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MEN'S ROLE IN FAMILY PLANNING DECISION-MAKING IN DUTSE LOCAL GOVERNMENT AREA, JIGAWA STATE NIGERIA

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Abstract---*The purpose of this paper is to assess men's role in family planning (FP) decision-making, awareness, attitude, and practice of modern method in Dutse Local Government Area of Jigawa State. A total of 402 copies of questionnaires were administered using multi stage sampling technique. Data were analyzed descriptive and multiple logistic regression. 89% of men approved of the use of family planning while only about 11% disapproved of it. 80%of men had ever used contraception while 564 of them were current users. Spousal communication about family planning and other family reproductive goals was very poor. The socio-demographic correlates of men's opinions included religion, marriage type, educational attainment, and occupation ($p<0.05$). Family planning programmes in northern Nigeria should focus on Muslim men Religions leaders should be involved in clarifying misconceptions on issues regarding family planning.*

Keywords---*Family Planning, Men, Reproductive Health, Role, Dutse.*

I. Introduction

Men's potentially positive role in family planning (FP) has often been neglected because of the negative attitudes many men may hold towards birth control. In the industrialized world, men frequently use the availability of effective female contraceptives as an excuse for not using any birth control themselves. In the Third World, some men still insist on having the sole right to decide whether and when to have a child; many deny their wives access to contraception because they fear it will encourage promiscuity [1]. Everywhere, there are men who oppose birth control and a woman's changing roles in society because it takes from them, their power father and unlimited number of children and seems to leave with a diminished position in the family (Ibid). Most couples operate under the unilateral decision influenced by the kinship group or lineage concerns. Ordinarily, a woman does not stand alone in confronting her husband; usually, she confronts him only when supported by her husband's relatives, especially his parents, or by her own relatives[2].

Reproductive health (RH) practitioners have recognized that failure to get men has weakened the impact of FP program because men can significantly influence their partners RH decisions and use of health services especially in societies where women do not possess the same decision-making power as men. FP program in Nigeria have remained female oriented but

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because of their subordinate status, women are often not able to make their decision alone regarding FP or health care [3]. As such understanding, the role of men in family welfare is critical to the success of FP anywhere in the world.

Men's involvement could be essentially prominent in the individual couple's FP effort. It is assumed in the African context that women do not have control over their own reproductive behavior. Most studies carried out in Nigeria and other African countries [4]; Oni and [5]; [6]; [7] have all asserted the domineering position of men in reproductive health matters. According these studies, men are dominant decision makers within the family.

In Dutse Local Government Area, Islam is the major religion with Christianity and other traditional religions forming a minority group. Among the Hausa/Fulani which is the dominant ethnic group in the study area, men dominate familial and social relations, including production and reproduction. By paying the bride prize, a man secures rights over his wife and her children; a wife is expected to bear children as her contribution to the continuity and viability of her husband's lineage. Irrespective of a man's status, age or accomplishment, he remains the head of the family even if his wife subsequently rises to a position of influence in society, she acts as his subordinate.

According to traditional and religious doctrine, men have a higher status in the home and society. Planning the family for economic reasons is abhorred in the Islamic belief. However, the Hausa culture and Islamic Religion do not object the child spacing and discourage short birth intervals. This is supported by the Qur'anic verse that encourages women to breastfeed for complete two years, for the health of both mother and child. This will give the mother time to recover before the next pregnancy and proper growth of the newborn. Nonetheless, women still have closely spaced births; and with early marriage deeply rooted in the Hausa custom, so many young girls are unable to complete even primary school education. This, therefore, raises the question of the role of men play in FP despite the widespread understanding of child spacing in Islam. The aim of this paper,therefore, is to assess the role men play in the practice of family planning in Dutse LGA. The objectives include: to examine the awareness and attitude of men towards FP; analyze practice of modern FP methods , and examine the relationship between socioeconomic characteristics and FP among couples in the study area.

II. Material and Methods

Study Area

Dutse Local Government Area is in Jigawa State of Nigeria. It is located between latitudes $11^0.42^0$N and $11^0.04$" N and between longitudes 90 2^0E and 90 31^0E. The local government area is bounded in the North by Taura L.G.A, in the South by Birnin Kudu L.G.A, East by Kiyawa L.G.A all Jigawa state and in the west by Kano state. It has a population estimate figure of 17,697[8].

The town Dutse serves as both the state capital and the headquarters of Local Government Area. The major languages spoken in the local government area are Hausa, Fulfude and Banawa. The local government area is made of the following towns Duru, Dundubus, Karnaya, Dutse, Shiwari, Sakwaya, Jaudi, Madobi, and Kudai and villages Chaichai, Yargaba, Dagwaje, Wurma, Warwade, Yalwa, Hammayayi and Baranda. Some of the crops grown in the L.G.A are maize, millets, beans, sorghum, rice, groundnuts, cotton, sesame, and the tree crops are Date palm, cashew, citrus, mangoes and Guava (JARDA). Lastly, the NIFOR, Date palm substation is cited in Dutse town

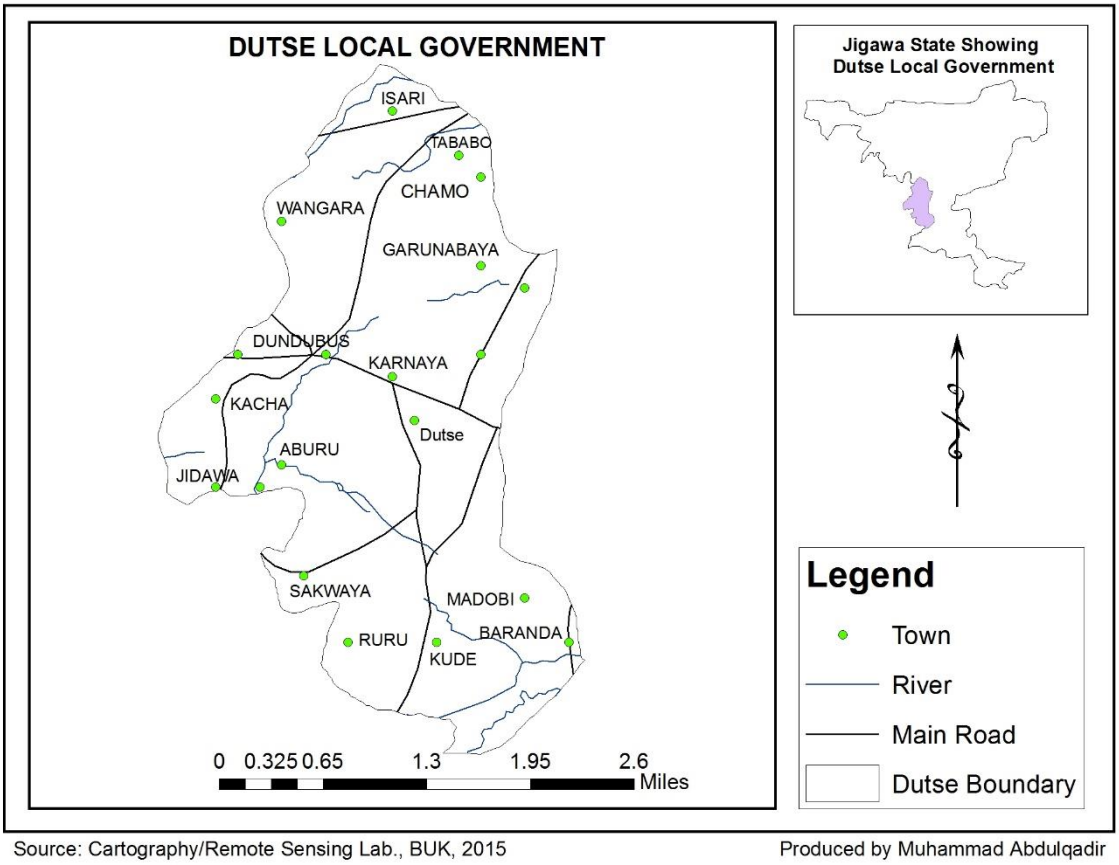

Figure 1. Map of the Study area

Study Design and Study Population

The study was cross-sectional and descriptive in design, employing quantitative and qualitative research methods.Study participants were males between the age of (15-59 years) of reproductive age [8]and family planning workers from selected health facilities

Sample Size Determination

Computer Programme for Epidemiologists (PEPI), version 3.01 was used to estimate the Sample size of respondents for the household interviews, employing the sample size formula for estimating single proportions as described by Armitage and Berry, and cited [9]. From the Nigeria Demographic and Health Survey [11] figures, the estimate of true proportion of the knowledge of modern family planning methods among men was 90 percent. Employing a standard normal deviate of 1.96 at 95 percent confidence level and a maximal allowable difference from true proportion of 3 percent (0.03), a sample size of 402 was obtained for men.

Sampling Technique

The 402 men were selected from 402 households through a multistage sampling technique. Dutse LGA of Jigawa State consists of 400 enumeration areas (EAs). These EAs were the first stage sampling units. Ten percent (10%) of the EAs were selected through a random sampling procedure. For all selected EAs, all the constituent households (second stage sampling unit) were listed. The final stage involved systematic random sampling. From each EA household listing, a first household

was randomly selected, and one eligible male respondent was interviewed from this household, and subsequently from every other K^{th} household until 10 eligible male respondents were recruited in the EA. The K factor was derived from the formula K= N/n, where N is the total number of households and n=10. Two of the EAs, however, had 11 male respondents recruited from them.

Data Collection Techniques

The study used structured questionnaire to collect information on socio-demographic characteristics of the household, information related to their awareness and knowledge of family planning methods and acceptance of modern contraceptives. Information on men's roles in communication about contraceptive choices, contraceptive decision making, family size, and child spacing were also collected.

In-depth interviews (IDIs): the only tertiary health facility in the study area were selected and, the two secondary health facilities. IDI was conducted per facility with a family planning provider. Eight (8) family planning providers were interviewed (2 females and 4 males).

Data Processing and Analysis

Out of 402 questionnaires, only 400 questionnaires were found to be valid for analysis. SPSS version 11 software were used for Quantitative data entry and analysis. Variables were summarized using frequency tables and percentages. Multiple logistic regression analyses were used to correlates the opinion of men's concerning their roles in family planning decision making, and adjusted odds ratios and confidence intervals were provided. Undecided men were removed from the multiple logistic regression analysis.

III. Results and Discussions

Sample Demographics

The age distribution for men between 18 and 59 years (Table 1), with more than two-thirds of them intheir fourth and fifth decades of life. Almost 85 percent of the men were in monogamous unions, the others in polygamous unions. Almost 3percent of men had never been to school, while about 80 percent had attained secondary or higher levels of education.

Awareness of family planning methods

Almost all (99.8%) respondents were aware of the availability ofthe modern contraceptives, and many of them were aware of two modern methods at least. As per theawareness condom was highest (98 %), withdrawal method, postpartum abstinence, and safe period was also very significant with 92.7%, 92%, and 89.4%t, respectively) (Table 2). The commonest information source about family planning was the radio (93%). Television and friends were also very common to the respondent (88.7% and 82%, respectively). The least mentioned sources of information about FP were the print media and Healthworkers (Table 3).

Table 1: Socio-demographic Variables of male survey respondents, in Dutse Local Government

Characteristics	Frequency(percent)n=400
Age (Years)	
<30	39 (9.8)
30-39	146 (36.5)

40-49	141(35.2)
50-59	74 (18.5)
Marriage type	
Monogamy	338 (84.5)
Polygamy	62 (15.5)
Education	
No formal	11 (2.8)
Primary	63 (15.7)
Juniorsecondary	25 (6.2)
Seniorsecondary	147 (36.8)
Tertiary	154 (38.5)
Religion	
Traditional	3 (0.7
Catholic	27 (6.7)
Protestant	56 (14.0)
Islam	93 (23.3)
OtherChristant	221 (55.3)

Table 2: Familyplanning methods known to male residents of Dutse Local Government area

Family Planning Methods (n=399) *	**Frequency**	**Percent**
Condom	391	98.0
Withdrawal method	369	92.7
Oral pill	367	92.0
Postpartum abstinence	366	92.0
Hormonal injections	365	91.5
Safe period	365	89.4
Traditional methods	322	80.7
Female sterilization	228	57.1
Male sterilization	189	47.4
Implant	46	11.5

Table 3: Sources of information regarding modern family planning methods

Source of information	New students	Frequency n=399*	Percent
Radio		371	93.0
Friends		354	88.7
Television		327	82.0
Health workers/Health Facility		55	13.8
Books/Journals		9	2.3

Men's attitude and practice about self/spousal use of family planning

About Eighty-nine percent (89%) of men are agreed their spouses to used family planning while only 11 percent (11%) of them opposed to it. However, almost 65% of the men objected of attending family planning clinics with their spouses, while only26 percent of them had agreed and done so. The most given reasons by men for approving of family planning use by their spouses were birth spacing (71%) and attainment of desired family size (20%). The most common reason given for not practicing of family planning use was religious dictates (44%). Even though more than 80% of the respondents had used family planning methods at one time or the other, less than 60 % of them were current users of any family planning method. Seventy-seven percent (77%) of the men reported the condom as the family planning method ever used by their families.

Table 4: Reasons for respondents' approval/disapproval of spousal use of family planning methods:

Variable	Frequency n=357	Percent	Percent
Reasons for approving spousal use of family planning			
Space birth	255	71.4	
Achieve desired family Size	72	20.4	
Avoid unwanted Pregnancy	15	4.4	
Promote child health	7	2.0	
Improve quality of child Care	7	2.0	
Marital bliss	1	0.3	

Total	**357**	**100**
Reasons for disapproving spousal use of family planning		
Religion	19	44.1
Side effects	14	30.5
Encourage infidelity	9	20.8
Reason unstated	2	4.6
Total	44	
		100

Table 5: Respondents' opinions about men's role in reproductive health decision making

Opinion regarding selected reproductive health issues:	Agree Frequency (percent)	Disagree Frequency (percent)	No response Frequency (percent)
Men should decide the family size	177 (44.3)	216 (54.0)	7 (1.8)
Men should decide on the adoption of FP	116 (29.0)	275 (68.8)	9 (2.3)
Men should decide which FP method to use	37 (9.3)	351 (87.8)	12 (3.0)
Men should decide what to do when unwanted pregnancy occurs	135 (33.8)	257 (64.3)	8 (2.0)

Spousal communication about family planning decision making

Constantly, 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 this study. Furthermore, 35 percent of men reported never discussing family planning issues with their spouses in the year preceding the survey. However,49 percent of men reported discussing family planning at least once or twice during the same period.

Correlates of men's opinions about their roles in family planning decision making

Men's opinions about their roles in family planning decision making were assessed on a three- tier scale of agree, undecided, and disagree. Generally, more male respondents disagreed than agreed that men should make decisions about selected family planning issues in the family. Forty-four percent of men agreed that men should determine family size while 54 percent disagreed; 29 percent agreed that men should make the decision about when to adopt family planning while 69 percent disagreed; 9 percent of men agreed that men should decide which family planning method to adopt while 88percent disagreed; 34 percent of men agreed that men should decide what to do about an unwanted pregnancy while 64 percent disagreed. The multivariate analysis in Table 5 controlled for age, religion, marriage type, educational attainment, and

occupation of men, and assessed the association of these variables with men's perceived opinions of their roles in family planning decision making. The following were the findings:

Family size

Compared with Protestants, Muslim men were less likely to agree that men should determine family size [OR=0.39, (95 percent CI=0.24-0.64); p<0.001]. Likewise, polygamous men compared with those in monogamous relationships were less likely to agree that men should determine family size [OR=0.37, (95 percent CI =0.18-0.72); p<0.05]. However, men who attained post-secondary education were more likely to agree that men should determine family size compared with men who attained only secondary education [OR=3.06, (95 percent CI=1.56-6.01); p<0.001]; and male traders were also more likely to agree that men should determine family size compared with male artisans [OR=2.21, (95 percent CI=1.17-4.18); p=0.05] and other occupational groups. Age did not affect male respondents' opinions about men deciding family size.

Adoption of family planning:

Men in their fifth decade, compared with those in their fourth decade, were less likely to agree that men should make decisions on adoption of family planning [OR=0.49, (95 percent CI=0.27-0.88); p<0.05] (Table 6). Likewise, polygamous men, compared with those in monogamous relationships, were less likely to opine that men should decide about adoption of family planning [OR=0.36, (95percent CI=0.18-0.72); p<0. 05]. Muslim men, compared with Protestant Christians, were less likely to agree that men should decide whether families should adopt family planning [OR=0.48, (95 percent CI=0.29-0.79); p<0.001]. Furthermore, men who attained post-secondary education were more likely to agree that men should decide the adoption of family planning compared with men who attained secondary school education only [OR=3.17, (95 percent CI=1.47-6.82; p<0.05]. Similarly, male traders were more likely to agree that men should decide adoption of family planning compared with artisans [OR=2.31, (95 percent CI=1.15-4.65); p<0.05].

Table 6: Odds ratios (OR) and (95 percent confidence intervals {CI}) from multiple logistic regression analyses assessing the association between men's socio-demographic characteristics and their opinions on the role of men in family planning decision making

Characteristic	Men should determine family size (n=400)	Men should decide on adoption of family planning (n=400)	Men should decide the type of family planning method (n=400)	Men should decide what to do with unwanted pregnancy (n=400)
	0R (95 percent CI)	0R (95 percent CI)	0R (95 percent CI)	0R (95 percent CI)
Age group (yrs)				
20-29	1.36(0.60-3.05)	1.05(0.41-2.66)	1.15(0.24-5.42)	1.61(0.65-3.98)
30-39 (ref.)	1.00	1.00	1.00	1.00
40-49	0.87(0.51-1.49)	0.49(0.27-0.88) *	0.58(0.24-1.39)	0.70(0.40-1.21)
50-59	1.36(0.69-2.69)	0.89(0.41-1.90)	0.92(0.30-2.84)	0.67(0.33-1.32)

Religion				
Catholic	2.29(0.89-5.90)	1.83(0.61-5.53)	0.62(0.17-2.25)	1.87(0.68-5.14
Protestants (ref.)	1.00	1.00	1.00	1.00
Islam	0.39(0.24-0.64) ***	0.48(0.29-0.79) **	0.56(0.26-1.20)	0.48(0.30-0.79) *
Marriage type				
Monogamy (ref.)	1.00	1.00	1.00	1.00
Polygamy	0.37(0.18-0.74) *	0.36(0.18-0.72) *	0.30(0.12-0.75) **	0.50(0.26-0.97) **
Education				
Non-formal	0.78(0.16-3.79)	0.63(0.14-2.86)	0.96(0.12-7.33)	1.49(0.31-7.07)
Primary	0.84(0.43-1.62)	1.14(0.59-2.20)	1.83(0.63-5.27)	1.04(0.55-1.97)
Secondary (ref.)	1.00	1.00	1.00	1.00
Post-Secondary	3.06(1.56-6.01) ***	3.17(1.47-6.82) *	1.82(0.61-5.44)	2.77(1.38-5.55) **
Occupation				
Artisan (ref.)	1.00	1.00	1.00	1.00
Professional	1.08(0.52-2.23	1.84(0.83-4.06)	1.35(0.43-4.25)	1.34(0.65-2.79)
Traders	2.21(1.17-4.18) *	2.31(1.15-4.65) *	2.67(0.81-8.82)	1.74(0.91-3.33)
Unemployed	0.80(0.12-5.42)	0.86(0.12-6.04)	0.39(0.01-4.00)	1.05(0.14-7.55)
Farmers	0.28(0.07-1.11)	0.44(0.14-1.39)	0.39(0.10-1.45)	0.24(0.07-0.84) *

*p<0.05 ** p<0.01; ***p<0.001 (ref.) = Reference group

Choice of family planning method:

Polygamous men, compared with those in monogamous relationships, were less likely to agree that men should decide on the type of family planning method to be adopted by the family [OR=0.30, (95 percent CI=0.12-0.75); p<0.01].

Decision if unwanted pregnancy occurs:

Muslim men, compared with their Protestant counterparts, were less likely to agree that men should decide what to do when unwanted pregnancy occurs [OR=0.48, (95 percent CI=0.30-0.79), p<0.05]. Polygamous men, compared with monogamous men, were also less likely to agree that men should decide what to do when unwanted pregnancy occurs [OR=0.50, (95 percent CI=0.26-0.97); p<0.01]. Similarly, male farmers, compared with artisans were least likely to agree that men should decide what to do when unwanted pregnancy occurs [OR=0.24, (95 percent CI=0.07-0.84); p<0.05]. However, men who attained postsecondary education, compared with less educated men, were more likely to agree that men should make decisions on what to do if unwanted pregnancy occurs [OR=2.77, (95 percent CI=1.38-5.55); p<0.01] (Table 6).

Family planning providers' perceptions of men's attendance at family planning clinics

All family planning providers interviewed corroborated men's low patronage of family planning services but reported to be favourably disposed to men attending their services. The providers were all the opinion that cultural beliefs, societal perception that family planning was a women's affair, and religious misconceptions were the main reasons for men's poor patronage.

IV. Discussion

The level of awareness of modern family planning methods by men was quite high in this study. The

pattern was similar to that found in the 2008 Nigerians, in which nine out of every 10 currently married men and women knew of at least one modern family planning method in the southwestern region of the country.[12]buttressed this point further in their study of family planning in rural Nigeria, which revealed that, generally, knowledge was high for any family planning method(91 percent), while knowledge for any modern family planning method was also high (73 percent); high level of knowledge alone was, however, not sufficient to promote a high level of use.

Among men in Ile-Ife, the condom was the most common family planning method ever used. This finding was in keeping with the findings of Orji and Onwud and the 2008 Nigeria NDHS, which both showed that the male condom was also the most common modern method ever used by married men. No male respondents had been sterilized. This might be partly since none of the facilities in Ile-Ife where the study wasconducted provided male sterilization services to their clients and partly because the cultural norm of the society is not in favour of male sterilization.21

In agreement with our findings, Orji andOnwudiegwu20 reported that religion was found to influence the attitude of married Nigerian men toward family planning. When men have a positive attitude towards family planning, use of effective contraceptive methods will be facilitated.21 Interspousal communication is an important intermediate step along the path to eventual adoption and sustained use of family planning. Men's report of the level of spousal communication about family planning and other reproductive health issues was quite poor in this study. Although discussion between a husband and wife about contraceptive use is not a precondition for adoption of contraception, its absence may be a serious impediment to use.11 Lack of discussion may reflect a lack of personal interest, hostility to the subject, or a customary reticence in talking about sex-related matters.

A multivariate analysis of the effect of sociodemographic characteristics of the male respondents on their opinions concerning the role of men on decision making about such reproductive health issues as the adoption of family planning, type of family planning method to adopt, and determination of family size revealed that age ofthe respondents hardly influenced their opinions andperceptions. More significantly, the religion, marriage type, educational attainment, and occupation of the men tended to influence what they perceived and believed. Specifically, well-educated men were more likely to attribute roles for reproductive health decision making to men, while men in polygamous relationships and Muslim men were less likely to attribute such roles to men.

These analyses clearly show that the customaryinstitutions, such as marriage and religion, continue to dominate the perceptions, beliefs, and opinions of men concerning family planning and other reproductive health decision making and must be taken into consideration when planning male directed interventions. Furthermore, the study

underscores the importance of extending partnerships for male involvement in family planning

and reproductive health to men's professional groups.

Findings from the literature revealed that family planning information and services in Africa are not

targeted towards men; services are instead traditionally presented within the context of maternal and child health.5 A technical report by United Nations Population Fund stated that most reproductive health/family planning service delivery

systems are almost entirely oriented to women and provide little or no information about male contraceptive methods. Health workers are sometimes poorly trained in counselling men about safer sexual practices and male methods and may communicate negative rumours about them.9 This focus on women has reinforced the belief that family planning is largely a woman's business, with the man playing a peripheral role.

One way to achieve greater participation of menus for the family planning providers to act as both motivators of men and their confidants. In the present study, all the family planning providers interviewed buttressed the position that men play meagre roles in matters of reproductive health and that they rarely attended family planning clinics. The service providers, though largely females, expressed a favourable disposition to men attending their clinics and always welcomed them. They reported, however, that men visited family planning clinics only to obtain condoms or in response to requests sent to them by the providers through their wives. All but one service provider encouraged the hiring of male service providers on the premise that it would increase the proportion of male clients who patronize family planning services. The literature revealed that some conventional family planning clinics have hired male staff and offered hours convenient for men, as well as additional reproductive health services for men. In Colombia, Profamily serves men at its women-oriented family planning clinics as well as in clinics for men only.23

This seemingly positive attitude of the family planning service providers in Ile-Ife is yet to be tested, as the clinics are rarely patronized by men. Itis only with the patronage of men that one can assess the field attitudes, practices, and competenciesof the providers to handle male clients and their specific needs.

A limitation of our study is the fact that the achieved sample size falls slightly short of the number needed to detect a difference of 3 percent from the true proportion of men who were aware of modern family planning methods with an alpha of 0.05 and power of 0.8. The reader is advised to exercise caution in interpreting the statistical significance of the findings. However, because relatively few studies focus on men, we believe the results offer helpful information about Nigerian male involvement in family planning.

V. Conclusion

Awareness of family planning methods among men in this study was almost universal. However, this did not translate into actual use of these methods or patronage of family planning services. In addition, male involvement in family planning decision making was poor. The correlates of men's opinions on the role of men in family planning decision making were religion, marriage type, educational attainment, and occupation. There is an urgent need to increase male involvement in family planning decision making if family planning uptake in the country will improve.

VI. Recommendation

Most decisions that affect family life, as well as political life, are made by men. They hold positions of leadership and influence from the family until right through the national level. Male role in FP means more than the number of men who encourage and support their partners to use FP methods. It also means government policy must be more conductive by developing male related programmes which include increasing the number of men using condoms and having vasectomies. The involvement of men in family planning would therefore not only ease the responsibility borne by women in terms of

decision making in family-planning matters but would also accelerate the understanding and practice of family planning in general.

Many sub-Saharan African countries are still decades away from attaining lower fertility levels. This continues to threaten the lives of women and children, but FP offers hope because it prevents women from having unplanned pregnancies. However, if FP programs are to accelerate the process of demographic change in Nigeria and Africa at large, then they would require the following:

i. Religious leaders must be involved in clarifying misconceptions on issues regarding family planning, such as FP is aimed at curbing the Muslim population or the FP promotes promiscuity among women etc.

ii. Greater political will from national leaders, which includes more commitment in implementing FP programs and not just population policies on paper. Husbands should be encouraged to support their wives by giving them permission to visit FP clinics as well as organizing transportation to the clinic, paying for family planning methods and services, and taking care of children during clinic visit.

iii. Government should provide jobs and income levels of Nigerians, which could improve their standards of living and make people desire smaller family size.

iv. Couples should be motivated to space their children beyond two years. This will reduce frequent childbirth and large family size that expose women to health problems which can contribute to high maternal mortality. Emphasizing the use of birth spacing to protect the health of mothers and children is effective and will have a better future economically.

REFERENCES

[1] Stokes, B. (1980). Men and Family Planning. World watch Paper 41. World watch Institute Washington D.C.

[2] Isiugo-Abanihe, U.C. (2003). *Male Role and Responsibility in Fertility and Reproductive Health:* Ababa Press Limited

[3] Char, A., Saavaala, M., Kulmala, T. (2009). Male Perceptions on Female *Perspectives on Sexual and Reproductive Health*. Vol. 35, No. 3. pp131- 138.

[4] Mbizvo, M.T and Adamchak, D.J. (1991). "Family Planning Knowledge, Attitude and Practice among Males in Zimbabwe". *Studies in Family Planning*, Vol. 22, No. 1, pp 31-38.

[5] Oni G.A. and MacCarthy, J. (1991). "Family Planning Knowledge, Attitude and Practice among Males in Ilorin, Nigeria. "*International Family Planning Perspective*, Vol. 17, No.2. pp 54.

[6] Isiugo-Abanihe, U.C. (1994). Reproductive Motivation and Family Size Preferences among Nigerian Men. *Studies in Family Planning*, Vol 25, No.3 pp 149-161.

[7] Lasee, A. and Becker, S. (1997). Husband-Wife Communication about Family Planning Communication and Contraceptive Use in Kenya. *International Family Planning perspective.* Vol. 30, No. 2.

[8] National Population Commission and ORC [Nigeria] Macro (2009). *Nigerian Demographic Health survey.* 2008. Calverton. Maryland, USA: NPC and ORC Macro.

[9] Lawoyin TO, Osinowo H, Babatunde M, Bajomo TG, BetikuAO, Busari KT, Fehintola A. Family planning in rural Nigeria: a study among men. Afr J Med Sci2002;31(2):159- 62.

[10] Orji EO, Onwudiegwu U. Contraceptive practice among married men in Nigeria. East Afr Med J 200;(80) 7:357-60.

[11] Umoh A.V., Abah G.M and Ekanem, U.S. (2012). A study of Fertility Intentions of Women in Uyo, Nigeria. *Journal Public Health and Epidemiology.* Vol. 4, No. 1, pp 14-18.

[12] Wright, J. B. and McCarthy, P. (1970) "Geology of Zaria" In Mortimore, M.J. (Edo Zaria and its Region: A *Nigerian Savannah City and Its Environs.* Occasional Paper No. 4, Department of Geography, Ahmadu Bello University, Zaria.

[13] Solomon, A., Larai A., Ado Z. M., Sunday A., Oladapo, S., Ejembi C. (2010). Fertility Intentions, Contraceptive Awareness and Contraceptive Use Among Women in their Communities in Northern Nigeria. africanJournal of Reproductive Health. Vol. 14, No. 3, pp 47.

[14] Tyoden, C.L. (2010). *Gender Roles and Responsibilities in Zaria.* An Unpublished M.Sc. Project. Department of Geography, Ahmadu Bello University, Zaria.

[15] Morgan, S.P. nad Niraula, B. (1995). How Gender Roles Influence Sexual and Reproductive Health among South African Adolescent. *Studies in Family Planning*, Vol. 34, No.3, pp 160-172.

[16] Mortimore, M.J. (1970). Zaria and Its Region: A Nigerian Savannah City and Its Environs. Occasional Paper No. 4, Department of Geography, Ahmadu Bello University, Zaria