PREDICTORS OF MEN'S PARTICIPATION IN FAMILY PLANNING IN IKOLE LOCAL GOVERNMENT AREA, NIGERIA

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ABSTRACT

The study examined the predictors of men's participation in family planning in Ikole Local Government Area, Nigeria. The study considered a total of 250 men and analysis was done at three levels – univariate analysis was done using frequency table, bivariate analysis using chi-square and multivariate analysis using binary logistic regression to access the relationship between the dependent and independent variables. The study observed that 60% do not participate in choosing family planning programs for their family and the bivariate analysis showed that age, level of education, intended number of children, religion. ethnicity and number of living children had significant relationship with men's participation in family planning ($P < 0.05$). The study therefore conclude thatage, level of education, intended number of children, religion, ethnicity and number of living children can influence men's participation in family planning methods for the family and again, income and employment status may not be paramount factors to examine when designing policy and intervention programs.

CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND OF THE STUDY

Family planning involves a conscious effort by persons in union or sexually active person not in union to use contraceptive methods or any means to limit their family size, control timing of birth(birth spacing) and prevent pregnancy for the never married. The rapid increase in population has been recognized as one of the most serious problems in developing countries. Family planning allows people to attain their desired number of children an helps in spacing of pregnancies. It is achieved through use of contraceptive methods and the treatment of infertility. A woman's ability to decide when to become pregnant has a direct impact on her health and well-being. Family planning allows spacing of pregnancies and can delay pregnancies in young women at increased risk of health problems and death from early childbearing. It prevents unintended pregnancies, including those of older women who face increased risks related to pregnancy. Family planning enables women who wish to limit the size of their families to do so. Evidence suggests that women who have more than 4 children are at increased risk of maternal mortality. Over the years, family planning has helped in preventing unintended pregnancies, reducing infant mortality, preventing sexually transmitted infections among others and major emphasis has been played on women but men play an equally important role in realization of reproductive health and family planning decisions and behaviors. Many societies in sub-Saharan Africa have a patriarchal structure especially Nigeria, with all the important decisions taken by the male head while the woman's fundamental social role is to bear children and they are socially and economically dependent on their husband.

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The International Population and Development Conference held in Cairo(ICPD, 1994) stated that "Special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behavior, including family planning; prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV; prevention of unwanted and high-risk pregnancies; shared control and contribution to family income, children's education, health and nutrition; and recognition and promotion of the equal value of children of both sexes". Since, the 1994 International Conference on Population and Development (ICPD), and the 1995 UN World Conference on Women, interest in men's involvement in reproductive health has increased. There has also been a shift in objectives of male participation and concerns, from increasing contraceptive use and achieving demographic goals to achieving gender equality and fulfilling various reproductive responsibilities. Evidence indicates that male involvement can lead to contraceptive uptake through the pathway of increased spousal communication. However, family planning programs have traditionally focused on women as the primary beneficiaries and men have been considered as the silent partners of the services and the role of men in the acceptance, correct and consistent use cannot be overemphasized. This study therefore will focus on the predictors of men's participation in family planning in Ikole Local Government area, Nigeria.

1.2   STATEMENT OF THE PROBLEM

According to Nigeria Demographic and Health Survey (NDHS 2013), knowledge of any contraceptive method is widespread in Nigeria, with 85 percent of all women and 95 percent of all men knowing at least one method of contraception and only fifteen percent of currently married women use at least a contraceptive method. This clearly reflects a wide gap in knowledge and use of family planning, the patriarchal family structure in Nigeria is another

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factor. There are barriers that may impede male involvement in family planning such as poverty, unemployment, religion, cultural and societal norms and education (Engle, 2000). Men's involvement in family planning may increase contraceptive uptake of women. In Nigeria, men seem to be in control of the family. This is because in most of the families, they are the older partners, breadwinners, head of family, e.t.c. Exploring situational advantage of men to boost family planning in Nigeria and thereby increase the health of the women, children, and welfare of the family. Therefore this study will examine the predictors of men's participation in family planning in Ikole Local Government area, Nigeria.

1.3 SIGNIFICANCE OF THE STUDY

In sub-Saharan Africa, family planning and reproductive health care research and interventions place a disproportionate emphasis on women and largely ignore the role of men (Mbizvo and Adamchak, 1991; Fakeye and Babaniyi, 1989; Odhiambo, 1992; Ringheim, 1993). As a result, male participation in family planning and reproductive health has been low (WHO, 1995). Men in Africa, who are heads of their households, are often key figures in domestic decision making, particularly about fertility behavior and preferences (Isiugo-Abanihe 1994), and that authority is supported by tradition. Indeed, an understanding of men's participation in family planning and reproductive health could provide more insights that are possible,because men seems to have more power than women in reproductive decision making, including the number of children and whether or not to use family planning. In Nigeria, unfortunately, data on male participation in reproductive health isgenerally scanty or limite. More so, little or no study has been previously done on men's participation in family planning in this study area of interest.

1.4   OBJECTIVES OF THE STUDY

1.4.1   MAIN OBJECTIVE

The main objective of the study is to examine the predictors of men's participation in family planning in Ikole Local Government Area, Nigeria.

1.4.2 SPECIFIC OBJECTIVES

The specific objectives are to:

1-Ascertain the prevalence level of men's participation in family planning in Ikole Local Government Area, Nigeria.

2- Examine the predictors of men's participation in family planning in Ikole Local Government area, Nigeria.

1.5   RESEARCH QUESTIONS

1- What is the prevalence level of men's participation in family planning in Ikole Local Government area, Nigeria.

2- What are the predictors of men's participation in family planning in Ikole Local Government area, Nigeria.

1.6   DEFINITION OF TERMS

Family planning: Family planning refers to a conscious effort by persons in union or sexually active person not in union to use contraceptive methods or any means to limit their family size, control timing of birth(birth spacing) and prevent pregnancy for the never married.

Contraception: Refers to the devices or medication used for reducing the likelihood of the fertilization of an ovum by a spermatozoon. The contraceptive effect can be obtained through temporary (periodic abstinence during fertile period, withdrawal) or permanent means (such as male and female sterilization)

Fertility: The term fertility refers to the frequency with which births occur within groups or subgroups of humans who are of an age to procreate. As applied to the results rather than the ability to procreate, the words fertility and infertility are used to denote, respectively, that procreation has or has not taken place (Fathalla, 1992). In this study, the term fertility refers to the frequency with which births occur in a family.

Pregnancy: Refers to the condition of having a developing embryo or fetus in the body, after union of an ovum and spermatozoon such union places the beginning of pregnancy (Dorland, 2007).

Abortion: Abortion is pregnancy termination prior to 20 weeks' gestation or a fetus born weighing less than 500 g.(WHO)

Men: An adult male human

Predictors: They are the factors influencing or determinants of men's participation in Family planning

CHAPTER TWO

LITERATURE REVIEW

2.1 OVERVIEW OF THE STUDY

2.1.1 MEN'S PARTICIPATION IN FAMILY PLANNING IN AFRICA

Generally in Africa, one serious problem many countries still have to solve or have been battling to solve that of their rapid and uncontrolled increase in population, compounded by the patriarchal nature of many Africa families. It is well documented that men's general knowledge and attitudes concerning the ideal family size, gender preference of children, ideal spacing between child births, and contraceptive method use greatly influence women's preferences and opinions. However, since ICPD held in Cairo (1994) and other international conferences, the role of men which was previously ignored has been improved and various programs bringing about a gender balance in men's and women's reproductive rights and responsibilities have been stressed. The World Health Organization (WHO) estimated in 2012 that 287,000 maternal deaths occurred in 2010; sub-Saharan Africa (56%) and Southern Asia (29%) accounted for the global burden of maternal deaths. The role of men in acceptance and consistent use of contraceptive methods cannot be over emphasized and they were regarded to have contributed to large proportion of ill reproductive health suffered by their partners. A study on male involvement in family planning decision making in sub-Saharan Africa (Vouking, M. Z., et al) showed that the concept of family planning was well known to men. In the Nigerian study, almost (99%) men were aware of the existence of modern contraceptives, and most of them were aware of at least two modern methods. Awareness of the condom was highest (98%). In the Malawi study, all of the participants reported that they were not using contraception before the intervention. In

Ethiopia, above 90% of male respondents have supported and approved using and choosing family planning methods, but none of them practiced terminal methods. Generally in Africa, more male respondents disagreed than agreed that men should make decisions about selected family planning issues in the family.

2.1.2 MEN'S PARTICIPATION IN FAMILY PLANNING IN NIGERIA

In Nigeria, the high rate of population growth has been driven by high fertility rates, which have fallen much less rapidly than the crude death rate. The country's total fertility rate has declined only slightly, from 6.3 births per woman in 1981-1982,and to 6.0 births per woman in 1990, to 5.7 births per woman in 2008 and to 5.5 birth per woman in 2013(ICF/MCF 2013). Despite the high fertility rate, acceptance and utilization of modern family planning methods remain low, several researchers have suggested various reasons. Some of the factors may include poor accessibility of services, the low status of women, high illiteracy rate among the female population, the patriarchal nature of the society, and a general lack of male involvement in family planning. Several studies on men's participation have been done in the past by different researchers in Nigeria, for instance. The role of men in family planning decision-making in rural and urban Nigeria showed that there is high level of awareness of family planning among both study groups (rural and urban). Most men in both groups believe that a decision about family planning should be made jointly by the spouses instead of being the prerogative of either. This contrasts with the generally held belief that men are opposed to family planning and a take predominant role in contraceptive decision-making (Orji. E. O et al0). Another study on Male involvement in family planning decision making in Ile-Ife, Osun State, Nigeria which assessed men's awareness, attitude, and practice of modern contraceptive methods, determined the level of spousal communication, and investigated the correlates of men's opinion in family planning

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decision making described that from over 400 male participants, eighty-nine percent of men approved of the use of family planning while only about 11 percent disapproved of it. Eighty percent of men had ever used contraception while 56 percent of them were current users. Spousal communication about family planning and other family reproductive goals was quite poor. The socio-demographic correlates of men's opinions included religion, marriage type, educational attainment, and occupation (Ijadunola M. Y., et al)

2.2. PREDICTORS OF MEN'S PARTICIPATION IN FAMILY PLANNING

Different studies has been previously done on predictors of men's participation in family planning, some of them are reviewed below.

A study on on male involvement in family planning designed to explore the challenges and determine way forward to male involvement in family planning in Olorunda Local Government Area, Osogbo, Nigeria discussed that Some (37.9%) of the respondents' spouse had ever used FP and out of which 19.0% were currently using FP. Only 4.8% of the respondents had ever been involved in FP. Identified barriers to male involvement included the perception that FP is woman's activity and was not their custom to participate in family planning programmes (Adelekan A. et al., 2014)

Involving men in family planning could increase contraceptive prevalence in several ways: By providing alternatives to couples dissatisfied with their current method; by increasing male contraceptive use; by promoting greater discussion between sexual partners; and by changing male attitudes regarding contraception. A study in Ethiopia found that couple, in which the husband participated in discussions during home visits, were more likely to initiate and maintain

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contraceptive use (Terefe and Larson, 1993).

A study on male involvement in Family Planning and Associated Factors among Marriedin Malegedo Town West Shoa Zone, Oromia, Ethiopia described that Men are not only act as decision-makers for women and children's access to health services, but also through abuse or neglect, men's actions can have a direct bearing on the health of their female partners and children. However the result showed that from total study respondents about 54% respondents had good knowledge. the prevalence of decision making power by both husband and wife together and current use of family planning were 40.8% and 30.9%. Again the prevalence of male involvement on family planning was 36% and the predictor of discussion with partner, current use of family planning, informing partner or other to use contraceptive and had information the presence of contraceptive for male (Demissie, D. D et al., 2016)

Another study carried out in rural Vietnam on increasing male involvement in family planning decision making which focused on social-cognitive intervention to influence contraceptive practices among men living in rural communes in Vietnam. It was predicted that participants who received a stage-targeted program based on the Trans-theoretical Model (TTM) would report positive movement in their stage of motivational readiness for their wife to use an intrauterine device (IUD) compared to those in a control condition. Result showed that a significant positive movement in men's stage of readiness for IUD use by their wife occurred in the intervention group, with a decrease in the proportions in the pre-centuplication stage from 28.6 to 20.2% and an increase in action/maintenance from 59.8 to 74.4%. However the study concluded that Interventions based on social-cognitive theory can increase men's involvement in IUD use in rural Vietnam and should assist in reducing future rates of unwanted pregnancy.(Bui Thi Thu Ha. et Al., 2005).

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A study on role of men in family planning decision-making in rural and urban Nigeria. The purpose of the study is to determined the role of men in family planning decision-making in both rural and urban areas of Nigeria. However the result showed that results showed a high level of awareness of family planning among both study groups (98.3% rural and 98.4% urban). Most men in both groups believe that a decision about family planning should be made jointly by the spouses instead of being the prerogative of either. This contrasts with the generally held belief that men are opposed to family planning and a take predominant role in contraceptive decision-making. The condom was the most commonly known and used method with a preponderance among urban (81.1%) over rural men (69.4%). Many men would use family planning if their wives demanded it. (Orji. E. O.,et al. 2007)

A study carried out in southern Ethiopia to assess Male Involvement in Family Planning use in Loka Abaya district showed that total number of children mainly to their wives method use, spousal communication to both model and method approval by husband to their partner are important predictive variables for the use of contraception in the study area. (Berhanu Bifato Hawassa. 2016)

A study on Family planning in rural among men in Nigeria described that too few family planning studies in Nigeria have focused on the men. The study determined the level of knowledge, attitude to and the practice of contraception among married men in a rural community in south west Nigeria. The study also identified socio-demographic and other variables associated with male contraceptive use. Knowledge was high for any family planning and any modern family planning method (90.9% and 73.3%). High level of knowledge alone was however not sufficient enough to promote a high level of use. The men's attitude was generally positive. 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. The study therefore concluded 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. It could be further improved when child survival is assured and when there is an improvement in the general level of education in the community. (Lawoyin TO, et al., 2002)

In Africa, the concept of male participation in family planning emerged after the International Conference on Population and Development held in Cairo 1994. The conference main agenda emphasized among others on the special efforts to be made to emphasize men's shared responsibility and promote their active participation in responsible parenthood, sexual and reproductive behavior, including family planning; prenatal, maternal and child health prevention of sexually transmitted diseases (STD's); and prevention of unwanted and high risk pregnancies. Use of male methods is one important aspect of male participation in family planning. The same message was emphasized in the 1995 World Conference on Women in Beijing where the shared responsibility between men and women in matters related to reproductive health and sexual behavior emerged as the main agenda as a response to improve effectiveness of endeavors aimed at reducing fertility rate. The main focus was the inclusion of other people who are sexually active who had been excluded by family planning programs (Richey, 2008).

2.3 BENEFITS OF FAMILY PLANNING

Family planning allows people to attain their desired number of children and determine the spacing of pregnancies. It is achieved through use of contraceptive methods and the treatment of infertility. The World Health Organization(WHO) described various benefits of family planning, some of them are reviewed below.

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Preventing pregnancy-related health risks in women: A woman's ability to choose if and when to become pregnant has a direct impact on her health and well-being. Family planning allows spacing of pregnancies and can delay pregnancies in young women at increased risk of health problems and death from early childbearing. It prevents unintended pregnancies, including those of older women who face increased risks related to pregnancy. Family planning enables women who wish to limit the size of their families to do so.

Reducing infant mortality:

Family planning can prevent closely spaced and ill-timed pregnancies and births, which contribute to some of the world's highest infant mortality rates. Infants of mothers who die as a result of giving birth also have a greater risk of death and poor health.

Helping to prevent HIV/AIDS: Family planning reduces the risk of unintended pregnancies among women living with HIV, resulting in fewer infected babies and orphans. In addition, male and female condoms provide dual protection against unintended pregnancies and against STIs including HIV.

Empowering people and enhancing education:

Family planning enables people to make informed choices about their sexual and reproductive health. Family planning represents an opportunity for women to pursue additional education and participate in public life, including paid employment in non-family organizations. Additionally, having smaller families allows parents to invest more in each child. Children with fewer siblings tend to stay in school longer than those with many siblings.

Reducing adolescent pregnancies:

Pregnant adolescents are more likely to have preterm or low birth-weight babies. Babies born to adolescents have higher rates of neonatal mortality. Many adolescent girls who become pregnant have to leave school. This has long-term implications for them as individuals, their families and communities.

2.4 THEORETICAL FRAMEWORK

Encarta dictionary (2009) defined theory as the body of rules, ideas, principles and techniques that apply to a subject especially when seen as distinct from actual practice. However, this study anchored on the health belief model.

2.4.1 THE HEALTH BELIEF MODEL

The health belief model (HBM) is a psychological health behavior change model developed to explain and predict health-related behaviors, particularly in regard to the uptake of health services (i.e. family planning participation). The health belief model was developed in the 1950s by social psychologists at the U.S. Public Health Service and remains one of the best known and most widely used theories in health behavior research. The health belief model suggests that people's beliefs about health problems, perceived benefits of action and barriers to action, and self-efficacy explain engagement (or lack of engagement) in health-promoting behavior. Stimulus, or cue to action, must also be present in order to trigger the health-promoting behavior. The Health Belief Model is a framework for motivating people to take positive health actions that uses the desire to avoid a negative health consequence (pregnancy related issues) as the prime motivation. It's important to note that avoiding a negative health consequence is a key element of the HBM.

Health Belief Model: Major Concepts

HBM is based on seven key concepts. The following table, excerpted with minor modifications from "Theory at a Glance: A Guide for Health Promotion Practice" (1997), presents definitions and applications for each of the key concepts.

Perceived severity

Perceived severity refers to the subjective assessment of the severity of a health problem and its potential consequences. The health belief model proposes that individuals who perceive a given health problem as serious are more likely to engage in behaviors to prevent the health problem from occurring (or reduce its severity).

Perceived susceptibility

Perceived susceptibility refers to subjective assessment of risk of developing a health problem. The health belief model predicts that individuals who perceive that they are susceptible to a particular health problem will engage in behaviors to reduce their risk of developing the health problem. Individuals with low perceived susceptibility may deny that they are at risk for contracting a particular illness. Others may acknowledge the possibility that they could develop the illness, but believe it is unlikely. Individuals who believe they are at low risk of developing an illness are more likely to engage in unhealthy, or risky, behaviors. Individuals who perceive a high risk that they will be personally affected by a particular health problem are more likely to engage in behaviours to decrease their risk of developing the condition.

The combination of perceived severity and perceived susceptibility is referred to as perceived threat. Perceived severity and perceived susceptibility to a given health condition depend on knowledge about the condition. The health belief model predicts that higher perceived threat leads to higher likelihood of engagement in health-promoting behaviours (antenatal care utilization).

Perceived benefits

Health-related behaviours are also influenced by the perceived benefits of taking action. Perceived benefits refer to an individual's assessment of the value or efficacy of engaging in a health-promoting behaviour to decrease risk of disease. If an individual believes that a particular action will reduce susceptibility to a health problem or decrease its seriousness, then he or she is likely to engage in that behaviour regardless of objective facts regarding the effectiveness of the action. For example, individuals who believe that wearing sunscreen prevents skin cancer are more likely to wear sunscreen than individuals who believe that wearing sunscreen will not prevent the occurrence of skin cancer.

Perceived barriers

Health-related behaviours are also a function of perceived barriers to taking action. Perceived barriers refer to an individual's assessment of the obstacles to behaviour change. Even if an individual perceives a health condition as threatening and believes that a particular action will effectively reduce the threat, barriers may prevent engagement in the health-promoting behaviour. In other words, the perceived benefits must outweigh the perceived barriers in order for behaviour change to occur. Perceived barriers to taking action include the perceived inconvenience, expense, danger (e.g., side effects of a medical procedure) and discomfort (e.g.,

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pain, emotional upset) involved in engaging in the behaviour. For instance, lack of access to affordable health care and the perception that it will breed complication in pregnancy will cause significant pain may act as barriers to utilizing antenatal care.

Modifying variables

Individual characteristics, including demographic, social, structural and economic factors can affect perceptions (i.e., perceived seriousness, susceptibility, benefits, and barriers) of health-related behaviours. Demographic variables include age, sex, ethnicity, and education, among others. Structural variables include knowledge about a given disease and prior contact with the disease, among other factors. The health belief model suggests that modifying variables affect health-related behaviours indirectly by affecting perceived seriousness, perceived susceptibility, perceived benefits to action, and barriers of non-engagement

Cues to action

The health belief model posits that a cue, or trigger, is necessary for prompting engagement in health-promoting behaviours. Cues to action can be internal or external. Physiological cues (e.g., pain, symptoms) are an example of internal cues to action. External cues include events or information from close others, the media, or health care providers promoting engagement in health-related behaviors. Examples of cues to action include a reminder postcard from a dentist, the illness of a friend or family member, and product health warning labels. The intensity of cues needed to prompt action varies between individuals by perceived susceptibility, seriousness, benefits, and barriers. For example, individuals who believe they are at high risk for a serious illness and who have an established relationship with a primary care doctor may be easily persuaded to get screened for the illness after seeing a public service announcement, whereas

individuals who believe they are at low risk for the same illness and also do not have reliable access to health care may require more intense external cues in order to get screened.

Self-efficacy

Self-efficacy was added to the four components of the health belief model (i.e., perceived susceptibility, seriousness, benefits, and barriers) in 1988. Self-efficacy refers to an individual's perception of his or her competence to successfully perform behavior. Self-efficacy was added to the health belief model in an attempt to better explain individual differences in health behaviors.

2.5 CONCEPTUAL FRAMEWORK

The conceptual framework describes the relationships among several variables that have been identified important to the study. The framework is divided into two categories, the first category describe the Independent variables which include predictor variables(Age, knowledge of FP, Ethnicity, Religion etc.) and the second category include the dependent variable(men participation in family planning). The framework describes how predictor variables could affect or predict men participation in family planning. The figure below shows a diagrammatic illustration.

Figure 2.1

INDEPENDENT VARIABLE

PREDICTORVARIABLES

Knowledge of family planning

Spousal communication

Age

Level of Education

Income

Employment status

Religion

Ethnicity

DEPENDENT VARIABLE

Men's participation in Family planning
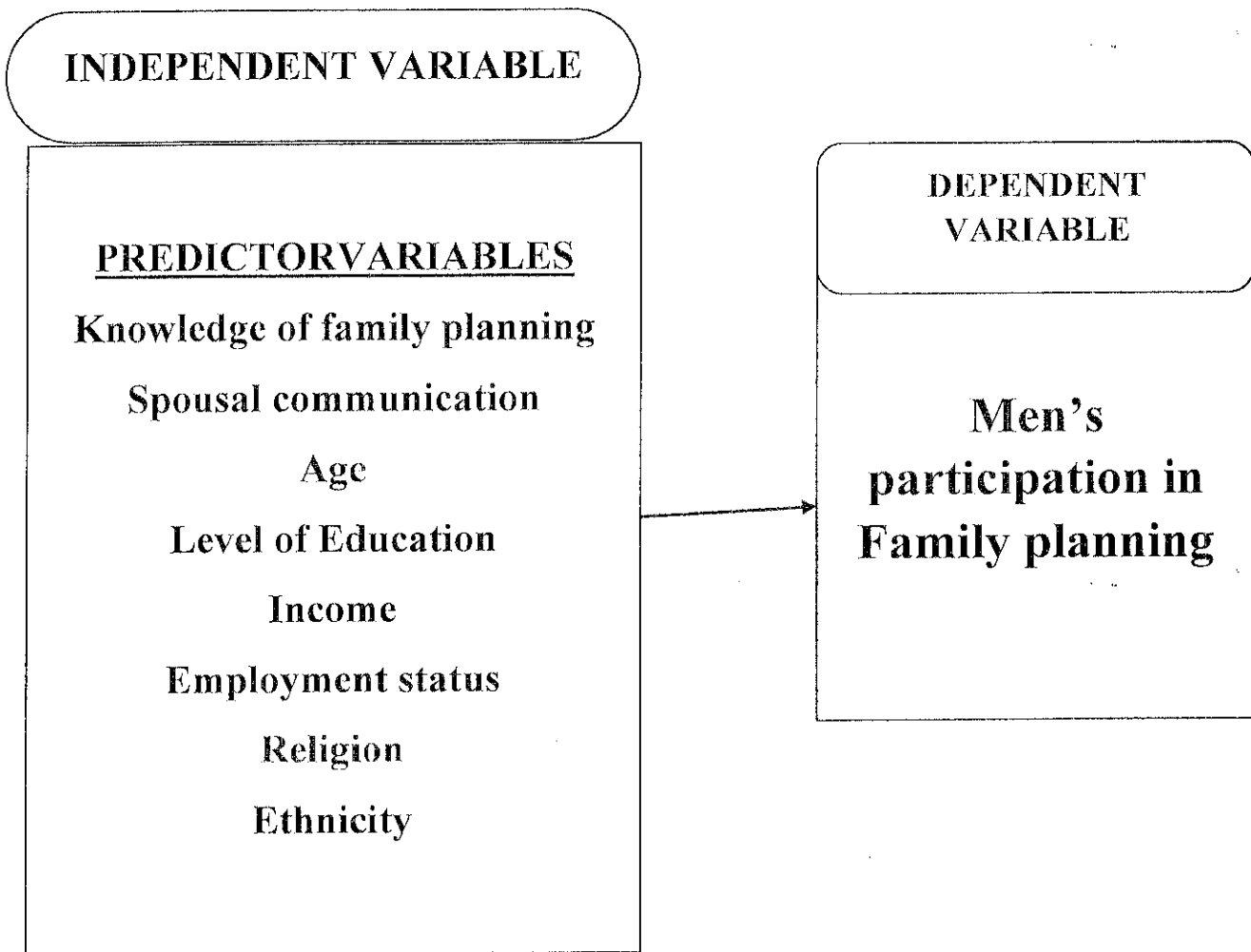
Source: Author's construct, 2018

CHAPTER THREE

METHODOLOGY

3.1 DESCRIPTION OF THE STUDY AREA

3.1.1   STUDY AREA

Ekiti is one of the states in western Nigeria, came into an existence on 1st October, 1996 alongside five other state. These states were created by the military under the dictatorship of General Sani Abacha. The state, carved out of the territory of old Ondo State, covers the former twelve local government areas that made up the Ekiti Zone of old Ondo State. On creation, it had sixteen Local Government Areas (LGAs), having had an additional four carved out of the old ones.

In Nigeria, Ekiti state is on the 32 place by area and on the 29 by the population number. The number of inhabitants of the state is about 3 million. Ado Ekiti is a municipal center of the state, the population of Ado Ekiti is over 360 thousand people. (Wikipedia, 2017)

The Ekiti, whose ancestors migrated from Ile-Ife as a people. form one of the largest ethnic groups in Yoruba land. Ekitis are culturally homogeneous and they speak a dialect of Yoruba Language known as Ekiti. The homogeneous nature of Ekiti confers on the state some uniqueness among the states of the federation. Slight differences are noticeable in the Ekiti dialects of the Yoruba Language spoken by the border communities to other states. For example, the people of Ado Local government Area do not speak exactly the same dialect with the people of Ijero Local government area, while the people of Ikole area speak something different from the people of Ikere area. The communities influenced by their locations include Otun (Moba

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Land) that speaks a dialect close to the one spoken by the Igbominas in Kwara State. The people of Oke-Ako, Irele, Omuo speak a similar dialect to that of Ijesas of Osun State. However, part of the uniqueness of the Ekiti is that wherever is your own part of the state, you will understand well, when the other Ekiti man/woman speaks, in spite of the dialectal variations. In addition, all towns in Ekiti State take a common suffix, "Ekiti," after their names. The main staple food of the people of Ekiti is pounded yam with Isapa soup or vegetable soup.

3.1.2 STUDY POPULATION

Ikole is a Local Gov Area of Ekiti State, Nigeria. Its headquarters are in the town of Ikole. It has an area of 321 km² and a population of 168,436 at the 2006 census. The LGA comprises of twenty four town and villages. Towns that comprise the LGA are:Ikole, Ijesha, Isu, Oke Ayedun, Ootunja, Odo-Oro, Ipao, Itapaji, Ara, Isaba, Usin, Orin, Odo, Odo Ayedun, Ayebode, Oke Ako, Irele, Iyemero, Ikosi, Igbona, Asin, Esun, Temidire, Ikunri, Ijebu-Agege and Ilamo. The Local Government is predominantly a homogenous society and carefully populated by Ekiti speaking people of the South West Zone of Nigeria. The Religion of the people are mainly Christian and Islamic while a percentage of the people are Traditional worshippers.The thriving industries in the local government are Agriculture and Lumbering which include Timber/Saw mills which include Olo Sawmill, Okejebu, Eleyero Sawmill, Ilamo and Ara Sawmill, Ara; Pharmacies which include Chuks Pharmacy and Okoli Pharmacy both located at Ikole. Ikole's land are one of the most fertile, and with high degree of accessibility to water bodies. Itapaji dam with enormous mini-hydroelectric power potential, as well as water supply opportunities for irrigation and townships is located in Ikole. Even as Oye river nearby flows into River Ele and provides substantial alluvial deposits in the Ikole plains for year round agriculture

3.2   RESEARCH DESIGN AND SAMPLING PROCEDURE

The target sample size comprise of 205men randomly selected in their respective homes and in their different places of work during the study period.

3.2.1 SAMPLING TECHNIQUES

In view of the size of the study area, a representative sample of 250 men was randomly selected using simple random sampling. All the major streets were clearly designated and random selections were done to select eligible respondents. Data were collected through the use of detailed questionnaire.

3.4   SOURCE OF DATA

The major instrument of data collection was structured questionnaire which comprised both the open ended and close ended questions to yield appropriate response. The questionnaire was divided into two major sections. The first section described the socio-demographic characteristics of the respondent while the other section related to described the information on men's participation in family planning.

3.5   DATA COLLECTION METHOD

Primary Data was used in this course of research, A simple random sampling was used to conduct elicit responses to coded questions, informed consent from each participant was sought, respondents were clearly informed they couldn't quit the interview at any time and were guaranteed the information given would be kept strictly confidential.

3.6. VARIABLE DESCRIPTION AND MEASUREMENT

DEPENDENT VARIABLE

VARIABLE	DESCRIPTION	MEASUREMENT
Men's participation in family planning	This is the extent to which men participate in decision making, purchasing and use pertaining to choice of family planning used by couple.	-Decision making -Purchase - Use -Non involvement

INDEPENDENT VARIABLES

VARIABLE	DESCRIPTION	MEASUREMENT
Knowledge of family planning	This describes Knowledge or awareness about various family planning methods.	Aware Not aware
Spousal communication	This is the extent to which men communicate with there spouse in decision making pertaining to choice family planning methods.	Communicate Do not communicate

Age	Age the length of an existence extending from the beginning to any given time- 15-24, 25-34, 35-44, 45+	15-24, 25-34, 35-44, 45+
Education attainment	This is the highest education attained by respondent in the study area	No education Primary education Secondary education Post-secondary education Others(specify)
Religion	This indicates the religion of respondent in the study area	Christianity Islam Traditionalist Others(specify)
Ethnicity	This refers to the ethnic group of the women in the study area. Categorized to three	Igbo Yoruba Hausa/Fulani Others(specify)
Incom	This describes the total money receivable by couple in a month	Below minimum wage Above minimum wage
Employment status	This refer to the employment	Unemployed(Not working)

	status of respondent in the study area classified into two major group: employed or unemployed	Employed (working)

3.7 METHOD OF ANALYSIS

The analyses were done at three levels. univariate, bivariate and multivariate using statistical software for social sciences(SPSS 20). At the univariate level, frequency distribution table was used to describe both the dependent and the independent variables. Also, Chi square and logistics regression were used at the bivariate level and multivariate level respectively to determine the relationship and effect of independent variable on dependent variables

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.1 INTRODUCTION

This chapter consists of data analysis, presentation and interpretation. Data collected through questionnaire were analyzed using Statistical Package for Social Science (IBM SPSS statistics 20) according to research questions of the study. The first part of the analysis was based on a Univariate level of analysis, using simple frequencies and percentages to describe the dependent and the independent variables. The second and the last part describe the relationship and effect of independent variable on dependent variables at a Bivariate and Multivariate level of analysis.

4.2 SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

The participants were asked some demographic and socio-economic questions which included their age, highest level of education, marital status, employment status, religion, ethnicity, intended number of children and number of living children.

The age of respondents were asked and reported in single ages but were recoded to grouped ages in the course of the analysis. Table 4.1 describe age of respondents in 9 years interval, it showed that 28.0% (46) of respondents are within age range 25 to 34 which clearly depict a youthful population and people within age range of 45-54 and 55+ had the least frequency proportion of 10.4% and 13.2% respectively. The table described level of education in four categories of which more than two-third of the respondents attended at least a primary education in fact 39.6% of the respondents had post-secondary education while only 19.6% of the respondents have no formal education. This pose high level of education (literacy) in the local government and education has a direct influence on use of contraceptive. The table also showed that majorities (73.2%) of the

respondents were working and 24.0% reported they were not working. This implies that most of the respondent can afford to pay for family planning methods. As expected, a large proportion of men in Ikole Local Government Area were Christians (86.4%) while a few of them reported they were Muslims and Traditionalist. Again, majority were Yoruba (86.7%) while others were Igbo and Hausa. As a matter of fact ha43.6% of the respondents reported they received less than 20,000 monthly and 44% were found receiving between 20,000 and 40,000 and 12% said they received more than 40,000 monthly. Finally 32.8 reported no children while 49.6% had between 1 to 4 children and 17.6% had 5 or more children.

TABEL 4.1 DISTRIBUTION OF MEN BY SELECTED SOCIO-DEMOGRAPHIC VARIABLES

VARIABLE	FREQUENCY	PERCENTAGE (%)
AGE		
15-24	52	20.8
25-34	70	28.0
35-44	69	27.6
45-54	26	10.4
55+	33	13.2
Total	250	100.0
LEVEL OF EDUCATION		
No education	49	19.6
Primary education	48	19.2
Secondary education	44	17.6
Post-secondary	99	39.6
others	9	3.6
Total	249	99.6
EMPLOYMENT STATUS		

Not Working	67	26.8
Working	183	73.2
Total	250	100.0
RELIGION		
Islam	31	12.4
Christian	209	83.6
Traditional	10	4.0
Total	250	100.0
ETHNICITY		
Igbo	16	6.5
Yoruba	216	87.4
Hausa/Fulani	11	4.5
Others	4	1.6
Total	247	100.0
INCOME		
Less than 18,000	109	43.6
18,000-40000	110	44.0
40000+	31	12.4
Total	250	100.0
INTENDED NUMBER OF CHILDREN		
No children	2	0.8
1-4	144	57.6
5+	104	41.6
Total	250	100.0
NUMBER OF LIVING CHILDREN		
No children	82	32.8

1-4	124	49.6
5+	44	17.6
Total	250	100.0

SOURCE: AUTHOR'S WORK, 2018

4.3 AWEARNESS OR KNOWLEDGE OF CONTRACEPTIVE METHODS

Table 4.2 describes the attitude and knowledge of men in Ikole Local Government Area towards various contraceptive methods. It's important to access what and to what extent they know about various contraceptive methods. Majority (85.2%) of respondents reported they have heard about contraceptive methods, 37.3% reported they have heard or know Female sterilization while a larger percentage (41.3%) has heard about male sterilization. 63% reported they don't know female sterilization while 36% said they knew men sterilization. 20% reported they knew IUD while more than half (52%) reported they knew injectable. As expected, more than 80% knew about male condom and withdrawer methods.

Table 4.2DISTRIBUTIONS OF MEN BY AWEARNESS OR KNOWLEDGE OF CONTRACEPTIVE METHODS

VARIABLE	FREQUENCY	PERCENTGE (%)
AWEAR OF CONTRACEPTIVEMETHOD		
Yes	213	85.2
No	37	14.8
Total	250	100.0
Female sterilization		

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Yes	90	36.0
No	159	63.6
Total	249	99.6
Male Sterilization(Vasectomy)		
Yes	92	36.8
No	150	60.0
Total	242	96.8
IUD		
Yes	51	20.3
No	198	79.2
Total	249	99.6
INJECTABLES		
Yes	131	52.4
No	117	46.8
Total	248	99.2
CONDOM		
Yes	223	89.2
No	27	10.8
Total	250	100.0
WITHDRAWER METHOD		
Yes	191	76.4
No	54	21.6
Total	245	98.0
DIAPHRAM		
Yes	57	22.8
No	192	76.8
Total	249	96.6

SOURCE: AUTHOR'S WORK, 2018

4.4 PARTICIPATION IN FAMILY PLANNING PROGRAMS

The table below shows the participation rate of Men in family planning programs in Ikole Local Government Area. 60% reported they do not participate in choosing family planning programs for their family while 40% reported they participated in choosing the programs for their family. Again the table showed that a larger percentage (72.0%) of men reported they discuss family planning with their spouse.

Table 4.3 UNIVARIATE ANALYSIS OF MENS' PARTICIPTION IN CHOOSING FAMILY PLANNING

PARTICIPATE IN FAMILY PLANNING	FREQUENCY	PERCENTAGE (%)
Yes	100	40.0
No	150	60.0
Total	250	100.0
DISCUSSED FAMILY PLANNING		
Yes	68	27.2
No	180	72.0
Total	248	99.2

SOURCE: AUTHOR'S WORK, 2018

4.5: RELATIONSHIP BETWEEN DEPENDENT VARIABLE AND INDEPENDENT VARIABLES

4.5.1: BIVARIATE ANALYSIS OF MEN'S SOCIO-DEMOGRAPHIC CHARACTERISTICS AND PARTICIPATION IN CHOOSING FAMILY PLANNING PROGRAMS

Bivariate analysis was conducted to investigate the relationship between dependent and independent variables and to ascertain significant relationship at 95% significant level. Chi-square was employed to state the significant level of each predictor variables in relation to participating in family planning. Age, highest level of education, ethnicity, income, employment status, number of intended children, number of living children and religion were observed.

From the table, age showed a chi-square value of 20.191 and p-value of 0.000 considered too good or statistically significant (p-value< 0.05) and said to have relationship with participation in family planning. Religion of respondents were considered and it had statistical significance with men's participation in family in the study area (α 0.010<0.05). Also, the level of education of men in Ikole Local Government Area had a significant relationship with participating in family planning (table value of 28.02 and α 0.000). However, the current number of living children of respondent in the study area had a significant relationship with participating in family planning with p-value of 0.000 and table value of 12.47 and the ethnicity of the respondent had a significant relationship with participating in family planning in the study area(α 0.048<0.05). Furthermore, income and employment status were found not statistically significant (p-value> 0.05) and said not having relationship with men's participation in family planning in the study area.

Table 4.4 BIVARIATE ANALYSIS SHOWING RELATIONSHIP BETWEEEN MEN'S SOCIO-DEMOGRAPHIC CHARACTERISTICS AND PARTICIPATION IN CHOOSING FAMILY PLANNING IN IKOLE EKITI, NIGERIA

VARIABLE	PARTICIPATE	DO NOT PARTICIPATE	TOTAL
AGE			
15-24	26(50.0%)	26(50.0%)	52(100.0%)
25-34	35(50.0%)	35(50.0%)	70(100.0%)
35-44	29(42.0%)	40(58.0%)	69(100.0%)
45-54	7(23.5%)	19(73.1%)	26(100.0%)
55+	3(9.1%)	30(90.9%)	33(100.0%)
Total	100(40.0%)	150(60.0%)	250(100.0%)

CHI-SQUARE= 20.191   P-VALUE = 0.000

LEVEL OF EDUCATION			
No education	7(14.3%)	42(85.7%)	49(100.0%)
Primary education	10(20.8%)	38(79.2%)	48(100.0%)
Secondary education	17(36.6%)	27(61.4%)	44(100.0%)
Post-secondary	62(62.6%)	37(37.4%)	99(100.0%)
others	3(40.0%)	6(66.7%)	9(100.0%)
Total	99(39.8%)	150(57.7%)	249(100.0%)

CHI-SQUARE= 42.246   P-VALUE= 0.000

MARITAL STATUS			
Single	34(51.5%)	32(48.5%)	66(100.0%)
Married	27(45.0%)	33(55.0%)	60(100.0%)

Separated/divorced	0(0.0%)	8(100.0%)	8(100.0%)
Widowed	0(0.0%)	15(100.0%)	15(100.0%)
Total	61(40.9%)	88(59.1%)	149(100.0%)

CHI-SQUARE=19.405   P-VALUE=0.000

EMPLOYMENT STATUS			
Not Working	23(36.3%)	44(65.7%)	67(100.0%)
Working	77(42.1%)	106(57.9%)	183(100%)
Total	100(40.0%)	150(60.0%)	250(100.0%)

CHI-SQUARE= 1.227   P-VALUE= 0.268

RELIGION			
Islam	9(29.0%)	22(71.0.7%)	31(100.0%)
Christian	91(43.5%)	118(56.5%)	209(100.0%)
Traditional	0(0.0%)	10(100.0%)	10(100.0%)
Total	100(40.0%)	150(60.0%)	250(100.0%)

CHI-SQUARE= 9.312   P-VALUE= 0.010

ETHNICITY			
Igbo	7(43.8%)	9(56.2%)	16(100.0%)
Yoruba	89(41.2%)	127(58.8%)	216(100.0%)
Hausa/Fulani	0(0.0%)	11(100.0%)	11(100.0%)
Others	1(25.0%)	3(75.0%)	4(100.0%)
Total	97(39.3%)	150(60.7%)	247(100.0%)

CHI-SQUARE 7.928	P-VALUE 0.048		
INCOME			
Less than 18,000	38(34.9%)	71(65.1%)	109(100.0%)
18,000-40000	46(41.8%)	64(58.2%)	110(100.0%)
40000+	16(51.6%)	15(48.4%)	31(100.0%)
Total	100(40.0%)	150(60.0%)	250(100.0%)
CHI-SQUARE = 3.093	P-VALUE= 0.213		
INTENDED NUMBER OF CHILDREN			
No children	2(100.0%)	0(0.0%)	2(100.0%)
1-4	75(52.1%)	69(47.9%)	144(100.0%)
5+	13(22.1%)	81(77.9%)	104(100.0%)
Total	100(40.0%)	150(60.0)	250(100%)
CHI-SQUARE = 25.621	P-VALUE = 0.000		
NUMBER OF LIVING CHILDREN			
No children	38(46.3%)	44(53.7%)	82(100.0%)
1-4	59(47.6%)	65(52.4%)	124(100.0%)
5+	3(6.8%)	41(93.2%)	44(100.0%)
Total	100(40.0%)	150(60.0%)	250(100.0%)
CHI-SQUARE= 24.529	P-VALUE-= 0.000		

SOURCE: AUTHOR'S WORK, 2018

4.6 LOGISTIC REGRESSION MODEL PREDICTING MENS' PARTICIPATION IN FAMILY PLANNING IN IKOLE LOCAL GOVERNMENT AREA, NIGERIA.

A logistic regression was performed to ascertain the effect of age, religion, ethnicity, income, level of education and number of living children on likelihood that participant will involve in choosing various family planning methods for their family. Considering age of respondents, age 15-24 was taken as reference category however age 25-34 were found statically significant (α 0.013< .05) and 9% less likely to participate in choosing FP methods in comparison to age 15-24(reference category) while age 35-44 was found statistically significant (α 0.031) while age 45-54 and 55+ were 17%, 23% and 49% respectively less likely to participate in choosing family planning. Considering education of respondents, haven taken no education as reference category, primary education were 53% less likely to participate while secondary and post-secondary were 8% and 1.7% more likely to participate in choosing FP methods for their family. Furthermore, religion of respondents was not found significant and had no relationship with men's participation. Considering number of living children haven taken no children as reference category, those who had 1-4 children were 47% more likely to participate while those who had 5+ were 32% less likely to participate in choosing family planning methods for their family.

Table 4.5 LOGISTIC REGRESSION MODEL SHOWING RELATIONSHIP BETWEEN DEPENDENT AND INDEPENDENT VARIABLES.

VARIABLES	ODD RATIO	P>Z	(95% CONF.)	
			UPPER INTERVAL	LOWER INTERVAL
AGE 15-24RC	1.0			

25-34	0.099	0.013	0.016	0.611
35-44	0.173	0.031	0.035	0.851
45-54	0.234	0.064	0.050	1.089
55+	0.495	0.421	0.089	2.744
RELIGION				
IslamRC	1.0			
Christian	0.000	0.998	0.000	
Traditional	0.000	0.998	0.000	
ETHNICITY				
IgboRC	1.0	****	****	
Yoruba	23.0	0.999	0.000	
Hausa/Fulani	15.2	0.999	0.000	
Others	1.4	0.998	0.000	
INCOME				
Less than 18,000 RC	1.0	***	****	***
18,000-40000	1.683	0.266	0.672	4.216
40000+	1.413	0.483	0.538	3.708
NUMBER OF LIVING CHILDREN				
No childrenRC	1.0			
1-4	0.478	0.389	0.089	2.562
5+	0.328	0.156	0.070	1.531

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

The study set out to predict, establish and understandmen'sparticipation in family planning in Ikole Local Government Area, Nigeria. This chapter provides the summary of the findings, discussion of the findings, conclusion of the findings from the research, and recommendations for improving utilization and effective (correct and consistent) useof available FP methods and for further research.

5.2 SUMMARY OF THE FINDINGS

The first specific objective of this study was to ascertain the prevalence level of men's participation in family planning in Ikole Local Government area, Nigeria. The findings demonstrated the level (table 4.3) by categorizing to either participating or not participating and the result showed that 60% do not participate in choosing family planning programs for their family while 40% reported they participated in choosing the programs for their family.

The content of the study was to examine the predictors of men's participation in family planning and two level of analysis was employed (bivariate using chi-square and Multivariate using logistic regression model). The bivariate analysis (table 4.4) considered age and it showed a chi-square value of 20.191 and p-value of 0.000 considered too good or statistically significant (p-value< 0.05) and said to have relationship with participation in family planning. Religion of respondents were considered and it had statistical significance with men's participation in family

in the study area (α 0.010<0.05). Also, the level of education of men in Ikole Local Government Area had a significant relationship with participating in family planning (table value of 28.02 and α 0.000). However, the current number of living children of respondent in the study area had a significant relationship with participating in family planning with p-value of 0.000 and table value of 12.47 and the ethnicity of the respondent had a significant relationship with participating in family planning in the study area(α 0.048<0.05). Furthermore, income and employment status were found not statistically significant (p-value> 0.05) and considered not having relationship with men's participation in family planning in the study area.

The logistic regression model considering age of respondents, age 15-24 was taken as reference category however age 25-34 were found statically significant (α 0.013< .05) and 9% less likely to participate in choosing FP methods in comparison to age 15-24(reference category). The statistics speaks and clearly describe the level and key predictor variables that have major influence in participating in choosing family planning methods.

5.3   CONCLUSION

More than half(60%) of the men in Ikole local Government Area were found not fully participating in choosing contraceptive methods for their families and the prevalence poses need to revisit and re-orientate about need to take part in the process. However the study has done justice to the objectives of the research and clearly conclude that predictor variables such as age, level of education, intended number of children, religion, ethnicity and number of living children can influence participation in choosing family planning methods for the family and again, income and employment status may not be paramount factors to examine when designing policy and intervention programs.

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4   RECOMMENDATIONS

Based on the findings of this study, the researcher made the following recommendations

1.   Respondents were found not having interest in choosing family planning for their family however there is still need to educate..

2.   Majority (84.7%) of respondents reported they have heard about contraceptive methods but few were involved however impactful programs to encourage effective use should be introduced.

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PREDICTORS OF MEN'S PARTICIPATION IN FAMILY PLANNING IN IKOLE LOCAL GOVERNMENT AREA, NIGERIA.

QUESTIONNAIRE

INTRODUCTION

Dear Sir, my name is OLANIYI AISHA, a final year student from the Department of Demography and Social Statistics, Federal University Oye-Ekiti. I am conducting a survey on **The predictors of men's participation in family planning in Ikole Local Government Area, Nigeria.** I would appreciate your participation and the information you give will be kept strictly confidential. Please, if you come across any question you don't want to answer, you can answer the next question or stop the interview at any time. However I hope you will participate in this survey since your views are important.

Thank You

_____

SECTION A: SOCIO-DEMOGRAPHIC CHARACTERISTICS

1. How old are you as at your last birthday? ....

2. What is your highest level of education? No formal education...(1) Primary education......(2) Secondary education........(3) Post-secondary.........(4) Others(specify)...............(5)

3. What is your marital status? Single..........(1) Married.........(2) Separated/Divorced..........(3) Widower..........(4) Others(specify)

4. What is your employment status? Not working.......(1) Working.....(2)

5. What is your religion? Christian....(1) ....Islam....... Traditional.....(2) Others (3) specify.......(3)

6. What is your ethnic origin? Yoruba..........(1) Igbo.........(2) Hausa/Fulani............(3) Others specify........(4)

7. What is your average total income per month?.............

8. How many children do you intend to have? ....

9. How many children do you currently have? ....

SECTION B (FAMILY PLANNING PARTICIPATION)

10. Have you ever heard about family planning?

Yes.........1   No.........2

11. Have you ever heard about any of these family planning method?(Tick as many as you know)

Female sterilization	Yes ... ... 1 No........2	COCs or "the pills"	Y e s ... 1 No........2
Male sterilization(vasectomy)	Yes ... ... 1 No........2	Female condom	Y e s ... 1 No........2
IUD	Yes ... ... 1 No........2	hysterectomy	Y e s .... 1 No........2
Injectables	Yes ... ... 1 No........2	Implant	Yes ... ... 1 No........2
Male condom	Yes ... ... 1 No........2	Rhythm	Yes ... ... 1 No........2
Withdrawal	Yes ... ... 1 No........2	Lactational amenorrhea	Yes ... ... 1 No........2
Diaphragm	Y e s ... 1 No........2	Others(specify)	

12. Do you participate or involve in choosing family planning methods for your family?

Yes......(1) No..........(2)

13. In last few months, have you discussed family planning with your sexual partner or wife?

Yes.........(1) No.........(2)

14. In last few months, have you discussed family planning with a health worker or health professional?

Yes.........(1) No.........(2)

15. From one menstrual period to the next, are there certain days when a woman is more likely to become pregnant when she has sexual relations?

Yes.........(1) No.............(2) Don't know.......(3)

16. is this time just before her period begins, during her period, right after her period has ended or halfway between two periods?

Just before her period begins ....(2)   During her period ....(1)
Right after her period has ended ....(3)   Halfway between two periods ....(4) Others(specify)............(5) Don't know.......(6)

Read the following statements and tick if you agree or disagree with each one

	agree	Disagree	Don't know
Contraception is a woman's business and a man should not have to worry about it			
Women who use contraception may become promiscuous			