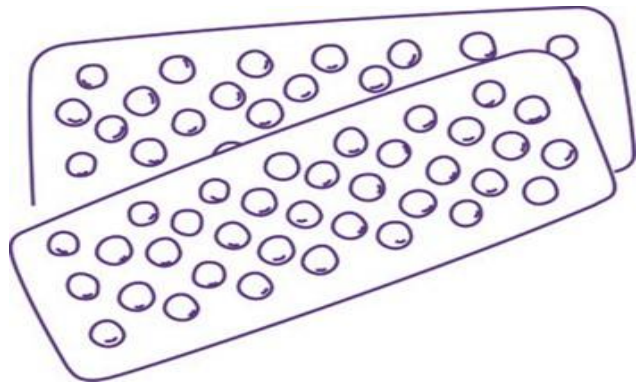
(a.) The Pill, and

(b.) the Depo Provera injection.

Two Types of Pill

(ai). **Combined Oral Contraceptive Pill**: It is a type of pill which as family planning client (woman) can take every day to prevent getting pregnant. The combined pill contains two hormones - oestrogen and progestogen. This pill is different from the progestogen-only pill.

The oestrogen and progestogen stop eggs developing, so no egg is released from the ovary. Hence, conception cannot occur.



Combined Oral Pill

Advantages;

i. The combined pills offer very high level of effectiveness.

ii. It is easy to use.

iii. Does not get in the way of sex.

iv. A woman can choose to have lighter, less cramps during periods or no period at all.

v. As soon as one stops taking the pill, one can get pregnant.

vi. It reduces your risk of ovarian and endometrial (lining of the uterus) cancer to a great extent.

vii. Some pills can help ti reduce pimples/acne.

Disadvantages;

i. A woman has to take it every day – even if one does not have sex that day.

ii. It might cause irregular bleeding in the first month or two.

iii. It might cause dark patches on your face.

(Aii) **The Progestogen only Pill**: The progestogen-only pill is a pill taken to prevent pregnancy. The progestogen-only pill contains one hormone – progestogen. It does not contain any oestrogen. Progestogen-only pills work mainly by thickening the mucus in the cervix so sperm cannot travel through it. They also change the lining of the uterus so it is less likely to accept a fertilized egg.

Progestogen-

OnlyPill

Advantages

i. The Progestogen-only Pill (P.O.P.) is easy to use – it is simple and convenient.

ii. It does not interfere with sexual intercourse.

iii. It does not affect breastfeeding.

iv. It can be used by women of any age.

v. There are only very few side effects.

Disadvantages

i. The pill must be taken every day whether a woman has sexual intercourse on that day or not.

ii. Some progestogen-only pills need to be taken at the same time every day. That makes it inconvenient.

iii. This pill may change a woman's periods. Some irregular bleeding for a few months after starting the pill may be observed. However, this does not mean the pill is less effective as long as a client has not missed pills.

B. **The Depo Provera**: Depo Provera is a contraceptive injection containing progestogen. It can also be called “the injection” or "the jab". The injection is given every 13 weeks.

Depo Provera prevents pregnancy by stopping the ovaries releasing an egg each month. There are also changes to the lining of the uterus (endometrium).

Depo Provera

Advantages

i. The Depo Provera is very effective and convenient.

ii. It lasts for 13 weeks.

iii. No daily pill taking.

iv. Does not interfere with sexual intercourse.

v. It reduces the risk of endometrial cancer (cancer of the lining of the uterus).

vi. Helps to reduce pain during heavy or painful periods.

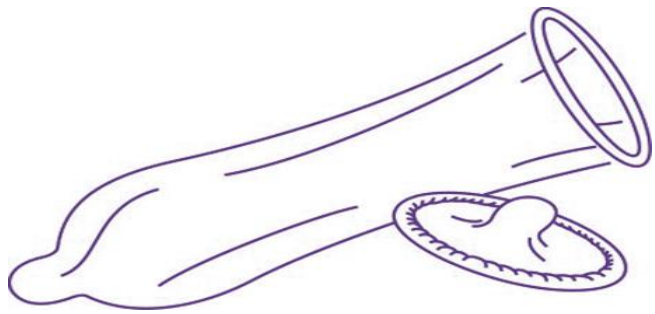
Disadvantages

i. Once a woman has had an injection of Depo-Provera, it lasts at least 13 weeks which can be a nuisance if a woman experiences a side effect.

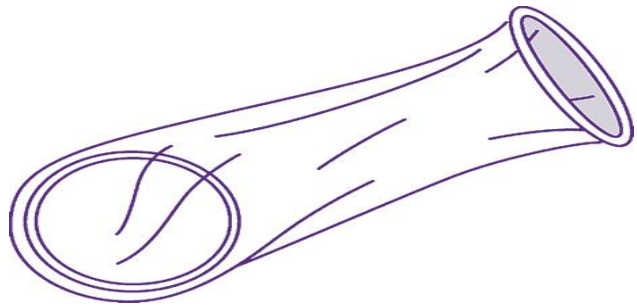
ii. It can cause irregular or longer-than-usual bleeding. This is more common when one starts to use Depo Provera, but often improves with time.

3. **Barrier Method**: Barrier methods stop sperm from entering the vagina. The two barrier methods are:

(a). **Male Condom** (AKA External Condom): A condom is a fine tube which is rolled on to the penis before sex. It is a barrier which prevents sperm and even infections from passing between sexual partners. It is usually made of rubber.

A Male Condom 

(b). **Female Condom** (or Internal Condom. A.K.A. FC2): The internal condom is used during intercourse to prevent pregnancy. It also reduces the risk of sexually transmitted infections (STIs). It is a tube with flexible rings at each end – one end is closed and the other is open.

Internal/female condom 

The internal condom is inserted deep into the vagina just before vaginal intercourse. The ring at the closed end holds the pouch in the vagina and the ring at the open end stays outside the vaginal opening during intercourse. It is removed by carefully pulling the outer ring immediately after sexual intercourse.

The FC2 is made from thin polyurethane which is twice as strong as the latex used for regular condoms and can be used as your regular method of contraception.

4. **Emergency Contraception**: Emergency contraception refers to methods of contraception that can be used to prevent pregnancy after sexual intercourse. These are recommended for use within 5 days but are more effective the sooner they are used after the act of intercourse.

Two Types of Emergency Contraceptive

(a) **The Emergency Contraceptive Pill (ECP)**: - The emergency contraceptive pill (ECP) is a pill that is taken after unprotected sex to prevent pregnancy. Examples if ECPs include Levonelle or ellaOne ("the morning' after pill)

The Emergency Contraceptive Pill:

i. Stops or delays the release of an egg from the ovaries until the sperm are not active in woman's body any more.
ii. Prevents the sperm from fertilizing an egg by changing the way the sperm moves in the woman's body.
iii. Does not work once the egg has been fertilized.
iv. Does not cause harm on a developing embryo.

NB: The ECP is not as effective as other contraceptive methods, does protect from sexually transmissible infections (STIs), and does from pregnancy for future sex, so it is unwise to use it as a regular method of contraception.

Emergency Contraceptive Pill (E.C.P.)

(b) **A Copper I. U. D** (Intra Uterine Device): The Copper IUD is a T-shaped plastic and copper device inserted by a family planning professional into the woman's uterus to effectively prevent pregnancy by stopping the egg implanting in the womb or being fertilized.

The Copper IUD is very effective and can be inserted up to 5days after unprotected sex, or up to 5days after the earliest time a woman could have ovulated to pregnancy. Noted that a couple can also choose to have the copper IUD left in the woman as an ongoing method of contraception.

5. **Fertility Awareness**: Fertility awareness is a contraception method which can be utilized by learning the signs of fertility during the menstrual cycle to help plan or avoid a pregnancy.

Fertility awareness is a method to plan or avoid a pregnancy by recognizing the signs of fertility in the menstrual cycle.

A graph to track a woman's fertility.

The method can be very effective if a woman can easily recognize the fertile phase and use the method correctly. Otherwise, pregnancy could set in.

It is important for a family planning client to know or understand her menstrual cycle (I.e., her ovulation/unsafe days and free/safe days), check cervical mucus, take body temperature, recognize other signs of her fertile phase so as to effective use the information to plan for a safe sexual intercourse with her spouse and avoid unintended pregnancy.

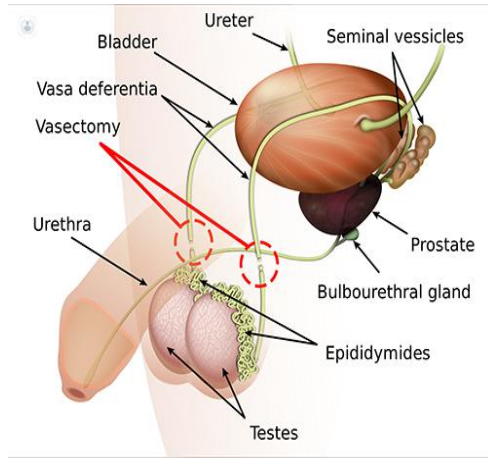
NB: While learning the fertility awareness method it is recommended for a woman not to have sex unless a condom is used. This is because activity could alter the discharge and physiology of her reproductive system.

6. **Permanent Contraception**: Permanent contraception, sometimes called sterilization, prevents all future pregnancies. It is very difficult or impossible to reverse. Permanent contraception is either a:

(a) Vasectomy, or

(b) tubal ligation.

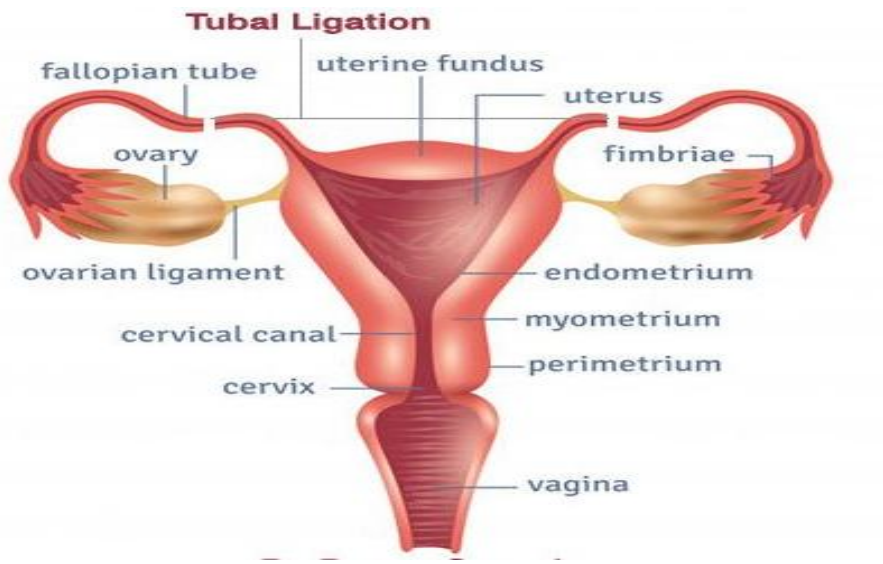
(a) **Vasectomy**: Vasectomy is a surgical procedure for male sterilization or permanent contraception. During the procedure, the male vasa deferentia are cut and tied or sealed so as to prevent sperm from entering into the urethra and thereby prevent fertilization of a female through sexual intercourse.



Vasectomy

After a vasectomy there are no sperm in the semen. The testicles still make sperm but they are absorbed by the body.

(b) **Tubal Ligation**: A tubal ligation (also known as 'having the fallopian tubes tied') is a procedure to close both fallopian tubes (in a woman) which means that sperm cannot get to an egg to fertilize it.



It is not always possible to reverse tubal ligation and the reversal procedure is not usually available in public hospitals. Decision should be carefully considered (never feel pressured) before undergoing tubal ligation.

Family Planning Methods Available for Men only

As part of the aforementioned and discussed family planning methods, basically, the following options are available for men alone.

1. Natural methods.

    i. Withdrawal method, and even

    ii. Abstinence.

2. Barrier Method; male condom, and

3. Vasectomy (also called sterilization), (Eka & Yohanes, 2018).

1. **Natural Methods**: Natural birth control is a method of preventing pregnancy without the use of medications or physical devices. These concepts are based on awareness and observations about the body. For men, natural birth control methods include:

i. **Withdrawal** (or Pulling Out) Method: It is also called “coitus interruptus” in Latin (Traci, 2020). According to Traci, withdrawal is one of the oldest and simplest forms of birth control, but one of the least effective. Here, the male partner pulls the penis out of the vagina just before ejaculation occurs.

The goal of the withdrawal method - also called "pulling out" - is to prevent sperm from entering the vagina (Mayo Foundation for Medical Education and Research, [MFMER], 2020).

Advantages

According to Nazario (2020), the pull-out method:

i. Has no side-effects or health risks.
ii. Costs nothing but merely consciousness of that introduces ejaculation.
iii. Does not interferes with sexual sensations, as optimal sexual sensation is guaranteed for a married couple.
iv. Is suitable when a couple do not want to use other types of birth control for religious, health or philosophical reasons.
v. Is suitable when they need some kind of birth control right away, and it is late to use other methods.
vi. Is suitable when couple do not have sex very often.

vii. Is free and convenient.

viii. Does not involve any hormones or other chemicals.

ix. Does not required one to see a doctor or get a prescription.

Disadvantages

Nazario (2020) asserts that pulling out method:

i. The withdrawal method does not protect partners from STDs.

ii. Is important, however, does not work only if it is done aright.

iii. It takes a lot of control for the man to pull out before ejaculation.

iv. The woman has no control over it at all.

v. The man may feel that pulling-out gets in the way of sexual pleasure.

vi. Even if the man urinates before sex, the man could still release fluid before they ejaculate. This pre-ejaculate (or pre - cum) does contain sperm

vii. **Abstinence**: According to Planned Parenthood Federation of America (2021), abstinence is simply not having sexual intercourse. If an adult male is abstinent, it means he decides not to have sex - this includes vaginal, oral and anal sex. Abstinence prevents pregnancy by not giving the opportunity for semen to enter the vagina. A sperm cannot fertilize an egg if there is not intercourse.

Abstinence works as an effective form of birth control by eliminating all chances of sperm fertilizing an egg. Unlike other forms of birth control that work to prevent pregnancy

regardless of the exchange of sexual fluids, abstinence prevents semen from coming into contact with the vagina.

Abstinence and outercourse are suggested as safe, effective, and free ways to prevent pregnancy. But some people have a hard time avoiding sex.

Advantages

According to Planned Parenthood Federation of America (2021) abstinence help adults and couples:

i. Wait until they feel ready for a sexual relationship.
ii. Wait to find the right partner.
iii. Enjoy their partner's company without having to deal with a sexual relationship.
iv. Focus on school, their job, or hobbies.
v. Follow their personal, moral, or religious beliefs and values.
vi. USE abstinence to get over a breakup.
vii. Heal from the death of a partner.
viii. Follow their doctor's advice during or after a sickness, infection, or medical procedure.

Disadvantages

According to Planned Parenthood Federation of America (2021):

i. While abstinence and outercourse are super-effective ways to prevent pregnancy and STDs, avoiding sex can be hard for some people. And if you plan on being abstinent

but end up having vaginal sex, pregnancy can happen if couples do not use birth control.

ii. Most people end up having sexual contact with another person at some point in their lives. That is why it is a good idea to always have a backup birth control plan, like keeping condoms around, as condoms are suggested as the only birth control method that also helps protect you from STDs.

Outercourse (which Abstinence allows) can have some disadvantages, too. Some types of outercourse can spread STDs - like anything that involves skin-to-skin genital touching or sharing sexual fluids. If semen gets on a vulva or in a vagina during outercourse, pregnancy can happen. Many adults find it hard to avoid vaginal sex when they are doing other sexual activities. Sometimes people who are planning to use outercourse to prevent pregnancy do not have a backup birth control method ready, just in case. If they get caught up in the heat of the moment and have unprotected sex, it can lead to pregnancy and spread STDs.

2. **Barrier Method**: Barrier contraceptives prevent sperm from entering a woman's uterus. For men barrier method refers to the male condom. Some condoms contain spermicides.

Spermicides may be used with condoms and other barrier contraceptives that do not already contain them as they are effective in killing sperms and thus preventing pregnancies.

i. **Male Condom**: According to Nazario (2020), a male condom is a thin, fitted tube worn over the penis during sex. Condoms can help prevent pregnancies and Sexually

Transmitted Infections (STIs). They create a barrier that keeps semen and other body fluids out of the vagina, rectum, or mouth. You might hear a condom called a rubber or the barrier method.

NB: According to World Health Organization (WHO). It is not advisable to use male and female condoms at the same time. One can stick to the other and pull it out of place or tear it. Only latex or polyurethane condoms kept in a cool and dry place that should be used. Condoms made with lambskin or different materials may not protect against HIV and other viruses.

How to Use male Condom:

The correct use of condom refers to application of male condom before vaginal penetration, preferably before any penile-vaginal contact must not be compromised on the ground of sexual urge. On application, the tip of the condom must be pressed to release trapped air and consequently provide space for semen (Chaudhury, Bhattacharyya , Guha, 200).

According the Guha, the following guidelines on the use of male condom are necessary.

ii. Avoid carrying condoms in your wallet, where heat and friction could damage them.
iii. Check the expiration date on the wrapper to be sure the condom is not too old. Use
iv. lubricants that are water- or silicone-based. They are less likely to break the condom than those with oil. It is also important to follow these steps when you put on and take off a condom.

v. Place the condom on the head of erect penis. Pinch out any air that may be trapped in the tip, and leave a little space there for semen.

vi. Unroll the condom all the way to the base of the erect penis.

vii. For men who are not circumcised, their foreskin should be pulled back before before sliding down the condom.

viii. Upon the completing intercourse, grab the base of the penis and hold the condom in place while it is pull out.

ix. Properly dispose the condom.

3. **Vasectomy**: Vasectomy is also known as "male sterilization". In this method, a surgeon professionally cuts and seals off the tubes that sperm pass through to reach the testicles. It is the most effective birth control option for men, as only about 15 out of 10,000 couples get pregnant in the year after a man has the surgery (Traci, 2020).

Vasectomy is a procedure in which the vas deferens are divided and ligated so as to prevent flow of sperm from testis. This is an outpatient procedure, conducted with local anesthesia with minimal side effects. Following vasectomies, pregnancy rates drop to below 1%, however, reversibility rates after vasectomy is less than 50% and there is no effect on libido (Guha, 2007). Vasectomy does not depend on the occurrence of intercourse, but has poor reversibility rates and is therefore not ideal for men who still plan on having children (Matthew & Bantwal, 2012; Nya-Ngatchou & Amory, 2013; & Yapar & Inal, 2012).

Male Contraceptives (On-going Development)

Long term, reversible male contraceptives are currently being developed. Male contraceptives are aimed to interfere with normal spermatogenesis (production of sperm), or motility, orientation, and binding of spermatozoon (male reproductive gamete) to ovum - female reproductive gamete (Eka & Yohanes, 2015).

Thus, this study reviews previous studies on the on-going male contraceptives to give a general picture of the possibilities of the current and/or future contraception methods of family planning available for men, as a way of positively influencing their knowledge, attitudes and behaviour towards family planning.

According to Matthew and Bantwal (2012), in "Indian Journal of Endocrinology"; Nya-Ngatchou and Amory (2013) in "New Approaches to Male Hormonal Contraception"; and Yapar and Inal (2012) in "Tropical Journal of Pharmaceutical Research", the following are ongoing studied men contraceptives.

i. **Reversible Inhibition of Sperm Under Guidance (RISUG):** RISUG is a method of contraception directed at destruction of sperm as it passes through the vas deferens.

   RISUG is applied by injection of steric maleic anhydride (SMA) and dimethyl sulfoxide (DMSO) into the vas deferens. Within the next 72 hours, RISUG forms electrically charged precipitates in the lumen, with positive charges dominating (Guha, 2007). This forms an acidic environment. The precipitate then layers the lumen wall, implanting themselves on the micro-folds on the vas deferens' inner

walls. Sperm that pass through the RISUG injected vas deferens, suffer ionic and pH stress, causing acrosomal damage, rendering them unable to fertilize oocytes (Chaudhury, Bhattacharyya, & Guha, 2004; Sharma, Chaudhury, Jagannathan, & Guha, 2001).

Studies so far have shown RISUG to be 100% effective as this is due to the time needed for action (Sharma, Chaudhury, Jagannathan, & Guha, 2001). However, condom use is suggested to be use in the first 10 days after injection.

RISUG can be flushed out with intra-vasal injections which will reverse its infertility effects, as has been shown in mice, although reversibility testing in humans has not been performed (Jha, & Guha, 2009).

There has been no serious side effect within 10 years after RISUG injections in humans. Scrotal swelling may occur after injection, but resolves on its own. A study that studied RISUG's side effects on the prostate found that there was no increased risk of developing prostatic diseases even after a period of 8 years (Jha & Guha, 2009).

Smart RISUG and has been shown to give better spermicidal action in vitro and in vivo in rats. Copper has been known to displace molecules such as zinc from sperm membrane, decreasing their potential to fertilize. However, studies need to be conducted on toxicity of this new drug before application on humans (Jha & Guha, 2009).

ii. **Ultrasound Method**: According to a 10man research team; Tsuruta et al (2012), this contraception method refers to the application of low intensity ultrasound to the scrotum to elevate tissue temperatures in the testes. Spermatogenesis (i.e. production of sperm) cannot occur in normal body temperature, which is why the human testes are suspended in the scrotal sack with a network of blood vessels to allow for cooling. Studies show that heat stress on the testes lead to apoptosis (programmed cell death) of germ cells (VandeVoor & Tollner, 2012). In the past, local application of heat to the testes, such as immersing in a hot bath, has been used as a method of contraception available for men (Matthew & Bantwal, 2012).

Intensity of ultrasound required to cause infertility depended on testes size (VandeVoort & Tollner, 2012). Heat treatment during therapy by dipping scrotum in 37°C water or saline increased ultrasound potential as seen in rats and monkeys. There are no side effects noted in ultrasound treatments, however there is concern that heat treatment may cause DNA (Deoxyribonucleic Acid) damage in consecutive sperm productions (Tsuruta et al, 2012).

iii. **Vaccines**: Contraceptive vaccines are developed under the concept of targeting sperm specific antigens (Naz, 2011; Matthew & Bantwal, 2012). Vaccination with these sperm antigens (recombinant/synthetic peptide/DNA) has been found to cause reversible contraceptive effects in animals through formation of systemic and local anti-sperm antibody responses. The sperm antigens which have been examined for contraceptive effect include: FA-1, YLP12, LDH-C4, P10G, A9D, SP56, 80

kDaHSA, Eppin, and Izumo. Eppin is a protein secreted by the epididymis for sperm maturation (Matthew & Bantwal, 2012). It is found on sperm surface and aids in fertilization. The vaccinated subjects (men) produce antibodies against Eppin molecules, thus impairing sperm maturation and its capability to fertilize (Naz, 2011; & Karande, 2004).

Studies are being conducted to improve safety, efficacy and reversibility before application in humans (Karande, 2004).

iv. **Indenopyridines**: CDB-4022, an indenopyridine, is being studied as a potential oral contraceptive for men (Koduri, Hild, Pessaint, Reel, & Attardi, 2008). This compound was found to affect sertoli and germ cells, causing alterations in sertoli-germ cell junctions and causing apoptosis (programmed death) of germ cells in rats. It causes irreversible azoospermia in rats, but reversible oligospermia in monkeys. There are no changes to serum Leutinizing Hormone and Testosterone levels, but increased levels of Folicle Stimulating Hormine attributed to reduction of inhibin B caused by destruction of germ cells (Mok, Mruk, Lie, Lui, & Cheng, 2011).

v. Adjudin: Adjudin is derived from an anticancer drug, lonidamine. Lonidamine was found to be anti-spermatogenic, thereby causing infertility. However, it also caused several side effects such as muscular pain, testicular pain, and liver damage. To attain the anti-fertility functions without the toxicity, Adjudin was developed and it targets adherence junctions between Sertoli cells and spermatids, causing early

spermiation [release of sperm from production site] (Koduri, Hild, Pessaint, Reel, & Attardi, 2008).

A study conducted by Wang, Chen, Wang, Mao, Zhou, and Sha (2010) to assess the possibility of adjudin to be as a spermicide, In-vitro evaluation showed that adjudin was found to significantly limit sperm motility and viability by targeting sperm mitochondria (Wang et al., 2010).

vi. **Gamendazole**: Gamendazole is also derived from ionidamine. From from studies, it can be used to achieve infertility in men (Tash, Attardi, Hild, Chakrasali, Jakkaraj, George, 2008; & Tash, Chakrasali, Jakkaraj, Hughes, Smith, & Hornbaker, 2008). Their findings show that gamendazole presents no noticeable side effects, but it offers high level of infertility with reversibility in mammals although human trials are still pending (Tach et al, 2008).

vii. **Gandarusa**: Gandarusa is derived from the plant Justicia gendarussa, which has been used by many tribes in eastern Indonesia as a contraceptive medicine. The roots and leaves are boiled in water and the water is then consumed twice a month to elicit contraceptive effects. This plant is also used as herbal medication for pain and inflammation. Gandarusa has since been standardized and is now available in pill form (Yapar & Inal, 2012).

According to Yepar and Inal, Gandarusa was found to affect spermatogenesis in rats as well as human. The proposed mechanism of Gandarusa is weakening of the

sperm's hyaluronidase activities required for penetration of sperm into ovum, thus preventing fertilization. Animal studies have shown no liver or kidney toxicities. This drug is currently undergoing clinical trials. There is no available data on efficacy of gandarusa as a contraceptive in humans, as well as reversibility rates and effects on libido.

viii. **Testosterone Alone Men Contraceptive**: Oral preparations of testosterone that are safe for consumption are not readily available. Long-acting injections and implants are being developed as alternatives. Testosterone gel and patches are under development. However, they are costly and require frequent application thus making them unaffordable as a commercial contraceptive for men (Prajogo, Ifadotunnikmah, Febriyanti & Jusak & Efek, 2008).

Common side effects of testosterone are acne, oily skin, mood changes, increased hemoglobin, weight gain, decreased testicular volume, gynecomastia, and dyslipidemia. Long term effects of testosterone supplementation on the prostate are still unclear. Other considerations in using testosterone preparations are the possible misuse as anabolic steroids (Yapar & Inal, 2012).

ix. **Testosterone Enanthate (TE):** Testosterone Enanthate is a long acting hormonal male contraceptive that requires weekly administration through intramuscular injections (Nieschlag, Kumar & Sitruk-Wareb, 2013).

A study by WHO. shows that TE can be effectively used alone as a contraceptive; with 0.8% failure rate. While reversibility was reported to be 100% within an

average of 4 months after discontinuation, it is reversible after cessation of use and side effects are minimal.

x. **α-Methyl-19-Nortestosterone (MENT)**: MENT is a synthetic androgen five times more potent than testosterone (Yapar & Inal, 2012; Nieschlag, Kumar & Sitruk-Wareb, 2013). MENT was developed to replace testosterone for contraceptive use because of the large amount of testosterone required to achieve long term infertility. However, substituting testosterone with MENT leads to a decrease in bone density.

Yapar (2012) and Nieschlage et al (2013) reported that MENT has been introduced in implant form as a contraceptive for males and has been found to cause azoospermia in two thirds of men receiving it. To improve its efficacy researchers combined it with etonogestrel implants and levonorgestrel implants. Results were the same as with MENT alone. In addition, men receiving MENT and etonogestrel experienced loss of libido. Researches are continuously being conducted on a form of dosing that will attain a higher rate of azoospermia with minimal side effects.

xi. **Combination Therapy Male Contraceptive**: There have been several researches, combining various progestins with androgens for male contraceptive. Among them are:

a. Depot medroxyprogesterone acetate (DMPA) + TE [efficacy 98%] (Yapar, & Inal, 2012).

b. Antiandrogenic Progestogen Cyproterone Acetate (CPA) + TE [Yapar, & Inal, 2012].
c. Androgenic progestin Norethisterone (NET) + TU (efficacy 92%) [Yapar, & Inal, 2012].
d. Oral Levonorgestrel (LNG) + testosterone patches (efficacy < 60%) [Yapar, & Inal, 201].
e. Synthetic progestin Desogestrel (DSG) + TE (efficacy 100%) [Yapar E.A., & Inal O., 2012].
f. MENT implant + Jadelle implant (efficacy < 60%) [Nieschlag, & Kumar, 2013].

NB: Data on reversibility and effect on libido, of these tested regiments were not found on the literature.

Conclusively, the world's population has been growing exponentially in the recent decades and expected to reach 9 billion in 2050 (Matthew & Bantwal 2012). Considering the current difficulties in managing health and poverty associated with high population growth, contraception is becoming increasingly important (Matthew & Bantwal, 2012; & Nya-Ngatchou & Amory, 2013). Contraception is the intentional prevention of conception or pregnancy by various methods; barrier methods, hormonal contraception, intrauterine devices, sterilization and behavioral methods (i.e. natural method). Of these methods, only two (3) are available for men, the male condom (barrier), and vasectomy (sterilization). The

male condom is an effective method of contraception with the added benefit of prevention of STIs, however, relies on discipline, availability and accessibility of condom at the time of intercourse. Vasectomy does effectively prevent conception, but has poor reversibility rates and is therefore not ideal for men who still plan on having children (Matthew & Bantwal 2012; Yapar, & Inal, 2012; Chaudhury, Bhattacharyya & Guha, 2004).

Factors affecting Knowledge, Attidude and Family Planning Behaviours of Men

Men's knowledge, attitude and family planning behaviors are influenced by several factors which include socio-economic factors, socio-cultural factors, religious factor, certain myths and misconceptions to mention but a few.

Socio-economic Factors and Family Planning Behaviours of men

Socio-economic factor may be referred to as characteristics that affect men's socio-economic status and inturn influence their knowledge, attitudes and family planning behaviours. These factors include; education, income level, employment, location, etc. They influence men's perceptions, beliefs, attitudes and ability to make healthy family planning choices that facilitate the adoption of beneficial family planning behaviours.

With industrialization, men have better **economic opportunities** and social security. Thus, aggravating living conditions, taking more roles in work life, acquisition of family planning knowledge and navigation of family planning programme reduce their desire to have many children. On the contrary, men, especially rural dwellers, with low socioeconomic

(education, income, employment, etc.) status tend to be less engaged with work and thus likely to have more interest in their wives and the desire to have many children. A study by Nazli et al (2018) indicates that men have an important role in the socioeconomic progress of their families especially their spouses. Thus, when designing social sex-based policies, ignoring men increases both their ineffectiveness and inequality with respect to family planning. That is to say that the use of family planning methods in developing countries is associated with socioeconomic status and other relevant factors affecting men.

Men's **educational** level has a great influence on many aspects of health and is one of the most commonly studied determinants of their knowledge, attitudes and utilization of family planning services. Men's attitudes toward family planning are influenced by experiences such as education. As the level of education increases, the number of children required decreases (Mosher, Martinez, Chandra, Abma & Willson, 2002). According to Mosher et al (2002), women whose spouses had a primary school or higher education, had 1- 3 pregnancies and did not want more children in the future, were found to get higher scores on the family planning attitude scale. It was further identified that the collective decision by couples on the use of effective modern methods, intrauterine devices and oral contraceptives, increased as the education level and socioeconomic status of the men and their spouses women improved. The reason for this can be explained by the opportunity to learn about family planning and to raise awareness about the issue, which education affords men and their spouses.

In societies with high levels of education and socioeconomic status, marriage, pregnancy and childbearing age occur at a later stage and therefore the need for contraceptive methods increases. Thus, using contraceptive or family planning methods by couples prevent advanced pregnancies and high fertility. As the interval between births increases, the number of high-risk pregnancies decreases and maternal mortality declines. Additionally, failure rate of contraceptive methods is reduced by informed couples, where audiovisual media also play an important role in information provision and in creating awareness.

Location creates a large difference in the knowledge, attitudes and family planning behaviours of men. Men's perception, beliefs, feelings, choices and involvement in family planning is largely influenced by their level of development, as well as, what is obtainable where they live. The results of a study support that social factors such as place of residence, affect the contraceptive utilization patterns. A study showed that the use of contraceptives was much lower in less developed countries (40%), and was especially low in Africa (33%). Furthermore, among other large geographical regions, the use of contraceptives increased significantly in 2015 from 59% in Oceania to 75% in North America (UNDP, 2015). Hence, place of residence has an impact on the use of contraceptive, and may be higher in urban areas than in rural areas. The factors revealing these differences are better availability of social services such as education, access to health services, information and family planning services.

Another study showed that utilization of family planning methods was found more among couples of age group 30 or more, educational level up to high school and above and those of

higher socioeconomic status whereas their residential area (urban or rural) was not found an influencing factor on practice of family planning by them. The study showed that most of the couples, both in urban and rural area, were willing to adopt a family planning method in future. When comparing modern and traditional methods, the difference between the preferences of future family planning methods between urban and rural areas was statistically significant. Conservative use of the condom in rural areas (44.6%) and modern methods in urban areas (32.3%) seem to be at the highest level of future use preferences. The study also revealed a good knowledge and favorable attitude toward future use of family planning methods (Vasundhara, Uday, Vinita & Shally, 2012).

Socio-cultural Factors and Family Planning

Sociocultural factors are the larger scale forces within cultures and societies that affect the thoughts, feeling, believes and behaviours of individuals. Sociocultural factors are also associated with the knowledge, attitudes and family planning behaviours of men.

In every cultural group events such as coitus, pregnancy and birth show differences. In a society, appropriate conditions for fertility and bringing the child to the world, pregnancy, how birth will be, what the prenatal and postnatal care standards are, the 'birth culture', etc are taught from generation to other generations. These, cultural and societal norms, values, beliefs and expectations further influence the knowledge, attitudes and behaviours of men

towards family planning. A study by Wright (2011) indicates that family structure, gender roles, beliefs of society, marriage models (polygamy, same place, same family marriage, relatives marriage, etc.), sexual behaviors (premarital, out-of-marriage relationships, marriage prohibitions, etc.), using or not using contraceptive or family planning methods vary from community to community , and the ban of some contraceptive methods in that society, opinion about abortions, concerns about using several contraceptive methods, population policies, religion, the idea of sin, traditional practices, etc, all of which are among the most important factors influence an individual's knowledge, attitudes and family planning behaviours.

Reproduction is a dual commitment, but in most of the world it is often seen as the responsibility of women entirely, and many family planning programs have focused mainly on women. Men are often described as forgotten reproductive health clients in family planning services.

Gender indicates the characteristics, positions and roles of man and woman in all social relationships. Gender norms, beliefs and expectations influence men's views, knowledge, attitudes to behave in a stereotypically more masculine ways toward family planning. But in most studies on family planning, women are usually on the front line of factors that affect outcomes (Nazli et al, 2018). However, the role of men in the family has made population planners to receive more interest in recent years as they begin to notice the importance of male influence on reproductive decisions around the world. Up to this point, many activities are in the effort to determine or develop the knowledge, attitudes and corresponding

behaviours of men toward family planning. While men play a direct and major role in deciding contraceptives, they play an indirect role as a dominant factor in women's economic, social and family needs. The role of men in decision-making on women's fertility and birth is always dominant especially in the patriarchal and patrimonial society like Africa where major decisions in the family are on the man raising many children (especially males) is seen as prestige.

The **ages** of couples (men and their spouses) plays an important role in the process of deciding when women will start and finish the process of giving birth and how long to wait after the birth of the next child. These decisions reflect their perceptions, feeelings/attitudes and in turn influence their family planning behaviours. Moreso, the use of family planning method varies according to the ages of couples. As a couple (husband and wife) get older, their need for contraception and the rate of contraception decreases as this could be accrued to changes in body hormones, interests and life experiences (Vasundhara, Uday, Vinita & Shally, 2012). In a study, it was demonstrated that younger couples, often have a stronger fertility desire than older couples. In the study, 26% of the men aged 20 to 35 wanted another child with their wives aged 15 to 30 within 2 years compared to 16% among men aged 35 to 50 with their wives 30 to 40 (Asiimwe, Ndugga, Mushomi, Ntozi, 2014). Thus, the use of pills and condoms are preferred more when the average age is lower. No wonder when the contraceptive use of married and fertile couples was examined according to their age, it is observed that middle-aged couples tend to use the family planning method more than younger and older ones (Esselman, 2016).

Religious Factor

Religious factor refers to a person's belief system, faith and conviction in the supernatural or a deity. Religion is highly associated with the kind of knowledge man gains. This influences his attitudes and corresponding family planning behaviours. Having a strong religious identity affects willingness of men to discuss family planning with their partners/families/communities and an unwillingness to consider accessing it and eventually using it. Similarly, the institutionalized religious doctrines intersect with cultural beliefs in a society which bestows man as the overall head of the house and, such beliefs are inherently subsumed in a patriarchal structure, where women have been relegated as a weaker gender and could only measure their freedom of choice within the acceptable framework. Apparently, men whose religions hold that the essence of marriage is for procreation (which is a divine instruction) would likely not engage in adoption of family planning methods. Unlike others whose belief-system permits the utilization of family planning.

Conclusively, a number of factors affect the knowledge, attitudes and family planning behaviours of men. These factors revolve round social, economic, cultural and religious aspects of men.

Knowledge of Men on Family Planning

The feelings, perception and beliefs of men are a function of their knowledge, which inturn influence their involvement and behaviours toward family planning and reproductive health at large. Knowledge of family planning may be referred to as the awareness which

underpins a way of thinking and living that is adopted voluntarily to serve as bedrock of attitudes and responsible family planning behaviours. Hence the effectiveness and efficiency of family planning programmes on men is largely dependent on filling the lacuna in men's knowledge of family planning through rigorous research. No wonder relevant knowledge serves as the foundation of health education which helps to persuade the development of healthy attitudes and adoption of beneficial behaviours toward family planning.

Knowledge of family planning encapsulates the meaning, methods, benefits and challenges of family planning. Men's knowledge of family is key to the success of family planning programmes, reproductive health of couples and achievement of Sustainable Development Goals at large. Men need information about contraceptive methods for women as well as about those for men. Well-informed or knowledgeable men can use a method themselves or support their partners in using a method. They can also talk with their wives and cooperate in assessing their needs and choosing a family planning method. Hence, WHO (2012) documented that men's general knowledge and attitude concerning the ideal family size, gender preference of children, ideal spacing between child births, and contraceptive methods used greatly influence women's preferences and opinions.

Several studies have assessed men's knowledge or awareness of family planning in Nigeria. A study by Ijadunola, Abiona, Ijadunola, Afolabi, Esimai & OlaOlorun (2010) in African Journal or Reproducive Health reported that almost (99%) of men were aware of the existence of modern contraceptives, and most of them were aware of at least two modern methods. Another study further buttressed that most men have knowledge of family

planning, with the awareness of the condom (98%) being the highest, as the most popular source of information about family planning among them was the radio (Orji & Onwudiegwu, African Medical Journal, 2008). These, corroborates earlier study by Lawoyin et al (2002) in African Medical Journal that men's knowledge was high for any family planning and any modern family planning method (90.9% and 73.3%). They further suggested that men who used family planning were likely to have high formal education. Meanwhile, condom was identified as the most utilized but traditional methods of unproven efficacy. On the contrary, Lawoyin et al argued that current use of contraceptives by males in rural community was lower than what was generally reported for the country and the southwest region. No wonder Odu, Ijadunola Komolafe & Adebimpe (2006) concluded from the report of cross-sectional survey that Men's Knowledge of family planning in suburban and rural Nigeria is still poor or limited despite a global move to increase the involvement of men in reproductive health matters. This, they suggested could be further improved when child survival is assured and when there is an improvement in the general level of education in the community.

According to a study conducted by Orji & Onwudiegwu (2008), the results showed a high level of awareness of family planning among men in both study groups (98.3% rural and 98.4% urban). This contrasts with the generally held belief that men are opposed to family planning. The condom was also the most commonly known and used method with a majority among urban (81.1%) over rural men (69.4%). Pertinent to the foregoing, men are seen to have a high knowledge of family planning. Hence, efforts should be made to sustain

and further increase their knowledge so that they can inturn develop positive attitudes and behaviours towards family planning.

Attitudes of Men toward Family Planning

Attitudes may be defined as can be defined as a learned predisposition, opinion, tendency or feeling which makes an individual to act in a particular way towards an object, thing, event or situation. Apparently, negative attitudes culminate in detrimental behaviour, whereas, positive attitudes supports the development of beneficial behaviours. Changing and improving the attitudes of men toward family planning and reproductive health can also have a positive impact on women's, men's, and children's health. In this regard, the attitudes of men toward family planning influence the kind of family planning knowledge they desire to acquire and inturn influence the kind of behaviour they exhibit toward family planning.

In a study conducted by Lawoyin et al (2002), it was found that men's attitude was generally positive. Nearly half (47.3%) of respondents reported that they made, and are willing to continue making family planning decisions with their spouses, though the larger majority thought it was the wife's responsibility to go for family planning. A later study by Orji & Onwudiegwu (2008), reported that most men in urban and rural areas believe that a decision about family planning should be made jointly by the spouses instead of being the prerogative of either. The study indicated that many men were willing to use family planning if their wives demanded it. On the contrary, however, most respondents in both the

rural and urban araes believed that men should not accompany their wives to the family planning centre to obtain contraceptive supplies and advice.

In a cross-sectional studies conducted by Peter, Ebenezer & Ayotunde (2008) that many men appeared ready to change their reproductive behavior and are willing to participate more in family planning and reproductive health activities at large. However, some, for certain reasons (e.g., health concerns, side effects, or want of children) oppose such participation. According to when the respondents were asked if they approved or disapproved of the statement that "many couples should do something to delay or prevent a pregnancy so that they can have just the number of children that they want and have them when they want them." Approximately 63% of the men gave consent to the use of family planning.

Interestingly, a study by Cleland, Ndugwa & Zulu (2011) on men′s opinions about their roles in family planning decision making found that generally, more male respondents disagreed than agreed that men should make decisions about selected family planning issues in the family. From the study 40% of men agreed that men should determine family size while 54% disagreed; 29% agreed that men should make the decision about when to adopt family planning while 69% disagreed; 09% of men agreed that men should decide which family planning method to adopt while 88% disagreed; 34% of men agreed that men should decide what to do about an unwanted pregnancy while 64% disagreed. These findings further confirms the earlier study by Orji & Onwudiegwu (2008), that In Nigeria, consistently, less than a quarter of men individually are willing to initiate discussions on

such issues as when to achieve pregnancy, when to avoid pregnancy, and the use of contraceptives with their wives. They concluded that men have poor poor attitude toward family planning and recommended an intensive drive at a community based adult reproductive health education among others.

Conclusively, while some scholars view the attitudes of men to be positive, a number of others claim that the attitudes of men toward family planning are generally poor. However, men may be highly motivated toward involvement in family planning through inter-spousal communication, health education and counseling. These would go a long way to clear their fears and further develop in them positive attitudes which support beneficial family planning behaviours.

Family Planning Behaviours of Men, and the Relationship with Knowledge and Attitudes

Behaviour may be referred to as a recurrent or consistent way of thinking and acting towards a given situation, event or others. Thus, family planning behaviour may be seen as any activity undertaken for the purpose of preventing or spacing pregnancy, prevention of transmission of STIs in marriage and the achievement of the desired number of children.

The reproductive health of men is largely dependent on their choices and family planning behaviours. These choices and behaviours are inturn a function of an individual's knowledge (perception, thoughts, opinions, etc) and attitudes (learned disposition; feelings, beliefs, etc.) to act in a particular way. Conversely, men's behaviour exhibited goes a long way to affect what they are interested in, the kind of knowledge they acquire and furthermore, the attitudes they develop. Hence, a number of research strive to ascertain men's family planning behaviours in an attempt to influence them for an improved knowledge and attitudes necessary for positive behavioural outcomes in their reproductive health and population control.

i. Behaviour of Men toward Spousal Communication

Lawoyin et al (2002) reported in a study that nearly half (47.3%) of respondents (men) agreed that they made family planning decisions with their spouses, though the larger majority thought it was the wife's responsibility to go for family planning. Among the men, 55.7% had ever used, while 26.7% were current users of any method. High level of formal education and duration of marriage (10 years and longer) were predictive of ever-used of a family planning method while having fewer than 5 surviving children negatively affected the use of family planning methods.

The cross-sectional study conducted by Peter, Ebenezer & Ayotunde (2009), highlighted the relevance of spousal communication on family planning behaviours of men. Data for the study were obtained from a survey carried out in three states,

Oyo, Osun, and Ondo. The results indicate that men show positive family planning behaviours when engaged in effective spousal communication with their wives. Suffice it say that spousal communication was seen to a motivating factor for positive family planning behaviours in men. That is to say, men have a significant role to play in the adoption of positive family planning behaviour. From the study, about 37% of the respondents reported joint decision making on when to have another child, 40.8% on whether to stop having children, and 44% on what to do to stop childbearing.

In another study, conducted by Marius, Christine, & Carine (2014), with the objectives of assessing men's knowledge, attitude, and practice of spousal communication about family planning decision making, findings showed that in Nigeria, consistently, less than a quarter of men individually initiated discussions on such issues as when to achieve pregnancy, when to avoid pregnancy, and the use of contraceptives in the year prior to the study. Similarly, 78% of them were reported to approve that decisions were generally taken jointly with wife, while 21% felt that all decisions related to family planning should be taken by wives alone. Interestingly, it was noted that another 12% of men reported that elder family members and relatives, external power should decide.

It was concluded that communication between a husband and wife on family planning matters was also recognized as a motivating knowledge-exchange factor that triggers the development of positive attitudes which favour the development of

beneficial family planning behaviours of men. They further explain that many men to family planning showed readiness (attitude) to change their reproductive behaviours and were willing to participate more in reproductive health activities. However, some, for certain reasons (e.g., health concerns, side effects, or want of children) may oppose such participation.

ii. **Practice of Self-Use and Approval of Spousal Use of Family Planning**: In an attempt to ascertain family planning behaviours of men towards self/spousal use of family planning, three studies were employed in Nigeria (DeRose, Dodoo; Alex & Tom, 2004).). The results showed that in Nigeria, 89% of men approved of their spouses using family planning while only 11% of them objected to it. However, almost two-thirds (65%) of the men disapproved of attending family planning clinics with their spouses, while only 26% of them had ever done so. In general, only 4 out of 811 men were reported to have ever used family planning methods. Male respondents were asked specifically whether they would support their wives to use family planning. While 751 (93%) answered positively among the 811 male respondents, 22 (3%) negatively. The studies showed that majority of men who approve of their wives' use of family planning were educated. Hence, advancement in knowledge could be related to development of positive family planning attitudes that influence the development of benefit family planning behaviours.

iii. **Men's Opinions about their Roles in Family Planning Decision Making**: from a study by Marius et al (2014), the results revealed that, generally, more male respondents disagreed than those who agreed that men should make decisions about selected family planning issues in the family. 44% of men were reported to agree that men should determine family size while 54% disagreed; 29% agreed that men should make the decision about when to adopt family planning while 69% disagreed; 9% of men agreed that men should decide which family planning method to adopt while 88% disagreed; 34% of men agreed that men should decide what to do about an unwanted pregnancy while 64% disagreed.

Generally, it was concluded that more male respondents disagreed than agreed that men should make decisions about selected family planning issues in the family. Decision-making dynamics around method choice followed a slightly different pattern. Therefore, health education campaigns to improve beliefs and attitudes of men were suggested. Additionally, improving accessibility, affordability, availability, accommodation and acceptability of family planning service were suggested to positively influence the knowledge, attitudes and family planning behaviours of men.

iv. **Knowledge of and Attitude towards Family Planning Behaviours of men** A cross-sectional survey conducted by Odu, Ijadunola, Komolafe, & Adebimpe (2006) aimed at determining men's knowledge of and attitude to family planning ina sub-urban community on the outskirts of Ilorin, Nigeria revealed that the knowledge of respondent was high. Whereas their attitudes towards family planning was also

relatively poor (which corroborates several of the above reviewed literature), as only a moderate proportion of men supported the family planning concept (52.7%) and the Nigerian Population Policy (54.8%) of "four children to a woman". Some 54.8% of respondents were in support of men discussing about family planning with their spouses. The major reasons for non-approval of family planning by men were the fear of side-effects (70.4%) and perception of family planning as being against religion (52.1%). The predictors of poor family planning attitude were not having formal education, practice of polygyny and to a lesser extent being a Muslim. Odu et al (2006) concluded that, men showed poor attitude to family planning and an intensive drive at a community-based adult reproductive health education was advocated among other recommendations.

Another study argued that family planning behaviours of men was relatively positive, unlike previously-highlighted studies. According to them, nearly half (47.3%) of respondents reported that they made family planning decisions with their spouses, though the larger majority thought it was the wife's responsibility to go for family planning. Among the men, 55.7% had ever used, while 26.7% were current users of any method (Lawoyin et al, 2002).

Lawoyin et al (2002) therefore concluded that current users of any family planning method were likely to be men with high formal education and with two or more surviving female children. Additionally, they agreed that condom was the most utilized method but traditional methods of unproven efficacy, some of which were

hitherto thought to be used only by women, were also widely used. They further stressed that current use of contraceptives by males in this rural community is lower than what is generally reported for the country and the southwest region, which could further be improved when child survival is assured and when there is an improvement in the general level of education in the community.

Theoretical Framework For Explaining Men's Behaviour Towards Family Planning

Theories and models both include concepts and constructs. Concepts are the primary components of a model or theory while constructs are components that have been created for use in a specific model or theory. These terms are important to understand when discussing models and theories (Glanz, Rimer & Lewis, 2002).

Health behavior models and theories help to explain why individuals and communities behave the way they do. Planners can use these models and theories to increase the effectiveness of their program design, implementation, and evaluation. It is useful to remember that different models may be appropriate in different situations. There is no onesize-fits-all approach; each individual or community requires programming that is tailored specifically to their needs (Glanz, Rimer, & Lewis, 2002).

Health Belief Model – A Framework for Explaining Change in Knowledge, Attitudes and Family Planning Behaviours of men.

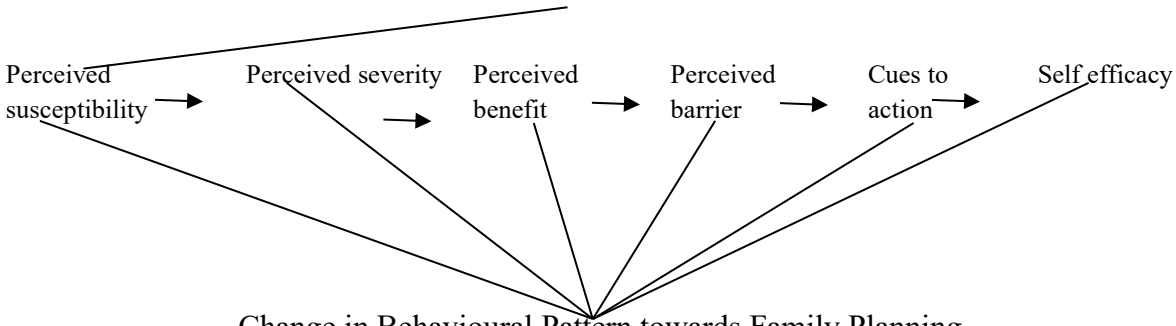
According to Simpson (2015), the health belief model is one of the oldest models of health behavior, but is still very relevant when discussing health behavioral pattern and/or change. The focal point of Health Education is on behavioural change. As one of the models of behavioural change, Health Belief Model (HBM), is relevant in analyzing possible outcomes in behaviour of individuals by looking at their belief-system and attitudinal predisposition (Simpson, 2015). Pertinently, this study attempts to explain change in **Knowledge, Attitudes and Family Planning Behaviours of men** using the Health Belief Model.

Definitions:

i. Behavioural Change: this refers to efforts put in place to change people's personal habits and attitudes, to prevent disease. It is any transformation or modification of human behaviour. Behavioural change (in public health) may also be called social and behaviour change communication which focuses on a broad range of activities and approaches directed at the individual, community and environmental influences.

ii. Health Belief Model: this can be defined as a theoretical model that can be used to guide health promotion and disease prevention programmes. It is used to explain and predict individual changes in health behaviours, as well as, one of the most widely used models for understanding health behaviours.

The Constructs for Explaining Health Belief Model:



Change in Behavioural Pattern towards Family Planning

When individuals perceive they are susceptible to a condition (perceived susceptibility) and that the condition could be severe (perceived severity), they will most likely take action to avoid the condition. The likelihood of action is enhanced if the perceived benefits outweigh the perceived barriers. The model also includes two other constructs: cues to action and self-efficacy.

In the light of the above, four (4) constructs which were later modified (or extended to 6 constructs) of health belief model shall be used to explain change in behavioural pattern of men towards family planning.

1. **Perceived Susceptibility**: this construct refers to beliefs concerning risk or susceptibility to a condition or disease. It refers to the subjective assessment of the risk of developing or experience a health-related challenge due to either the use or non-use of family planning method which will inturn influence their attitudes and family planning behaviours (Wayne, 2019).

According to health belief model, men who perceive that, non-utilization of family planning options could lead to unintended pregnancies in their spouses and/or an increased risk of maternal mortality will likely develop a positive attitudes and family planning behaviours through the acquisition of relavant knowledge. On the contrast, individuals who do not feel that non-utilization of family planning methods will not lead to unintended pregnancy will likely not show positive attitudes and family planning behaviours.

2. **Perceived Severity (Seriousness) Risk associated with Use of Family Planning Methods**: this refers to the subjective assessment of/or the belief of a health-related challenge and its potential consequences on an individual. It refers to beliefs concerning the possible severity of a disease or condition (Wayne, 2019).

   Practically, the health belief model explains that a married man who perceives that the non-utilization of family planning methods could lead to unplanned pregnancy and increased hardship due to increased number of children will likely adopt a positive behavioural pattern towards the use of family planning options available for men. The reverse is the case, for a married man who does not perceive the severity of risk associated with the non-utilization of family planning.

3. **Perceived Net Benefit of use of Family Planning:** Perceived benefit refers to an individual's assessment of the value of engaging in the use of contraceptive – a health promoting behaviour. It refers to the perceived value or benefit of behavior changes in reducing the risk of a condition or disease (Simpson, 2015).

According health belief model, a married who believes that the involvement in family planning practice (e.g., condom use) will reduce the susceptibility to unplanned pregnancy will likely develop the positive attitudes and family planning behaviours (triggered by health education), while the reverse is the case for an individual who does not hold same belief.

4. **Perceived Barrier to Developing Attitudes and Family Planning Behaviours**: this refers to any obstacles or barriers to the behavior changes being considered to decrease risk (Simpson, 2015). Sequel to this, health belief model predicts that an a married man who senses or encouters obstacles or difficulties (such as high cost, method of usage, disposal difficulty, accessibility challenge, etc) in the effective and efficient utilization of family planning options will most likely not engage or will display a negative attitudes and family planning behaviours. While, an individual who perceive no, or fewer obstacles/difficulties in the use of contraceptive through awareness gotten from health education will like develop positive attitudes and family planning behaviours (Wayne, 2019).
5. **Cues to Family Planning Action (trigger):** cues to action refer to triggers, knowledge/information or events that prompt the development of right attitude towards family planning. These cues to action could be internal (symptoms or pains which signal S.T.I) or external (information from mass media) which trigger the expression of proper attitudes and family planning behaviours (Simpson, 2015).

According to health belief model, a married man who experiences cues to action such as external information or internal prompts, will be motivated or triggered to develop favourable behaviour towards family planning. On the other hand, a married who does not experience cues to action on family planning will not likely exhibit positive attitudes and family planning behaviours. This is because cues (information) to action activates readiness (attitude) and stimulate overt behaviour and self-efficacy of use of contraceptive (Wayne 2019).

6. **Self-efficacy in Practice of effective Action**: this refers to an individual's perception of his competence to correctly utilize family planning options. It is the confidence in one's ability to effectively and efficiently navigate family planning options available to men.

   Health belief model, therefore, explains that a married who believes in his ability to use effectively and efficiently utilize family planning resources (or options) to plan pregnancy with his spouse, will like show positive attitudes and family planning behaviours, whereas an individual who does not have confidence in his ability to effectively use contraceptive will likely not engage in beneficial behaviour towards family planning.

In conclusion, the health belief model explains a change in knowledge, attitudes and family planning behaviours of men by x-raying their attitudes and beliefs about family planning. Thus, attitudes and family planning behaviours are influenced by perceived

threat/susceptibility, barriers, severity, net benefit cues to action, and self-efficacy (Glanz, Rimer, &. Lewis, 2002).

Summary of Review of Related Literature

This chapter reviewed several literatures related to knowledge, attitudes and family planning behaviours of men which began with the concept of family planning, historical overview of family planning and progressed to family planning methods, as well as, family planning methods available for men only. Furthermore, effort was made to x-ray the knowledge level, attitudes and family planning behaviours of men and relationships between the trio (3 variables) with copious evidence drawn from recent related research. It climaxed with a theoretical framework – using the Health Belief Model (HBM) to explain and predict knowledge, attitudes and family planning behaviours of men in a bid to explaining why they behave the way they do toward family planning.

CHAPTER THREE

METHOD OF THE STUDY

This chapter presents the method and procedure proposed by the researcher to ascertain knowledge, attitudes and family planning behaviours of men in Oluku Community, Ovia North East L.G.A., Benin City. It is presented under the following Sub headings;

1. Research Design
2. Population of the Study
3. Sample and Sampling Techniques
4. Instrument for Data Collection
5. Validity of the Instrument
6. Reliability of the Instrument
7. Administration of the Instrument
8. Method of Data Collection
9. Method of Data Analysis

Research Design

This study employed a descriptive survey research design. This design was used by the researcher in gathering relevant data, appropriate for ascertaining the knowledge, attitudes and family planning behaviours of men in Oluku Community, Ovia North East Local Government Area, and Benin City.

Population of the Study

The population of this study consisted of five thousand, two hundred and sixty men (5 260) men, which was the total population of men in Oluku Community, Ovia North East L.G.A., Benin City (National Population Commission, 2021).

Sample and Sampling Technique

The study on knowledge, attitudes and family planning behaviours of men used a sample size of two hundred and sixty-three (263) respondents (men) which was selected through a simple random sampling technique as true representative of the total population of men in Oluku Community. The sample was 05% of the total population of men which was chosen for the sake of manageability

Instrument for Data Collection

The instrument for the study was a self-constructed questionnaire to ascertain the knowledge, attitudes and family planning behaviours of men in Oluku Community. The questionnaire was divided into four (4) sections. Section A covered the topic, purpose of the study and the expression of informed consent/confidentiality of the research respondents. Section B collected the demographic data of the respondents while Section C consisted of relevant items adequate for collecting data sufficient for answering the research questions of the study, while the last section D, was for an expression of gratitude to the respondents. A four-point scoring scale drawn along the modified Likert Summated Rating Scale for

measurement was adopted to provide the respondents with alternatives for the responding to the respective items provided in the questionnaire

Validity of the Instrument

The content validity of the instrument was established after an intensive screening by the supervisor and two other experts from the Department of Health, Safety and Environmental Education, University of Benin. Their inputs/corrections in terms of clarity and appropriateness of language were used to develop the final draft for administration.

Reliability of the Instrument

To determine the reliability of the instrument for the study (questionnaire), the test-retest method of estimating the reliability of the instrument was used. Consequently, the constructed instrument will be administered on a group of twenty (20) married men in Oluku Community who are not part of the study within an interval of two weeks. The correlation of the response was determined using the Pearson's Product Moment Correlation, Coefficients (PPMCC).

Administration of Instrument

The researcher personally administered the instrument to the respondents. The completed questionnaires by the respondents were retrieved personally by the researcher immediately after being filled so as to ensure high return rate.

Method of Data Analysis

Simple percentage, frequency-count, Pearson's Product Correlation Coefficient and Chi-square were used to analyse the data collected.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND DISCUSSION OF FINDINGS

This chapter focused on the presentation, analysis, interpretation of data and discussion of findings on the knowledge, attitudes and family planning behaviours of men in Oluku Community. To guide the study, five (05) research questions were raised and three (03)

hypotheses formulated. These were presented in the form of a 30-item questionnaire carefully constructed to collect data suitable for answering the questions and intelligent guesses raised to guide the study. The questionnaires were administered to 263 respondents who are residents of Oluku community. Their responses were carefully analyzed and presented in the following tables.

Options: Strongly Agree (SA), Agree (A), Disagree (D), Strongly Disagree (SD)

Research Question 1: Are men in Oluku community knowledgeable about family planning?

S/N	ITEMS	AGREED (%)	DISAGREED (%)
1.	I have not heard of family planning before	31(11.8%)	232 (88.2%)
2.	Family planning means prevention of	182 (69.2%)	81 (30.8%)

	pregnancy a for a period of time		
3.	Vasectomy is a family planning method	56 (21.3%)	207 (78.7%)
4.	Family planning helps to space childbirth	202 (76.8%)	61 (23.2%)
5.	Male condom is not an example of family planning method.	66 (25.1%)	197 (74.9%)
6.	Male condom can help to prevent STIs	247 (93.9%)	16 (6.1%)
7.	Family planning services can be gotten from the health centre.	97 (36.9%)	166 (63.1%)
8.	Withdrawal of pulling-out is not a family planning method	46 (17.5)	217 (82.5%)
9.	Family planning is not for married men.	41 (15.6%)	222 (84.4%)
10.	Family planning is a type of disease	06 (2.3)	257 (97.7%)

Table 1: Knowledge of Family Planning among Men in Oluku

Table 1 shows Knowledge of Family Planning among Men in Oluku. The table 1 above, shows that 232 (88.2%) of the respondents have heard of family planning before whereas 31 (11.8%) of the respondents have not. The table also reveals that 182 (69.2%) of the respondents know that family planning means prevention of pregnancy for a period of time while 81 (30.8%) of the respondents do not. Moreso, 56 (21.3%) of the respondents know that vasectomy is a family planning method whereas 207 (78.7%) of the respondents do not know. While 202 (76.8%) of the respondents agreed that family planning helps to space childbirth, 61 (23.2%) of the respondents disagreed. The table showed that 66 (25.1%) of the respondents agreed that male condom is not an example of family planning method but

66 (25.1%) of the respondents disagreed. While 247 (93.9%) of the respondents agreed that male condom can help to prevent STIs, 16 (6.1%) of the respondents disagreed.

The Table 1 revealed that 97 (36.9%) of the respondents agreed that family planning services can be gotten from the health centre, while 166 (63.1%) of the respondents disagreed. Furthermore, 46 (17.5%) of the respondents do not know that withdrawal or pulling-out is a family planning method but 217 (82.5%) of the respondents know. While 41 (15.6%) of the respondents agreed that family planning is not for married men, 222 (84.4%) disagreed. Table 1 finally revealed that 06 (02.3%) of the respondents agreed that family planning is a type of disease, whereas 257 (97.7%) of the respondents disagreed.

Figure 1: **Bar-chart showing Knowledge of Family Planning among Men in Oluku**

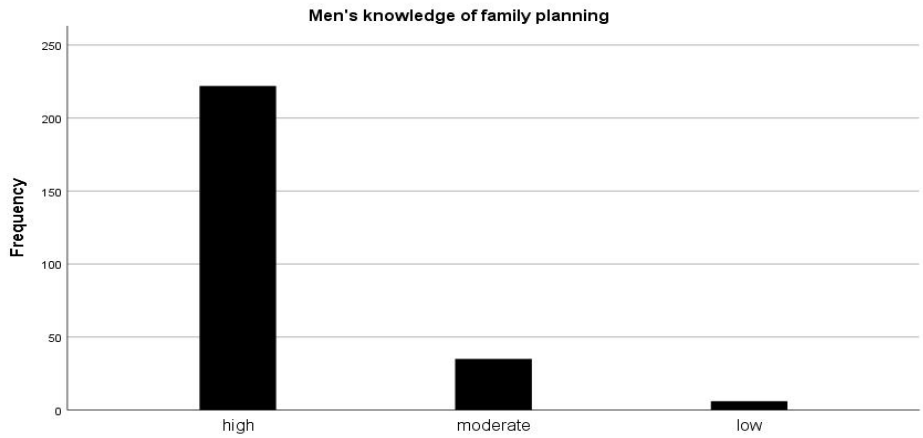


figure 1 above is a chat showing knowledge of family planning among men in Oluku. The chat shows that 210 (80%) of the respondents have high knowledge of family plannning. while

40 (15%) of the respondents have moderate knowledge, 13 (05%) of the respondents have low knowledge of family planning in oluku community.

Research Question 2: What are the attitudes of men in Oluku toward family planning?

Table 2: Attitudes of Men in Oluku Community toward Family Planning

S/N	ITEMS	AGREED (%)	DISAGREED (%)
1.	Men who do not use family planning after having four children should be arrested.	16 (6.1%)	247 (93.9%)
2.	Family planning is women's business	167(63.5%)	96 (36.5%)
3.	Use of family planning by men does not matter.	162 (61.6%)	101 (38.4%)
4.	African men should not discuss family planning with their wives	157 (56.7%)	106 (40.3)
5.	High socioeconomic status of men promotes	192 (73.0%)	71 (27.0)

	family planning behaviours of men		
6.	Family planning destroys African religion	157 (59.7%)	106 (40.3%)
7.	Couples should have as many children as they want without family planning.	142 (54.0%)	121 (46.0%)
8.	Using male condom during sexual intercourse reduces sexual pleasure.	126 (47.9%)	137 (52.1%)
9.	Women who use family planning should be sent parking.	46 (17.5%)	217 (82.5%)
10.	I feel scared of the side effects of family planning.	51 (19.4%)	212 (80.6%)

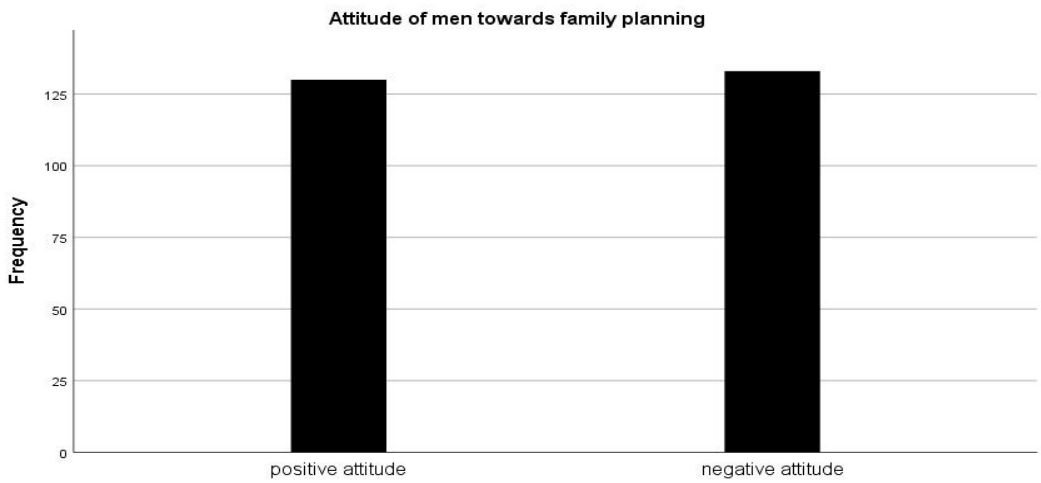
Table 2 shows attitudes of men in Oluku community toward family planning. From table 2, only 16 (06.1%) of the respondents agreed that men who do not use family planning after having four children should be arrested while 247 (93.9%) of the respondents disagreed. More so, a larger number of the respondents 167(63.5%) agreed that family planning is women's business, whereas 96 (36.5%) of the respondents disagreed. While the use of family planning by men does not matter to 162 (61.6%) of the respondents, others 101 (38.4%) affirmed that it matters.

Table 2 shows that 157 (56.7%) of the respondents believed that African men should not discuss family planning with their wives, while 106 (40.3%) of the respondents disagreed. Furthermore, it was agreed by 192 (73.0%) of the respondents that high socioeconomic status of men promotes family planning behaviours of men but disagreed by 71 (27.0%) of the respondents. While family planning destroys African religion was shown to be the opinion of 157 (59.7%) of the respondents, 106 (40.3%) of the respondents disagreed to the opinion. Meanwhile, it was agreed by a larger number, 142 (54.0%), of the respondents that

couples should have as many children as they want without family planning, 121 (46.0%) of the respondents were of an opposing disposition.

Table 2 further revealed that using male condom during sexual intercourse reduces sexual pleasure as agreed by 126 (47.9%) of the respondent. Notwithstanding, a greater number 137 (52.1%) of the respondents disagreed that using male condom during sexual intercourse reduces sexual pleasure. The attitudes of 46 (17.5%) of the respondents showed that women who use family planning should be sent parking, however, 217 (82.5%) of the respondents reflected a disposition that was in disagreement. Table 2 finally exposed that 51 (19.4%) of the respondents (men) in Oluku community feel scared of the side effects of family planning but a relatively very high number 212 (80.6%) of the respondents disagreed.

Figure 2**: Bar-chart showing Attitudes of Men toward Family Planning in OlukuCommunity.**



The figure 2 above is a chat which shows attitudes of men toward family planning. From the chat, 130 (49.4%) of the respondents show positive attitudes toward family planning, whereas 136 (50.6%) of the respondents show negative attitudes toward family planning in Oluku community.

Research Question 3: What are the family planning behaviours of men in Oluku community?

Table 3: Family Planning Behaviours of Men in Oluku Community.

S/N	ITEMS	AGREED (%)	DISAGREED (%)
1.	I attend family planning clinics with my wife.	26 (9.9%)	237 (90.1%)
2.	I do not discuss family planning with my wife.	177 (67.3%)	86 (32.7%)
3.	I use condom to prevent pregnancy.	227 (86.3%)	36 (13.7%)
4.	I remind my wife of her family planning pills.	61 (23.2%)	202 (76.8%)
5.	I make family planning decisions with my wife.	91 (34.6%)	172(65.4%)

6.	I use withdrawal or pulling-out method to prevent pregnancy.	152 (57.8%)	111 (42.2%)
7.	I have done vasectomy to prevent pregnancy.	61 (23.2%)	202 (76.8%)
8.	I use abstinence as a family planning method.	56 (21.3%)	207 (78.7)
9.	I take family planning advice from my friends.	187 (71.1%)	76 (28.9%)
10	I only take family planning advice from family planning experts.	76 (28.9%)	187 (71.1%)

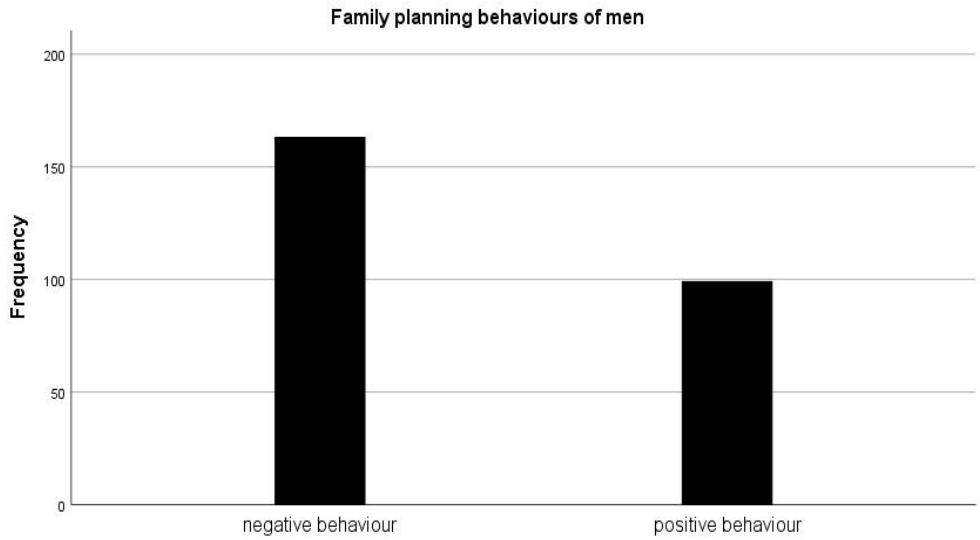
Table 3 above shows family planning behaviours of men in Oluku community. The table 3 shows that only 26 (9.9%) of the respondents attend family planning clinics with my wife, while a very high number 237 (90.1) of respondents do not. Furthermore, it was shown that 177 (67.3%) of the respondents do not discuss family planning with my wives, whereas 86 (32.7%) of the respondents do. Table 3 further showed that 227 (86.3%) of the respondents use condom to prevent pregnancy but 36 (13.7%) of the respondents do not. While only 61 (23.2%) of the respondents remind their wives of their family planning pills, 202 (76.8%) of the respondents do not.

The responses of 91 (34.6%) of the respondents showed that men in Oluku make family planning decisions with my wife, whereas the responses of 172(65.4%) of the respondents that men do not. While 152 (57.8%) of the respondents agreed that they use withdrawal or pulling-out method to prevent pregnancy, 111 (42.2%) of the respondents do not. The table further revealed that only 61 (23.2%) of the respondents have done vasectomy to prevent pregnancy, while 202 (76.8%) of the respondents have not. With respect to the use of abstinence as a family planning method, 56 (21.3%) of the respondents agreed that they do but 207 (78.7%) of the respondents disagreed.

Where to access family planning advice from was another important item to assess the behaviour of men towards family planning. Sequel to this, table 4 revealed that 187 (71.1%)

of the respondents take family planning advice from their friends while 76 (28.9%) of the respondents do not. Whereas 76 (28.9%) of the respondents agreed that they only take family planning advice from family planning experts, however, 187 (71.1%) of the respondents do not.

Figure 3: **Bar-chart showing Family Planning Behaviours of Men in Oluku Community**



The figure 3 above is a Bar-chart showing Family Planning Behaviours of Men in Oluku Community**.** From table 3, 100 (38%) of the total respondents have positive and beneficial behaviours toward family planning, while 163 (62%) of the total respondents have negative or detrimental attitudes toward family planning.

Table 4: Relationship between Knowledge and Family Planning Behaviours of Men in Oluku Community using Pearson's Correlation Coefficient Table

	Total (N)	Mean	R	Relationship	Level of Sig.	Decision
Knowledge	263	36.7605	-0.116	Negative	0.07	Accept
Behaviour		23.4677				

Table 4 shows relationship between knowledge and family planning behaviours of men in Oluku. It reveals a Pearson's Correlation Coefficient (r) value of -0.116 which indicates a

negative correlation. Furthermore, the level of significance is 0.07 which is greater than the set alpha level of 0.05. Thus, the null hypothesis which states that there is no significant relationship between the knowledge and family planning behaviours of men in Oluku is **accepted**. That is to say that the knowledge of men in Oluku does not influence their family planning behaviours as the two variables have a negative relationship. Hence, as the knowledge on family planning increases, their family planning behaviours either declines or remain unaffected.

Table 5: **Relationship between Attitudes and Family Planning Behaviours of men in Oluku.**

Pearson's Correlation Coefficient Table.

	Total	Mean	R	Relationship	Level of Sig.	Decision
ATTITUDES	263	24.9587	0.485	Positive	0.000	Reject The null hypothesis
BEHAVIOUR		23.4677				

The table 5 above shows relationship between attitudes and family planning behaviours of men in oluku. The table shows the Pearson's Correlation Coefficient (r) value of 0.485 which indicates positive correlation, while the level of significance is 0.000 which is less

than the set alpha level of 0.05. Thus, we **reject** the null hypothesis which states that there is no significant relationship between attitudes and family planning behaviours of men in Oluku. Therefore, table 5 reveals that there is moderate statiscally significant relationship between attitudes and family planning behaviours of men in Oluku. That is to say, development of family planning attitudes of men in Oluku promotes their family planning behaviours.

Table 6: **Influence of men's socio-economic status on family planning behaviours in Oluku** using Chi-square table.

Socio-economic status (income)	Total Respondents	X^2	DF	Level of Significance	Decision
10,000-49,999	263	9.219	03	0.027	Reject the null hypothesis
50,000-99,999					
100,000-149,999					
150,000 and above					

The table 6 above shows Influence of men's socio-economic status on family planning behaviours in Oluku using Chi-square table. The table shows a Chi-square value of 9.219 and the level of significance is 0.027 which is lesser than the conventional accepted alpha

level of 0.05. Thus, we **reject** the null hypothesis. From table 6, socio-economic status is statistically shown to be significantly related to the family planning behaviours of men in Oluku community.

Discussion of Findings

The study was conducted to ascertain the knowledge, attitudes and family planning behaviours of men in Oluku Community. The findings are deliberately below.

The current study found that majority of the respondents (men in Oluku Community) have high knowledge of family planning. This finding is consistent with the findings of Ijadunola et al. (2010) that almost (99%) of men were aware of the existence of modern contraceptives, and that most of them were aware of at least two modern methods. Especially when it comes to knowledge of male condom, almost all of the total respondents were found to have knowledge that it can help in preventing pregnancy and transmission of STIs. This further agrees with the findings that of Orji & Onwudiegwu (2008) that most men have knowledge of family planning, with the awareness of the condom (98%) being the highest, as the most popular source of information about family planning among them was the radio. On the contrary, the current study contradicts the findings of Odu, Ijadunola, Komolafe & Adebimpe (2006) who concluded from the report of cross-sectional survey that men's knowledge of family planning in sub-urban and rural Nigeria is still poor or limited despite a global move to increase the involvement of men in reproductive health matters. However, the current study discover that despite men have a realatively high knowledge of family planning in areas like condoms and natural methods, their awareness of vasectomy was

quite low. No wonder WHO (2010) posited that while natural methods are well known to some men and condoms are a bit popular, vasectomy is the rarely known and least accepted among men in developing countries. Hence, the findings from this study confirms that men in (Oluku community) have a relatively high knowledge of family planning due to the fact that most of the respondents affirmed that they are aware of family planning, the meaning, benefits and most of the methods.

The current study discovered that men in Oluku community show a relatively negative attitudes toward family planning as majority 167(63.5%) of the respondents believed that family planning is women's business. Moreso, they (157[56.7%]) respondents were of the opinion that men should not discuss family planning matters with their wives, perhaps they feel that family planning destroys African culture. Little wonder majority of them agreed that women who use family planning should be sent parking. Hence the current study contradicts the position of Lawoyin et al (2002) who found that men's attitude was generally positive as nearly half (47.3%) of respondents reported that they made, and are willing to continue making family planning decisions with their spouses. However, the later part of their findings agrees with the current study that a larger majority of men in rural and sub-urban communities thought it was their wives' responsibility to go for family planning. Hence the current study confirms the stance of Orji & Onwudiegwu (2008), that in Nigeria, consistently, less than a quarter of men individually are willing to initiate discussions on such issues as when to achieve pregnancy, when to avoid pregnancy, and the use of contraceptives with their wives, which they concluded that men have poor poor attitude

toward family planning and recommended an intensive drive at a community based adult reproductive health education among others. Moreso, the attitudes of men in Oluku towards the Nigerian Population Policy of "four children to a woman" was found to be poor as almost all of the respondents disagreed that men who do not used family planning after having four children should be arrested. This is a clear indication of what their attitudes toward family planning is

It is worthy to mention that the current study found that men in Oluku community have relatively negative family planning behaviours due to the fact that majority of the respondents affirmed that they 237 (90.1%) do not attend family planning clinics with their wives neither do they 202 (76.8%) remind their spouses to take family planning pills so as to prevent pregnancy. Although majority of the respondents claimed to practise the use of male condom, they actively do not engage in family discussions and decision with their wives, as many of them take family planning advices from friends rather than family planning experts. The current study disagrees with the findings of Lawoyin et al (2002) who reported in a study that nearly half (47.3%) of respondents (men) agreed that they made family planning decisions with their spouses. It further contradicts the findings of Peter, Ebenezer & Ayotunde (2009), who claimed that men show positive family planning behaviours when engaged in effective spousal communication with their wives. The current study agrees with the findings of Marius et al (2014), who revealed that, generally, more male respondents disagreed than those who agreed that men should make decisions about selected family planning issues in the family. In their study, 44% of men were reported to

agree that men should determine family size while 54% disagreed; 29% agreed that men should make the decision about when to adopt family planning while 69% disagreed; 9% of men agreed that men should decide which family planning method to adopt while 88% disagreed; 34% of men agreed that men should decide what to do about an unwanted pregnancy while 64% disagreed. Coming to whether men in Oluku have had vasectomy, almost all of the respondents responded negatively which may be associated with the fear they affirmed to have toward it.

It was revealed from the current study that there is no statistically significant relationship between knowledge and family planning behaviours of men in Oluku community. This finding agrees with the stance of Odu, Ijadunola, Komolafe, & Adebimpe (2006) who found that men's knowledge of and attitude to family planning in a sub-urban community on the outskirts of Ilorin, Nigeria was high, whereas their attitudes and corresponding behaviours toward family planning was also relatively poor which could be associated to their religion beliefs and cultural norms. However, the current study disagrees with the significant relationship between family planning knowledge and behaviours of men which Lawoyin et al (2002) hold.

It was discovered from the current study that there exist a significant relationship between the attitudes and family planning behaviours of men in Oluku community. This is consistent with the position of DeRose, Dodoo, Alex & Tom (2004) who also discovered from their study that men with negative family planning attitudes behaved negatively toward family planning. Whereas, men with positive attitudes, exhibited positive behaviours toward family

planning. According to them, behaviours are outwardly-expressed attitude. It will thus be safe to say that efforts tailored at positively influencing the beliefs, feelings, opinions, perceptions and disposition of men could translated into positive family planning behaviours of men in Oluku.

Important to mention is the fact that the current study found that socioeconomic status is statistically significantly related to the family planning behaviours of men in Oluku community. This finding is consistent with that of Nazli et al (2018) which indicated that the socio-economic status of men has an important role to play in their behaviour and in the overall progress of their families especially their spouses. They believed that men who are educated and gainfully employed can have better navigate family planning services with their spouses, unlike others in rural areas, unemployed and/poor. No wonder Mosher et al (2002) posited that women whose spouses had higher education, had 1-3 pregnancies and did not want more children in the future, were found to get higher scores on the family planning attitude scale.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

Summary

The researcher of the study ascertained the knowledge, attitudes and family planning behaviours of men in Oluku community Ovia North East LGA, Benin City. To guide the study, five (5) research questions were raised and three (3) hypotheses were formulated. Relevant literatures related to the study were reviewed with maximum attention to their relationships with the subject of interest. The study adopted the descriptive survey research design with the population of five thousand, two hundred and sixty (5 260) men in Oluku community, while two hundred and sixty-three respondents (263) made up the sample size which was carefully selected using simple random sampling technique.

A self- constructed questionnaire whose reliability was determined using test-retest method was validated by experts and used to collect relevant data necessary for the study. The data

were further analyzed using simple percentage, frequency counts, Pearson's Product Moment Correlation Coefficient (PPMC) and Chi-square statistical methods. The results were presented, interpreted by the researcher and findings were drawn.

Findings

1. Majority of the respondents (men in Oluku) have high knowledge of family planning.
2. Majority of the respondents (men in Oluku) have negative attitudes toward family planning.
3. Majority of the respondents (men in Oluku) have negative family planning behaviours.
4. A negative relationship between knowledge and family planning behaviours was found.
5. A statistically significant relationship between attitudes and family planning behaviours of men was found.
6. Majority of men in Oluku do not discuss family planning with their wives.
7. Condom use was found to be predominant among men in Oluku community.
8. Socio-economic status was found to influence family planning behaviours of men.

Conclusion

Based on the findings from the study, it was discovered that there is no positive relationship between knowledge and family planning behaviours of men in Oluku community. This could be tied to religious and cultural constraints. However, it was shown that there is a significant relationship between attitudes and family planning behaviours of men in Oluku. To this end, knowledge alone cannot guarantee positive family planning behaviours of men. Thus, should be complemented with policies, motivation for involvement of men, accessibility to family planning services and programme for a heightened level of awareness so as to influence their attitudes and corresponding family planning behaviours.

Recommendations

Based on the aforementioned findings, the recommendations below were made:

1. Stakeholders such as health practitioners; family planning experts, health educators, policy makers, including religious institutions should provide men with proper information on various family planning methods available and the benefits such have for them and their family members, as this information will further enhance the knowledge and attitudes of men toward family planning and as well forestall positive family planning behaviours in men.
2. Policies, adequate, in regulating family planning behaviours of men positively should not only be put in place but should be enforced by policy-makers and government, as this social sex-based policies will curb their ineffectiveness and inequality with respect to family planning.

3. Government should provide for a health system which guarantees child survival and an improvement in the general level of education in the community as some men, especially in the rural areas, are scared of, and believe that non-use of family planning could help them to still have many children in case of child-mortality.
4. **Researchers** should engage in further research to ascertain the impact of religion and culture on family planning behaviours of men and attempts should be made to redirect such influence in favour of practising family planning.

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APPENDIX

DEPARTMENT OF HEALTH, SAFETY AND ENVIRONMENTAL EDUCATION

FACULTY OF EDUCATION

UNIVERSITY OF BENIN

BENIN CITY, EDO STATE NIGERIA.

QUESTIONNAIRE ON KNOWLEDGE, ATTITUDES AND FAMILY PLANNING BEHAVIOURS OF MEN IN OLUKU COMMUNITY, OVIA NORTH EAST L.G.A., BENIN CITY

Section A:

Dear Respondents,

The researcher is a student of the above-named institution and the questionnaire is constructed for and undergraduate degree project on knowledge, attitudes and family planning behaviours of men in Oluku Community, Ovia North East L.G.A., Benin City. It is presented under the following Sub headings; Men's knowledge of family Planning, Men's Attitudes toward Family Planning and Family Plannning Behaviours of Men.

You are kindly requested to fill the questionnaire. All information gathered shall be used purely for research purposes and shall be treated with utmost confidentiality.

Thanks

_____

Daniel Eniebiat Udoh

SECTION B: Bio-Data of the Respondent

Instruction: Please tick (✓) where appropriate

Occupation: Teacher ( ) Doctor ( ) Farmer ( ) Trader ( ) Others ( )

Age Range: 18 - 30 ( ) 31 – 43 ( ) 44 – 54 ( ) 55 and above ( )

Religion: Christian ( ) Muslim ( ) Traditional ( )

Level of Education: Primary ( ) Secondary( ) Tertiary ( )

Income per Month: 10 000 – 49 999 ( ) 50 000 – 99 999 ( ) 10 000 – 149 000 ( )

150 000 and above ( )

SECTION C:

Information on Men's Knowledge of Family Planning in Oluku Community

S/N	QUESTIONNAIRE ITEMS	SA	A	D	SD
1.	I have not heard of family planning before				
2.	Family planning means prevention of pregnancy for a period of time.				
3.	Vasectomy is a family method.				

4.	Family planning helps to space childbirth				
5	Male condom is not an example of family planning method.				
6	Male condom can help to prevent STIs.				
7	Family planning services can be gotten from the health centre.				
8	Withdrawal of pulling-out is not a family planning method				
9	Family planning is not for married men.				
10	Family planning is a type of disease				

Key: SA –STRONGLY AGREE, A – AGREE, D – DISAGREE, SD – STRONGLY DISAGREE

Information on Attitudes of Men toward Family Planning

S/N	QUESTIONNAIRE ITEMS	SA	A	D	SD
1.	Men who do not use family planning after having four children should be arrested.				
2.	Family planning is women's business				
3.	Use of family planning by men does not matter.				
4.	African men should not discuss family planning with their wives				

5	High socioeconomic status of men promotes family planning behaviours of men.				
6	Family planning destroys African religion				
7.	Couples should have as many children as they want without family planning.				
8	Using male condom during sexual intercourse reduces sexual pleasure				
9	Women who use family planning should be sent parking				
10	I feel scared of the side effects of family planning.				

Family Planning Behaviours of men

S/N	QUESTIONNAIRE ITEMS	SA	A	D	SD
1.	I attend family planning clinics with my wife.				
2	I do not discuss family planning with my wife.				
3	I use condom to prevent pregnancy				
4	I remind my wife of her family planning pills				
5	I make family planning decisions with my wife				

6	I use withdrawal or pulling-out method to prevent pregnancy.				
7	I have done vasectomy to prevent pregnancy				
8	I use abstinence as a family planning method.				
9	I take family planning advice from my friends.				
10	I only take family planning advice from family planning experts.				

Section D:

Thank you for your responses. Please, return the questionnaire to the researcher.