KNOWLEDGE, ATTITUDE AND PRACTICES OF FAMILY PLANNING AMONG MEN IN IBADAN SOUTH EAST LOCAL GOVERNMENT AREA OF OYO STATE.

BY

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i

DEDICATION

Dedicated edo my beloved Parents

MR. ISAAC. U. AFFIA and MRS. ALICE E. AFFIA

for their love and care.

ABSTRACT

Men's role in the adoption and use of contraception has often been neglected in family health studies. This situation may be due to the assumption that they have negative attitude towards the use of contraceptives either by themselves or by their spouses. Factors that may contribute to this behaviour include among others demographic variables, knowledge of contraception and socio-cultural practice.

The purpose of this study is to assess men's knowledge, attitude and practices of family planning in the traditional inner core of Ibadan.

Using a combination of multistage and random sampling techniques, a total of 460 men was selected from the 10 wards of Ibadan South East Local Government.

Results showed that majority of the respondents' 398 (86.5%) have heard of family planning and the most important source of information was the radio (81.9%). Of this number, 22.3% and 87.7% could name at least one traditional and one modern method respectively. Although 366 (92.0%) respondents' felt that men should be involved in family planning programmes, 65.6% single-handedly decided whether or not their wives should use contraceptives. In addition, negative attitudes towards their spouses use of any method of contraception were recorded among 274 (68.8%) respondents. This attitudinal disposition was largely influenced by the fear of contraceptive side effects. It is not surprising therefore that only 23.6% of the respondents' spouses are currently using modern methods of contraception while only 19.4% of the respondents' are currently using the condom. The major reason for poor use was attributed to the lack

of specific and detailed information about condom use.

Based on these findings, better information dissemination methods about condom use for men and appropriate educational strategies for improving men's attitudes to their spouses' use of contraceptive methods are recommended.

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CERTIFICATION

I certify that this work was carried out by MISS AFFIA ISAAC AFFIA, in the Department of Preventive and Social Medicine, College of Medicine, University of Ibadan, Ibadan, Nigeria.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER ONE

INTRODUCTION

The control of fertility and the promotion of family well being through the adoption of family planning practices dates back to ancient times. The Christian's Holy Bible documented a situation where a man called Onan withdrew his sex organ during coitus to avoid pregnancy (Genesis 38.8). Similarly in the holy Koran, (Hadith) Prophet Mohammed advised his followers on the idea of penile withdrawal during intercourse and gave conditions under which it can be practiced (Sachedina 1990). Furthermore, in the years past, the Arabs who had to travel long distances across the Sahara desert with their camels were said to use stones in blocking the camels' uterus so that they do not become pregnant. These ancient practices are believed to have formed the basis of some modern methods of contraception especially the intrauterine devices.

According to Wulf (1985), the population of a country is likely to increase at a rapid rate if fertility is left uncontrolled. In addition, basic amenities and economic resources enough for a certain number of people may be overstretched. At present, Nigeria is said to be the most populous country in Africa and the 10th largest in the world (National Population Policy 1988). In 1963, the population estimate was 55.6 million. The results of the national census conducted in November 27th-29th 1991 just released puts Nigeria's population at a provisional figure of 88.5 million with males (44.5 million) more than females (43.9 million). (The Guardian Newspapers, 1992).

The fertility levels in Nigeria varies but on the average, the number of children born to each woman by the end of her reproductive life is between 6 and 7 (Nat. Pop.

Pol, 1988). From the last census of 1963 to that of 1991, there is a difference of 32.9 million in 28 years. According to the population policy of 1988, the growth rate of 3.2 needs to be reduced because at present, some resources are already overstretched and Nigeria's unemployment rate is on the increase. For any drop in fertility to be meaningful, the present rate of 6.3 births per woman would have to drop to 2-3 births. The only way to ensure this drop is by the use of modern family planning services to space and limit the number of children (Shah and Palmore 1979, Yaman and Poffenberger 1981).

Magnitude of the Problem:

Many reproductive health problems endanger the life of the Nigerian woman ranging from teenage pregnancies, repeated closely spaced births and abortions with high morbidity and mortality rates (National Population Policy 1988). For example, maternal mortality of about 6-8 per 1,000 deliveries and infant mortality of about 90 per 1,000 live births have been recorded from hospital based records. However, these data are under-estimated as they represent data from health institutions only (Wulf 1985). These adverse situations can be avoided if modern contraceptive methods are adopted and used (Trussell and Pebley 1986).

A large number of studies has investigated the views and behaviours of women and their use of contraceptive devices in order to improve family planning programmes especially in the areas of programme promotion and programme success (McGinn et al 1989, (Mbizvo and Adamchak 1991, Oni and McCarthy 1991). However, it has been observed that there is paucity of data on knowledge, use and perception of men towards

family planning (Stokes 1980, Adamchak and Mbizvo 1991). The importance of men especially within the socio-cultural context of Nigeria, where male dominance is the norm in couple-decision-making to adopt family planning methods cannot be underestimated. It therefore appears that poor attention to this group of people might have contributed to the poor use or inconsistent use or outright rejection of family planning by many women (Cook and Maine 1987).

Most family decisions are made by husbands as heads of households and such decisions can include among others; adopting contraceptive devices, desired family size and sometimes what methods to use if the husband approves of adopting (Khalifa 1988). In view of this, it is some how difficult for women to control their own fertility. Even in studies concerning women, Cook and Maine (1987) and Joesoef et al (1988) reported that women would often not use any contraceptive device without their husbands' approval. In view of this, there is no doubt that in places where the women are hardly allowed out (Purdah), it is only those contraceptive methods used by men (which are not as effective as female methods) that can be practiced (Olusanya 1969).

In the traditional African settings, the women are hardly consulted in decision making. Their role was mainly to rear children (Fadipe 1970) with a woman's life rotating between pregnancies (which often are very close) lactation and weaning until menopause (Cain 1977, Musa 1988). This situation exists because in most cultures, bearing and rearing children is said to be a woman's primary function (Oinidey: 1987, Musa 1988). The resultant effect of this aspect of the culture according to Musa (1988) is a situation where a woman is pregnant every year and has a comparatively low quality

of life. It is therefore important to ascertain the level of knowledge of men on their own contraception as well as that of the women.

In responding to these problems and to avert future occurrences, the Federal Government in 1988, came up with a population policy. The policy, among other objectives, targeted reduction of women who get pregnant below age 18 and above 35 years at 50% by 1995 and at 90% by the year 2,000. In addition, the Government intends to reduce the proportion of women bearing more than 4 children by 50% by 1995 and by 80% by 2,000 and to provide family planning services to all those who require them (National Population Policy, 1988).

Preliminary information from a recent UNICEF survey shows that many women of child bearing age do not support this policy and this may be a reflection of their men's view or position. Since men take majority of house-hold decisions, they are likely to determine to a great extent the attainment of this policy.

JUSTIFICATION FOR THE STUDY

The justification for this study is based on three parameters. First, in almost all Nigerian communities including the study location, men are the dominant household decision makers including decision on reproductive health and behaviour, Since studies have reported that one of the greatest obstacles to contraceptive use in Nigeria is male resistance and opposition to the concept (Olusanya 1969, Gallen et al 1986, Musa 1988) it is necessary to find out if these attitudes have changed over the years.

Secondly, the Federal Government has instituted many policies on population control which have far reaching consequences for family planning. Although involving

men in family planning programmes has been stated as one of the means of achieving these policies, the implementation of the policy breakdown are directed at women. It is therefore important to investigate men's perception not only to this policy but their knowledge, use and perceptions of family planning methods.

Thirdly, there is paucity of research work on men with regards to family planning. Most studies have focused on women (Stokes 1980). This study will further improve on the data situation on men.

Findings from this study can assist programme planners to better appreciate the salient issues relating to the role of men in fertility control and improved family wellbeing and incorporate same into their educational programmes. It is believed that if men know about family planning and have a favourable attitude towards family planning, they are likely to encourage their wives/girlfriends to use them since the men are major decision makers.

In respect to the magnitude of the problem posed by the non-use of family planning methods and the advantages that can be derived from involving men in family planning, this study intends to assess the knowledge, attitude and practices of the target population to family planning.

THE SCOPE OF THE STUDY:

The study was limited to men irrespective of their marital status who were currently residing in the traditional inner core of Ibadan South East local Government Council.

The text is made up of five chapters beginning with a general introduction and

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a justification for the study.

Chapter two synthesises relevant literature on issues related to family planning methods and factors influencing their adoption, use by men and past attempts at involving men in family planning. The chapter ends with a conceptual framework.

The third chapter presents the study methodology including the objectives, hypotheses, study population, study design sampling, data collection procedures and analysis.

The findings of the study are presented in chapter four.

Chapter five discusses the results in relation to previous studies and concludes with recommendations for effective strategies for improved participation of men in family planning programmes.

Operational Definitions

1. Family planning: a voluntary adoption of contraceptive methods by individuals or couples with a view to preventing unwanted pregnancies, birthspacing and limiting births with a resultant improvement in individuals or the family well being.
2. Contraception: Use of methods/devices by men or their spouses to prevent pregnancies.
3. Condom Use: Reported use of the condom by respondents during sexual intercourse.
4. Knowledge of family planning: Ability to recall or mention at least one method of contraception and to state at least one benefit of contraception.

5. Awareness of family planning: Ability of respondents to recall having heard of family planning.

6. Adoption of family planning: Use of contraceptives by respondents or their spouses based on awareness, knowledge and decision.

7. Use of family planning methods (synonymous with use of contraceptive methods and practice of family planning): continuous acceptance and compliance with use of contraceptive methods by respondents and their wives/girlfriends.

8. Social Marketing: Application of for-profit sales and marketing techniques to a public health problem.

9. Contraceptive Social Marketing (CSM): application of social marketing strategies to contraceptives to make them widely available and regain same programme cost.

CHAPTER TWO

LITERATURE REVIEW

Children who are wanted, loved and adequately catered for are more likely to grow up into loving and nurturing adults (Hogan, 1985). Conception control is the sure means to achieving this end.

This chapter presents a review of pertinent literature on methods of contraception with some details on male types, socio-cultural, religious and political factors that influence their use or non-use. In addition, previous attempts used in improving male participation in family planning programmes are examined.

CONCEPTION CONTROL:

Conception control involves the use of contraceptive methods in regulating fertility. Historically, contraception has been practiced over the years. As far back as 4,000 years ago, contraceptives and abortifacient were used for women of the court of Egypt (Bennet 1974). Modern contraceptive methods began in 1876 with the sale of vulcanised rubber condom at Philadelphia Centennial (Bennet 1974). Early vaginal spermicides were vinegar or lemon juice in water, and 20% salt solution. The pill and intrauterine device (IUD) were developed in the sixties, and the 70's witnessed the introduction of vasectomy and tubal ligation making modern contraceptive methods increasingly popular.

1. Traditional Family Planning:

In many parts of Nigeria especially in Yoruba areas, birth control is not a new concept as people have used different types of traditional contraceptives or abortifacts

such as rings, waistheads, scarification and prolonged breastfeeding to prevent pregnancies (Olusanya, 1969). Others are herbal portions and enemas.

A description of traditional methods of contraception is as follows:

a) Ring (amulets, Oruka): The ring is made locally from iron and usually worn on the finger by the woman during intercourse (Olusanya 1969); (Nlozi and Kabera 1991).

b) Waistbeads (Onde, Ijbadi): These types of waistbeads are specially prepared by the native doctor and stuffed with charms. It is worn by the woman round her waist and it is believed to have magical powers in preventing pregnancies. The native doctor must destroy its powers before fertility can return (Weiss and Udo 1981).

c) Herbal Portions: A preparation by the native doctor consisting of a variety of herbs given to the woman to eat. Sometimes these leaves can be dried and used as pessaries/abortifacts (Olusanya 1969, Kafaru 1992).

d) Scarifications/Native Inoculations (Gbere): This method consist of sharp cuts on the skin and some medicinal powder, believed to prevent pregnancy is applied to the cut areas (Traub 1978, Weiss and Udo 1981)

e) Enema/Douches: These methods are usually used after a woman suspects pregnancy. Some medicinal herbs and other hot substances are mixed and filtered. The filtrate is then used for enema or for douching (Kafaru 1992).

f) Prolonged Breast Feeding: According to Olusanya (1969), prolonged breast feeding is followed by abstinence. A nursing mother in Yorubaland is usually not

encouraged to have sex until the child is weaned for fear that the child may fall ill. This method has the advantage of spacing out successive births and limiting the number of children by one woman. Men who believe strongly in the lactation taboo may have no need for modern contraceptive device as they can exercise self-control. However, where they cannot control themselves, they marry more wives or take care of themselves outside their matrimonial homes (McGinn et al 1989).

g) Other methods of traditional birth control include appellations to deity, charms buried in a pot, barrier sponges, abortifacts consisting of cactus juice with eggs, potash, washing blue and local gin to make the mixture very potent (Olusanya 1969, Weiss and Udo 1981, Kafaru 1992).

Some traditional methods have scientific explanations like prolonged breastfeeding which may delay ovulation in some women; barrier sponges and douches which contain alum believed to contract the cervix and having spermicidal properties (Kafaru 1992). Inspite of these properties, traditional methods are characterised by high failure rates attributed to the lack of knowledge of fertile periods by men and women so that intercourse can be avoided (Hogan 1985).

Polygamy which is highly practiced in most Nigerian settings seems to have further worsened the situation as a woman may not want to miss her turn with the husband even when it is not safe for her (Musa 1988, Kafaru 1992). Since couples have seen the need to space births as evident in abstinence and use of

other traditional methods, efforts should be made to bridge this gap so that couples can have satisfactory sexual encounters even when the wife is nursing a baby.

2. **Modern Family Planning**

Modern family planning started in Nigeria about 28 years ago with activities of the Planned Parenthood Federation of Nigeria (Iweze 1987, Quality 1990).

There are two groups of modern family planning methods:

a) Those that do not require medical supervision:

i) Abstinence

ii) Coitus Interruptus (withdrawal)

iii) Rhythm method (Safe period, Natural family planning)

iv) Spermicides - foams, jelly, cream.

v) Condom.

b) Those that require medical supervision:

i) Vaginal cap and diaphragm

ii) Oral Pills

iii) Intrauterine devices (IUD)

iv) Injectables

v) Implants

vi) Voluntary Surgical Contraception

1) Vasectomy

2) Tubal Ligation.

Of all these methods listed, the following methods are used by men:

a) Abstinence

b) Withdrawal

c) Condom

d) Vasectomy.

1. Abstinence: By abstinence is meant complete abstention from sexual relations. It requires a lot of self control on the part of the man hence not usually reliable. It is usually practiced by men when their wives are lactating (Weiss and Udo 1981). According to McGinn et al (1989), what some men refer to as abstinence may not mean complete abstention from sex because when they abstain from intercourse with their wives, they still have sexual relations outside their homes. About 17 million men world wide are believed to use abstinence for birth control (Gallen et al 1986).

2. Withdrawal: It is one of the oldest methods of contraception practiced by men. The book of Genesis in the Holy Bible refers to Onan who spilled his semen on the ground to avoid a pregnancy (Genesis 38:8), and Sachedina 1990 citing the the Hadith said that Prophet Mohammed spoke favourably of withdrawal but insisted on the woman's consent. Withdrawal requires a man to be alert when he should be in ecstasy hence it interferes with physical and sexual satisfaction. Although it costs nothing and needs no medical prescription, it has a very high failure rate and offers no protection against sexual transmitted diseases including AIDS (Stokes 1980). It can only be successfully practiced when those involved

keep to one sexual partner and have basic knowledge of human reproductive biology. About 35 million couples worldwide are said to be practicing withdrawal (Gallen et al 1986).

3. The Condom: This is a thin sheath of latex rubber which is put on a man's erect penis before intercourse to act as barrier, keeping the sperm from entering the woman's vagina. After intercourse, the condom is removed and a new condom is used for each act of intercourse (Population Report 1985).

Although the condom has an expected failure rate of 2% (Trussell et al 1990), it is moderately effective if used alone and much more if combined with spermicides. Apart from protection against STD's including AIDS, newer condoms have an added advantage of increasing sensation and decreasing irritation because they are coated with spermicidal jelly (Hogon 1985).

The condom is said to be the chief contraceptive in Japan, Sweden and Britain and the third most popular in the United States of America (Hogan 1985). According to Liskin et al (1990), about 6,000 million condoms are being used annually worldwide but this falls short of the expected 13,000 million. This reveals a disparity between need and supplies. For now, an estimated 60 million persons worldwide use condoms for family planning purposes (Liskin et al, 1990). Out of this, 20 million are in developing countries. In Africa, less than 0.5% of married couples use the condom (Liskin et al 1990, Boulos et al 1991).

Success in condom use has been reported in some countries like Britain, Sweden with Japan ranking highest with 75.9% current use by married couples. This is largely

due to technical and cultural factors which favour condom use (Coleman 1981). Inspite of the high success rate in some countries, the condom is yet to make a break through in other countries. For example, in Thailand, the condom is still regarded as a spare tyre, the main wheels being sterilisation, pills, injectable and IUDS. The condoms are mostly used as backup measures especially when a lady forgets to take her pills (Mechai Viravaidya 1990). In Nigeria, less than 1% of men use the condom (Liskin et al 1990). Emphasis has always been on female methods which are many (Olukoya 1985, Oni and McCarthy 1991).

Reported problems associated with condom use include among others, bad image because it is associated with promiscuity as it is often used outside marriage (Stokes 1980, McGinn et. al 1988) problem of supply (Lampley et al 1978) method failure and breakage (Finger et al 1991), reduction of sexual sensation and interruption of foreplay (Sherris et al 1982, Hogan 1985), impotence and other cultural factors (Liskin et al 1990).

Inspite of these drawbacks, the condom has its merits:

1. They are simple to use, safe and effective if correctly used.
2. They do not need medical supervision.
3. Condoms - help to prevent transmission of STD's including Aids.
4. They can be obtained cheaply on the social marketing, community based distribution outlets and commercial outlets and commercial outlets. Among other benefits it might help in the prevention of pelvic inflaminatory disease due to STD's. (Richardson and Lyon 1981).

Strategies To Improve Condom Distribution:

In order to effectively distribute condoms, variety of channels have been used to make it available. These are:

1. Establishing Commercial channels
2. Contraceptive Social Marketing (CSM)
3. Family Planning Clinics and
4. Community-based distribution projects.

1. Established Commercial Channels:

In developed countries most condoms are sold through commercial channels like pharmacies and other stores. In addition to existing commercial channels, a house to house sales is practiced in Japan. More men than women buy the condoms except in Japan where women are employed to sell condoms mostly to other women.

In developing countries as in Africa, condoms are also sold through commercial outlets but the cost tends to be fairly expensive for those targeted for condom use. It is to make condoms more available that social marketing is preferred to commercial outlets in developing countries.

2. Contraceptive Social Marketing (CSM):

CSM has two basic goals which are:

a) To make contraceptives more widely available

b) To recover some programme costs.

It also has four components: having the right product, at the right price,

sold in the right place with the right promotion (Sara Townsend 1991, Brieger et al 1986).

Condoms, oral pills and foaming tablets are the three contraceptives sold by CSM programmes. Of the three, condoms are much easier to sell because they require no supervision; can be easily bought by men while shopping; requires little instructions on correct use and can be advertised by brand names (Sherris et al 1985). According to Stokes (1980) and Liskin et al (1990) the major problem with the condom is poor image. It is associated with prostitution and illicit sex to the effect that married couples feel embarrassed to use them. One solution to these problems is CSM, which is operated in developing countries like Nigeria, India, Zaire, Pakistan, Columbia. It combines easy access, privacy, high quality products at affordable prices.

Packaging designs like colour, style and brand names like Sultan, Raja, Dhaal improve sales by attracting attention and promoting the condom (Schellstede and Ciszewski 1984).

Price setting is such that those who desire to use condoms can afford them. From enquiry at the Fertility Research Unit, U.C.H. Ibadan, the writer was told that condoms were free at the unit but a service charge of 50k is charged at the Ibadan market women project. This is a paltry sum when compared to the commercial cost of N4.50k for the same pack of 3 condoms.

Distribution makes condom available to consumers at many convenient locations that they regularly visit, it also saves the cost of operating an independent supply

(Coleman 1981, Sherris et al 1985). Retail outlets include foodstores, door-to-door sales, bars and restaurants, clubs, health centres, family planning clinics and pharmacies. These are places where men frequent and they can easily purchase the condoms without embarrassment.

Promotion helps persuade men to buy the condom or oral pills by attracting attention; creating an image, telling how it works, cost and points of purchase (Church and Geller 1989). Promotion for CSM can be through any of these four media:

1. Advertising (radio, television, newspapers).
2. Point-of-Purchase promotions (posters, displays)
3. Public Relations techniques (news, rallies, talk shows)
4. Interpersonal approaches (programme staff, distributors, health workers).

Radio and television are the two most widely used medium for health advertising (Brieger 1990). Gilljuly and Moore (1986) reported that 62% of rural and 85% of urban Nigeria households have radio receivers. This makes the radio more widely used than any other media. Studies by Choudhury et al (1987), Betrand et al (1989), Oni and McCarthy (1991) Adamchak and Mbizvo (1991), have further confirmed the popularity of the radio in disseminating information about family planning to most people. Besides being cheaper to purchase and informative, programmes can be run in local languages.

Visual electronic media like television and video and films are also used for promotions. Entertainment Education (Enter-Educate) is the most recent

innovation in family planning promotion on television where popular artists are used so that their fans can listen to their messages. In Nigeria, music popstar Onyeka Owenu and "Juju" King Sunny Ade were used to sing "Wait For Me" and "Choices" (Church and Geller 1989). They entertained as well as delivered messages on family planning. Television promotion is reported by Pietrow et al (1990) to have greatly increased new acceptors of family planning in Ibadan, Enugu and Ilorin. Although television is mostly used in urban settings and very expensive to purchase, it has a visual component which is an advantage over the radio.

Other media like newspapers, posters, rallies, talk shows and use of health workers can be used for promotion. Sometimes a combination of two media can be very effective, for example, use of radio and health workers. However, for promotion to be effective, it has to be continuous and extensive (Sherris et al 1985).

Family Planning Clinics

Condoms are distributed in most family planning clinics free of charge; in others a fee of 50 kobo for a pack of 3 is charged. Women are most likely to frequent clinics but men are much more likely to buy condoms at retail outlets rather than go to clinics because the clinic setting may be embarrasing to them. (Gallen et al 1986). In the light of this revelation, the clinics may not be adequate for effective condom distribution for men.

Community-based Distribution Projects

According to Sherris et al (1982), community based distribution projects train local residents to distribute contraceptives in their communities; use primarily female workers and tend to serve women hence many more oral pills are distributed than the condom.

CBD is carried out in Nigeria, Ghana, Ecuador. In Nigeria, CSM and CBD models were used to make oral pills, condoms and foaming tables available to consumers in Ibadan through a market based distribution system from February 1986-June 1989. (Ladipo et al 1990). For this project, traders where trained as health agents by the Fertility Research Unit, UCH and promotion was by radio, television and talk shows. Commodities included, inatrial drugs, dressings, vitamins, ORS and contraceptives. The programme was originally meant for women but very few men were used later. Contraceptives were sold in some of the 12 markets in Ibadan and sales increased tremendously but women sold more oral pills and condom than men.

One major drawback of this project was that the IMG closed down some markets in the inner core of Ibadan so most markets used were in the transitional zone or suburban periphery. On the other hand, one good finding was that the traders took their contraceptives home to sell to their neighbours. This means, a door-to-door sales as in Japan (Coleman 1981) could enhance sales of condom. The display of condoms with other commodities for sale has helped to desensitise the people espxcially men to condom use.

Vasectomy: This is a permanent method of contraception for males in which the vas deferens is cut and blocked so that the sperm can no longer travel into the semen that is ejaculated (Population Reports 1985). This method of contraception does not enjoy the popularity the condom does in some countries because it is permanent. It has an estimated 41 million users (Gallen et al 1986). Men are usually of the opinion that surgical contraception should be done by women because they carry the egg and bear the burden of pregnancy and child rearing (Betrand et al 1989). Furthermore, men are usually reluctant to discuss vasectomy, they perceive it as a process of castration and believe it to reduce potency (Khalifa 1988). However, vasectomy is still practiced on an appreciable scale in the U.S.A. and India (Stokes 1980). Its success in India has been linked to the Hindu culture where celibacy is a virtue hence vasectomy offers the men such virtue without them foregoing sexual pleasures (Green 1978). It is possible that men do not favour vasectomy because it is permanent. Silver (1976) and Gallen et al (1986) have suggested the alternative of using a plug or valve to block the vas deferens thereby making it easily reversible. This method, they feel will improve acceptability. This suggestion by Gallen and his team may improve male acceptability of vasectomy in Nigeria.

New Male Contraceptives Methods:

Researchers are seeking for an effective, easily used, coitally independent, reversible contraceptives for men. They include;

a) Hormonal suppression of sperm production

b) Chemical interference at the sites of sperm production and maturation. (Gallen et al 1986).

Hormonal suppression of sperm production includes:

(i) analogues of luteintzing - hormone releasing hormone which can suppress sperm production by interfering with the action of LHRH.

(ii) Steriod hormones - androgens, progestins and oestrogens which inhibit follicle stimulating hormone and luteinising hormone in men can also suppress sperm production.

(iii) Inhibin - a peptide produced in the testes that inhibits release of Follicle Stimulating hormone which in turn should suppress sperm production.

b) Chemical interference with sperm production is basically by use of Gossypol, a cotton plant derivative which interferes with sperm production without affecting hormonal levels, (Stokes 1980). Gossypol was discovered in China and is still undergoing series of trials to make it fit for human consumption. If successful, it will be a major break through in male contraceptive (Gallen et al 1986).

So far, from literature, it will take a long time for a male pill to be developed and used. First, there is little understanding of male reproductive system unlike the female where a lot of studies and trials have been done with success. Secondly, it is far easier to stop one female egg during ovulation once a month than halting several million sperms produced daily by the males (Stokes 1980).

For now, men still have to contend with abstinence, withdrawal, condom and where possible vasectomy. However, some basic knowledge of the female reproductive system on the part of the men will enhance the success of the methods mentioned above. It is possible that men's negative disposition to contraceptive responsibilities may change for the better if they have a range of methods to choose from (Olukoya 1985, Musa 1988, Liskin et al 1989).

The Adoption Process and contraceptive choice

The process of adoption consist of five stages (Read 1975).

1. Awareness: The individual learns of the existence of a new idea such as condoms but lacks information about it. For example, hearing about family planning on radio, television, friends without detailed information.

2. Interest: The individual develops interest in the new idea (e.g. condoms). As a result of the interest, he/she seeks additional information.

3. Evaluation: The information sought in the interest step gives a basis for completing a mental evaluation. Cost and effectiveness of the condoms are assessed in the light of past experiences with similar ideas and practices to anticipate returns. A decision is then made whether or not to try it. For example, information received about contraception is judged against other methods (traditional) and other attributes of an innovation to arrive at a decision.

4. Trial: The new idea is applied on a small scale in order to determine its usefulness in the individuals evaluation. For example, following awareness,

interest and evaluation of the condom as a method of male contraception, a man may decide to try it out to see if he can put it on before coitus to prevent unwanted pregnancies and STD's as it is purported to do.

5. Adoption: Based on satisfactory trial, the individual may continue to use the new idea always or as occasion demands. When use of the idea continues overtime, he is said to be an adopter. For example, having successfully tried using the condom, a man may continue to use it each time he intends to have sex. When an adopter uses a new idea continuously overtime, he is considered an acceptor.

Family planning is a preventive innovation (Rogers and Adhikaiya 1979). Being an innovation, there is a need for an assessment using the five attributes of an innovation to identify factors that might encourage or inhibit the adoption of contraceptive methods.

a) Relative Advantage: This is the degree to which an innovation is perceived as being better than the idea it supersedes (Rogers and Shoemaker 1971). This means that modern contraceptive methods must exhibit relative advantage over and above existing (traditional) methods for them to be adopted. For example, traditional methods of abstinence, withdrawal, use of rings, waistbeads and other charms are characterised by high failure rates (Kafaru 1992) especially when used for birth spacing and for coitus during breast-feeding. Modern contraceptive methods offer effective protection irrespective of the time so that couples can enjoy sex without fear of pregnancy.

b) Compatibility: This is the degree to which an innovation is perceived as consistent with the existing values, past experiences and needs of the receivers (Rogers and Shoemaker 1971). Family planning practices are believed to be compatible with existing ways of life because man has always thought of ways of avoiding unwanted pregnancies (Bennet 1974, Sachedina 1990). On the other hand, it can be an incompatible innovation where religious (catholic) beliefs discourage the use of effective birth control devices for example oral pills, IUD (Hogan 1985); and where cultures favour many children to offset high mortality rates (Musa 1988).

c) Complexity: According to Rogers and Shoemaker (1971), complexity is the degree to which an innovation is perceived as difficult to understand and use. Innovations that are simply understood by people will be easily adopted but a difficult one takes a much longer time to adopt. For example, the rhythm method of family planning is relatively complex for women who have no formal education and understanding of female reproduction including the monthly cycle of ovulation. It is for this reason that most Indian women preferred the IUD to the rhythm method because it is less complex in the eyes of the receiver (Rogers and Shoemaker 1971).

d) Trialability: This is the degree to which an innovation may be experimented with on a limited basis. Trialability of a new idea represents less risk to the individual who is considering it (Rogers and Shoemaker 1971) and the more the idea can be tried on installments or temporary basis, the better the rate

of adoption. This may explain why more men use the condom than vasectomy as a contraceptive method (Gallen et al 1986) and more women prefer the pill, IUD and foaming tables to sterilisation.

c) Observability: It is the degree to which the results of an innovation are visible to others. The easier it is for an individual to see the results of an innovation, the more likely that he will adopt it (Rogers and Shoemaker 1971). Immediate observability may hinder adoption of family planning methods or affect compliance or rate of adoption because reward is visible overtime. Benefits of contraceptive methods like birthspacing and prevention of unwanted pregnancies with resultant improvement in family wellbeing take time to manifest but protection from STD's is immediate and can be capitalised upon to enhance adoption and use of the condom.

These five attributes are positively related to the rate of adoption of an innovation (Rogers and Shoemaker 1971).

Factors Influencing Adoption and Use of Modern Family Planning Methods by Men:

1. Socio-Cultural Factors:

Established societal values on marriage and children affect the use of modern contraceptive devices either by men or women because they encourage early marriage and to have many children (Olusanya 1969, Fadipe 1970).

i) The Value of Children: In Yorubaland, children are traditionally regarded as the "pillars" of the house because they perpetuate the family name and

save it from disintegrating (Olusanya 1969). Children are so highly valued that blessing bestowed on newly weds must include that of fertility to be complete. Even during the blessing of a newborn, the elders often say that the child should attain old age and have numerous followers (i.e. brothers and sisters) behind him (Olusanya 1969, Fadipe 1970). The socio-economic status of a family may not deter them from having many children as an economically indigent woman with a sick or marasmic child considers herself superior to a better economically placed childless woman (Olusanya 1969, Omideyi 1987).

ii) Large Families: Apart from the prestige a large family bestows on the man, this idea came into being largely due to the desire to cope with death rates, particularly the need to offset high infant mortality (Wulf 1985, Musa 1988). According to Musa (1988), this need encouraged early marriages by women who start having children from puberty to menopause.

iii) Sex Preference: It is another cultural practice that encourages large families. Sons are highly valued to carry on the family's name and take over the father's property when he dies. This encourages the woman to go on reproducing until she has male children (Fanmilayo 1987).

iv) Economic Values of Children: Children are not only valued as labour utility on farms in agricultural settlements (Cain 1977), but also as workers in the home. The boys go out to work to increase the family income and

the girls are engaged in household chores where they are prepared for marriages (Cain 1981, Beaujot 1988).

Musa (1988) contends that so long as most of the afore-mentioned cultural practices are allowed to continue, men may not see the need for fertility control. He suggests that high infant mortality must be addressed through expanded programme on immunization (EPI) to reduce deaths. In addition, men should be made aware of the inter-relatedness of family size, nutrition, health, education, the place of a woman in the family and consequently the health of the nation as a whole through family planning programmes. This, Musa (1988) feels is necessary to change the cultural practices that encourage large families.

v) Security for Old Age: The use of children as security for old age is common where parents are uncertain about their ability to be self-supporting in old age (Beaujot 1988, Yaman and Poffenberger 1988). The families are usually of low socio-economic class and they rely on their children for finance and other forms of social support in their old age (Nugent 1985). Hogan (1985) is of the opinion that except a visible compensatory alternative to children is put in place, dependance on children by families will continue.

vi) Male dominance: Male dominance is a cultural factor that affects the success of family planning programmes (Callen et al 1986). As earlier stated, most studies are focused on women neglecting men who are vested

with the responsibility of controlling the family (Olukoya 1985). Most family decisions are taken solely by men and these include that of family planning. According to Olusanya (1969) man is the only customary recognised active partner in the sex act and any departure from passivity on the wife's part is regarded as immoral. In view of this, women who must use family planning methods will require their husbands approval. Khalifa (1988) in a study on men in Sudan reported that almost all (97.3%) of ever married women said that their husbands permission was absolutely necessary for the practice of family planning. Similar findings were reported from other studies on men (Cook and Maine 1987, McGinn et al 1989, Oni and McCarthy 1991). To further express their dominant role in the family, Khalifa (1988) reported that men were not only involved in choice of contraceptives to be used by their spouses but took the responsibility of obtaining these devices for the women.

Decision on number of children in most families is under the man's portfolio as head of households (Yaman and Poffenberger 1988). Although studies have shown that some men are aware of the benefits of small family size (Beaujot 1988, Yaman and Poffenberger 1988), others may not sharethis view as having a small family strips them of the social status that supposedly comes with fathering many children (Stokes 1980). To maintain this status, in addition to other variables like high infant mortality than intervenes, the wife must give birth to many children

viii) Other Social Factors:

Interspousal communication is limited in African settings hence couples hardly engage in discussions about sexual matters (McGinn et al 1989). This situation also applies to the Yoruba settings where the man decides all matters relating to sex (Olusanya 1969). However, Olukoya (1985) and Oni and McCarthy (1991) in Studies at Lagos and Ilorin respectively have shown that interspousal communication is improving with education. In addition, studies have shown that couples who talk about their desired family size and family planning are more likely to use contraceptives to achieve their family goals than those who do not (Gallen et al 1986).

There is a general belief among men that modern contraceptive use by women encourages promiscuity (Olukoya 1985). Furthermore, some men have expressed fear of side effects of contraceptives as they believe it can suppress fertility permanently (Nair and Smith 1984, Choudluny et al 1987, McGinn et al 1989). In view of these reports, men may not adopt contraceptives as they believe that they can suppress fertility permanently (Nair and Smith 1984, Choudluny et al 1987, McGinn et al 1989). In view of these reports, men may not adopt contraceptive methods or allow use by their spouses.

Demographic and family planning surveys in most developing countries in the 90's (Ghana, Zaire, Jordan, Indonesia, Bangladesh) and isolated studies in Nigeria (Nichols et al 1986) Burkina Faso (McGinn et al 1989) Zimbabwe (Boohene et al 1991) have reported the lack of adequate and specific

information on contraceptive methods is one of the reasons for non-use of contraceptives. Judging from these reports, it seems that most information are directed at women which may make men not to pay attention. Furthermore, the media used may contribute to non-use. Television may be considered appropriate by programme planners for information and instruction on usage since it has a visual component but majority of the target group may not have access to a television set to view such programmes. Besides, timing of such programmes may also not be appropriate for the intended target group.

Education has been reported to be an important variable affecting awareness, knowledge and use of contraceptives (Kritz and Gurak 1989). It has been found by Rehan (1984) to be effective in changing negative attitudes towards use of modern contraceptive methods. In addition education is said to improve communication among couples (Oni and McCarthy 1991) and decisions in homes with educated husbands and wives are most likely to be made by both partners (Mbizvo and Adamchak 1991).

Socio-economic status is believed to affect family planning practices. In traditional settings, men marry many wives and have many children without adequate financial means as they are usually farm workers or labourers (Brieger and Adeniyi 1982). Stokes (1980) is of the view that economic status within the society is a determinant of men's attitude and behaviour to contraceptive use but this has two sides. Men with higher income tend to be concerned about repeated childbearing on the health of their wives; they have fewer children and are more

supportive of family planning than low income men. On the other hand, men in the low income stratum, in their bid to strike an economic balance marry more wives and use their children to supplement the family income (Beaujot 1988)

2. Religious Factors:

Nigeria is a secular state and allows for freedom of worship. The main religious groups in the country are christianity, Islam and African traditional religion. The doctrines of these groups have some practices that may favour or mitigate against family planning methods. However, with increasing concerns about Nigeria's present economic situation, modern family planning is increasingly accepted as a matter of religious teaching. The methods used are usually a matter of individual beliefs or as the doctrines of the church dictate.

Christianity:- Christianity as a whole cannot take a stand on modern family planning methods because they are diversified with different tenets.

Catholic church: Although the catholic church recognises the need to limit family size, it sees contraception methods including sterilisation as illicit because they interfere with the body's normal functioning. In view of this stand, the Catholic church only approves of the rhythm and Billings method for its members (Pope Paul VI 1968). Catholic may experience conflicts over the use of effective contraceptive devices because studies in the U. S. A have reported an increase in the use of contraceptives by Catholic women. In 1955, 30% of catholic women used contraceptives, this increased to 51% in 1965 and 68% between 1965-70 (Hogan 1985). Although no such figures are available in Nigeria, one is inclined

to believe from general observation in the country that Catholic women do use contraceptive even though the church may make one to believe that Catholics do not favour the use of contraceptives. To further express their dislike of contraceptives, the Catholic church has established an association known as the Pro Life Association of Nigeria (PLAN) to teach their followers and others so interested natural methods of contraception (Adejumo et al 1987). This stand will greatly affect the adoption and use of modern family planning methods as the catholic church has a lot of followers.

Protestants: The protestant churches generally are in favour of family planning and are liberal towards effective methods. These churches include Anglican, Methodist and some Pentecostal churches (Adejumo et al 1987). However, there are some christian groups that are completely opposed to family planning and would often quote a passage in the Bible that God said we should go and multiply.

Islamic View:

Islam like christianity has not taken a stand on family planning because of its various schools of thoughts. In Nigeria some educated moslem and emancipated Imams preach family planning because of prevailing economic situation in the country (Adejumo et al 1987). This is not to say that there are no oppositions to this stand. There are Islamic fundamentalists who are seriously opposed to the use of modern contraceptive devices. They often cite verses in the Koran to support their actions since according to them the Koran has laid down rules for

sexual relations (Sachedina 1990). However, Sachedina (1990) in his comments on Islam and procreation contends that Islam supports family planning like withdrawal and other effective methods under certain conditions.

African Traditional Religion:

This mode of worship is practiced generally all over Nigeria. They have a belief that ones future is not certain until one dies so it is not possible to know in advance which child will be responsible enough to give them a befitting burial. This belief encourages large families (Adejumo et al 1987). In addition, male sons are the only children allowed to participate in their sacrifices and other rituals. This has implications not only for children but the need for sons (Fadipe 1970, Musa 1988).

3. Political Influence:-

Some black leaders see a relationship between population and political power. The more populous a country is the greater is the political power and the opportunity to win elections (Hogan 1985, Funmilayo 1987). Closely following this numerical strength is the issue of revenue allocation which is based on population count. Furthermore, the law makers (who are mostly men) need some basic population education to be able to legislate positively on family planning as this has implication for government subsidy on family planning commodities.

Previous Attempts at Involving men in Family Planning Programmes:

Despite the fact that modern family planning devices started with the introduction of vulcanised condom in the 19th century (Bennet 1974),.men have generally

been excluded from organised family planning programes. Family planning clinics have generally been organised to cater for women. This female bias according to Stokes (1980) may be attributed to the originators of birth control clinics - Marie Stopes in Great Britain and Margaret Sanger in the U.S.A. who were concerned about the plight of their fellow women having too many children too close together. This focus is gradually changing to enable men take responsibilities in family welfare. Since men cannot carry pregnancies till term and nurse the infants adequately, they can participate in contraception to relief their spouses of some health risks associated with modern contraceptive devices. Although not much has been done by way of researches to draw definite conclusions about advantages and difficulties encountered by involving men in family planning, some programmes have been executed with some degree of success. The first programme involving men was reported in Essex County, New Jersey, in the early seventies. Male educators were used by the Planned Parenthood to talk to men about sex, reproductive issues and family planning responsibilities alongside distribution of condoms. The success of this programme led to the opening of a men's clinic in 1975 (Stokes 1980). A second effort by the United States department of health and human services in 1977 in providing separate clinics for men did not meet with much success. Young men did attend and got medical attention for other health problems but the turn out for birth control was not encouraging as there was hardly any decline in teenage pregnancies and venereal diseases (Stokes 1980). This poor attendance was

attributed to the fact that male contraceptives - withdrawal and condom - do not require medical supervision. Still in the United States of America, another attempt at involving men in the mid-seventies in Dillion County in South Carolina was rated very successful. Men were counselled at workplace, bars, Street corners, gas stations alongside distribution of condom by health educators. Within 3 years, the rate of out of wedlock births dropped drastically and there was a reported increase in the attendance at the health departments for venereal diseases (Stokes 1980).

In the early seventies, the Ghana government organised mobile family planning clinics for women in Danfa. Studies in Danfa after this programme revealed that the decline in fertility was related to male contraceptive use. This success had a cultural connotation as it allowed men extra marital sexual relations without the risk of pregnancies (Lamptey et al 1978).

The situation in Nigeria is not too different from the instances narrated in the preceding paragraphs. The first reported attempt at involving men in family planning was in 1974 when the Lagos Family Health Clinic organised a Father's Club. Members were composed of 20% of men living within the area. Organised discussions centered on relationship between family planning and family wellbeing and health education. It was believed that this number of men was enough to influence other men in the community to be favourably disposed towards family planning (Bamisaiye et al 1978).

Two other studies by Olukoya (1986) in Lagos and Oni and McCarthy (1991) at

Ilorin revealed that inspite of the fact that men still had some misconceptions about modern contraceptive devices, their negative attitudes towards use by their spouses are gradually changing for the better. These studies recommended including men in family planning programmes.

Still in Nigeria, there are other ongoing programmes involving men in family planning carried out mainly by the Planned Parenthood Federation of Nigeria (PPFN). In February 1988, the PPFN organised a 5-day Male Motivational Workshop for 17 factory workers' representatives in Lagos State. The aim of the workshop was to motivate men to get involved in family planning. Suggestions at the end of the workshop included the use of clubs and hotel as distribution points for non-prescriptive contraceptives (Planfed News 1988).

This male motivational workshop by PPFN continued in Aba, Imo State in May 1988 for 25 men of the National Union of Road Transport workers; in Enugu, Enugu State for 20 motor park workers and in Onitsha for 32 male factory workers (Planfed News 1989). In Jos, Plateau State 14 male motivation agents were trained as peer educators on family planning methods for men and in Calabar, Cross River State, 16 male motivators from companies and parastatals participated in a 3-day workshop in June 1989.

In a similar manner, the National Council For Women Societies on May 4-7th 1988 in Lagos organised a workshop on Better Health for women and children through family planning in which papers where presented on ways of involving men in family planning (Musa, 1988).

In India, several attempts have been made at involving men in family planning. One notable programme was the government 1976 crash programme on sterilisation to slow down India's birth rate. Men were adequately counselled and in most instances given incentives. Within 12 months, 6 million vasectomies were performed. Most of these cases were voluntarily but in some cases they were compulsory (Green 1980).

In China, men are actively involved in family planning activities but the condom and vasectomy are not as commonly used as the female methods. It is expected that when trials on Gossypol is completed, more men would be actively involved in contraception as they may prefer the pill to the condom (Gallen et al 1986).

In Sudan, studies by Khalija (1988) and Mustafa and Mumford (1984) showed that Sudanese males play a major role in family planning decision - making, and in most cases take the responsibility for providing contraceptives to their spouses when needed. Condoms and vasectomies had a very low acceptance rate due to misconceptions. They suggested involving men in family planning for programme success.

In Burkina Faso, McGinn et al (1989) reported that men had a favourable attitude towards family planning but condom use was associated with prostitution and disease prevention than with birth control. They suggested directing pertinent family planning information to men, a continuous programme promotion and constant supply of contraceptives.

In Bangladesh (Choudhury et al 1982), Indonesia (Joesoef et al 1988), Haiti

(Boulos et al 1991), Zimbabwe (Mbizvo and Adamchak 1991), studies have shown that involving men in family planning programmes can increase acceptors and enhance programme promotion. Findings from these studies and their suggested solutions in sub-saharan countries can be useful in Nigeria since these countries share similar cultural practices.

Conceptual Framework

Fishbein's Theory of Reasoned action can be used to predict and understand behaviours especially preventive health behaviours.

This theory proposes that behaviour can be predicted from intentions. Intentions have two basic determinants which are:

a) Attitudes toward behaviour and (b) a person's perception of the view/opinion that significant others hold about a specific behaviour. Furthermore, attitudes are determined by beliefs held about outcomes of a performed task and the evaluation of the results by the individual. From the above, it can be deduced that an individual will perform a behaviour if his attitudes towards it is positive, his significant others approve of it and the outcome is beneficial to him. Accordingly, a man's intention to practice modern family planning, can be judged by his attitudes towards it (positive or negative), what significant others (religious leaders, heads of households, spouses, father, friends, relatives) think about his using contraceptive devices and the expected outcomes of using the devices (prevention of unwanted pregnancies, limited births, birthspacing, improved family wellbeing).

Health Belief Model:-

The Health Belief Model (HBM) formulated by Rosenstock (1974) is said to have a predictive value for preventive and compliance behaviours. The variables which direct health actions in this model are:

1. the individual's perception of his/her vulnerability to a health threat
2. the perception of the severity of the threat
3. the perception of benefits versus the perception of cost of taking the recommended action and
4. Cues to action.

A man is most likely to use modern contraceptive methods if he feels his wife can get an unplanned pregnancy if he does not use the device and that such pregnancy can seriously affect the family owing to lack of money to take care of the pregnancy and the baby. Taking actions (using contraceptive devices) is further based on the added weight of the benefits to be derived from using the devices (for example condoms) and the cost of purchasing condoms. Certain cues are needed to translate the decisions to seek family planning services. This may include information from the mass media, compaigns, interpersonal communication, unwanted pregnancy and pregnancy scare.

The Precede Model

The PRECEDE model by Green et al (1980) is based on the premise that factors important to an outcome must be diagnosed before the intervention is designed

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The PRECEDE model by Green et al (1980) is based on the premise that factors important to an outcome must be diagnosed before the intervenuon is designed

to avoid guesswork and risk of being misdirected by the health educator. It is made up of seven phases (figure 1).

Phases 1 and 2 consist of social and epidemiological diagnosis which involves quality of life such as overcrowding; poor job and health problems such as morbidity mortality, prevalence.

Phase 3 is the behavioural diagnosis which includes finance, utilisation, preventive actions:

Phase 4-5 is concerned with educational diagnosis made up of predisposing, enabling and reinforcing factors.

Phase 6 involves actual development and implementation of a program. It is concerned with the administrative diagnosis of the problem where a combination of interventions is used.

Phase 7 is the evaluation part of PRECEDE. It is inbuilt in the model.

Using the PRECEDE model, to diagnose the behavioural and educational aspects of this study, the quality of life can be overcrowding resulting from having too many children. Predisposing factors are attitudes of men to family planning, cultural values, knowledge of family planning and beliefs. The enabling factors will include lack of skills to put on the condom, cost of obtaining condoms on commercial outlets, inadequate facilities, lack of time to attend clinics or embarrassment from others.

Reinforcing factors can include the influence of religious leaders, values placed on children and socio-cultural factors.

Strategies to overcome these factors can be counselling, training, peer education, reinforcing positive attitudes by continued media campaign; interpersonal communication, discussion and reaching men at work and social settings. The choice of appropriate strategies depends on the factors identified.

Phase 6
Administrative Diagnosis

Phases 4-5
Educational Diagnosis

Phase 3
Behavioral Diagnosis

Phases 1 - 2
Epidemiological and Social Diagnosis

Direct Communication Public Relations

Health Education Components of Health Program

Training Community organization

Predisposing Factors:
Knowledge
Attitudes
Values
Perceptions

Enabling Factors:
Availability of resources
Accessibility
Referrals
Skills

Reinforcing Factors:
Attitudes and behaviour of health and other personnel, peers, parents, employers, etc.

Behavioral Causes

Behavioral Indicators:
Utilization
Preventive action
Consumption patterns
Compliance
Self-care

Dimensions:
Earliness
Frequency
Quality
Range
Persistence

Nonbehavioral Causes

Nonhealth Factors

Health Problems

Vital Indicators:
Morbidity
Mortality
Fertility
Disability

Dimensions:
Incidence
Prevalence
Distribution
Intensity
Duration

Quality of Life

Subjectively defined problems of individuals or communities

Social Indicators:
Illegitimacy
Population
Welfare
Unemployment
Absenteeism
Alienation
Hostility
Discrimination
Votes
Riots
Crime
Crowding

Figure 1: Behavioural Antecedents Model
(Source: Green, et al., 1980).

CHAPTER THREE

METHODOLOGY

Description of the Study Area

This study was conducted in Ibadan the largest indigenous city in Nigeria. Ibadan is divided into 3 zones namely - the inner core, a transitional area and a sub urban periphery. The inner core where this study was carried out is highly congested and overcrowded. It is reported to house about half of the city's population (Brieger and Adeniyi 1982).

Ibadan is the capital of Oyo State and has a population of about 1.2 million from the 1991 census result (The Punch April, 1992). Ibadan used to have one local government (IMG) until August 1991 when new States and local councils were created it was split into 5 local councils - Ibadan North, Ibadan North East, Ibadan North West, Ibadan South East; Ibadan South West. Ibadan South East local council has a population of about 227,865 with females (115,721) more than males (112,144). It is divided into 10 political wards with headquarters at Mapo. It occupies the land mass from part of Bere, Oja-oba to Orita Ikerekudowu and Express. Some of the inner core areas in this council are Bere, Oja-oba, Isale Jebu, Ontiyale, Kobomoje and Labo; transitional areas are Odinjo, Academy, Molete and Fetele.

Inhabitants of Ibadan South East council inner core areas are basically small scale farmers, labourers, artisans, traders, auto-mechanics carpenters and tailors (Brieger and Adeniyi 1982). Houses are mostly mud buildings, some are plastered with cement and there are a few permanent buildings. Construction of these houses was done in an

unplanned random fashion with only a few narrow Streets and alleys. This arrangement has made accessibility to most areas by vehicles difficult and in some cases impossible. Social amenities are limited. People of this inner core still live in family compounds among which are Ogunniola, Kure and Koboinoje compounds.

Political Structure:

Traditionally, the local council which is part of Ibadan is governed by the Olubadan of Ibadan. Next in rank are the chiefs followed by the Mogajis who represent each extended family compound; then the Baales who are family heads and usually the eldest male member of each family; and lastly the members of the community. In addition to the above traditional structure is the government's local Council with a Chairman who heads the council and councillors representing all the wards. Together they run the affairs of the council.

Decision Making Process:

The Olubadan is the chairman of the traditional council of chiefs of Ibadan. Most decisions are taken at the council meetings but sometimes the Olubadan takes some decision on his own being the head. These decisions are communicated to the Magajis, then to the Baales for onward transmission to their respective families and other community members. In additions to decisions reached at the councils, Churches, Mosques, families, associations do meet and make decisions on matters that affect them. Similarly, the local council makes decisions as it relates to governance and improvements in the council.

Communication Process:

This is usually interpersonal in line with the traditional political structure. Information is also aired on radio and television in addition to circulars from the local government council. The language used is mostly Yoruba (that of Ibadan dialect). Transportation into and out of the council is by vehicles, motor cycles, bicycles, tricks and often the people trek as some roads are too narrow for vehicles.

Health and Human Services:

There are both government and private health care facilities in the local council. Some government health facilities are located at Oranyan, Agbongbon, Idi-Aro/Elekuro, Mapo and Molete. The service point for family planning is at Oranyan Health Centre (Daily Times 1991) and there are few other family planning clinics mostly in the transitional areas. Referrals from family planning clinics are either sent to Adeoyo Hospital or the Fertility Research Centre at U.C.H. Ibadan.

There are many private health care facilities some of which are Abiodun maternity centre and Babs hospital and maternity care. There are traditional healers who also see to the health needs of this community. Notable among them is Arekemase traditional modern clinic at Idi-Aro-Elekuro run by a Baale.

Although the writer could not obtain exact number of patent medicine stores as some of them were not registered, there are over 150 of them in the council.

There are more mosques (for example Kohiowu, Oghoriefon and many household mosques) than churches in the area. This may explain why most of them are moslems. There are also some inhabitants who are African traditional worshippers who

believe in Ogun (the god of Iron) and the Ifa oracle with Alhaji Dr. Arekemase, the Baale Isegun of Ibadan as one of the priests.

Social organisations are many and varied. They include among others -landlord association, vigilante group, community development association, association of patent medicine dealers and that of traditional medicine.

Broad Objective:

To assess the knowledge, attitude and practices of family planning among men in the traditional inner core of Ibadan South East local government.

Specific Objectives:

1. To determine the respondents knowledge of contraceptive methods.
2. To estimate the proportion of respondents who use condoms or adopt sterilisation as a method of contraception.
3. To assess the attitude of respondents towards self use of contraceptive devices and use by their spouses.
4. To examine the demographic characteristics (age, marital status, religion, education, etc) of the respondents who have a favourable attitudinal disposition to the use of modern contraceptive devices by themselves or their wives and those who do not.
5. To identify factors that encourage or inhibit the use of modern contraceptive devices.
6. Based on 1-5 above, make recommendations for effective family planning education.

Hypotheses (Stated in the Null form)

There is no relationship between:

1. Educational status of respondents and their level of awareness to family planning.
2. Educational status of respondents and level of knowledge of modern contraceptive methods.
3. Educational status of respondents and use of contraceptives devices (condoms).
4. Level of respondents knowledge of contraceptive methods and use of contraceptives (condoms).
5. Number of living children and use of contraceptive devices by the respondents.
6. Respondents religious disposition and practice of contraception.
7. Socio-economic status and use of contraception.

Target Population:

The target population for this study consisted of all men in the inner core of Ibadan south East local government council. The study population was made up of randomly selected men living in the study area irrespective of their marital or educational status.

Research Design:

The study is a cross-sectional descriptive survey which attempts to assess men's family planning knowledge, use and attitudes. It further explains the relationship between demographic variables like socio-economic status, educational qualifications, marital status and age on use of contraceptive methods.

Sampling Procedure:

A combination of multi-stage, and simple random sampling techniques was used. First, the local government council was divided into the 10 political wards (See Appendix 2). Next 50% of these wards were selected by balloting. These selected wards were C1, S1, S2A, S2B and S6A and are made up of an estimated 23 compounds (See Appendix 3).

Using a table of random number, 50% of the compounds from each selected ward was selected. This comprises of Ogunmola, Oluwo, Koboinoje, Kuru, Bungbose, Ita Apete, Olunloyo, Adeniyi, Oluukun, Ali and Onilu's compounds. A total of about 1120 houses were found in the eleven selected compounds (See Appendix 4). 45% of the houses in each of these compounds were selected by balloting. Thus the following number of houses were selected.

C1	54 houses
S1	86 "
S2A	207 "
S2B	11 "
S6A	146 "
Total	504 houses

All the 504 houses were thus selected; from each house, all men between ages 15 and above who were members of the household were listed, followed by random selection of one by balloting. If the selected man will not be at home during the period of the study, another is randomly selected.

Instrument and Method of Data Collection:

The instrument used for data collecuon was a questionnaire developed from a review of previous studies on family planning. The questionnaire which was divided into four parts sought information on the following:

1. Demographic characteristics including age, occupation, marital status, educational status, religion and number of living children.
2. Knowledge of family planning included questions on family planning awareness, source of information, contraceptive methods and benefits.
3. Attitudes and beliefs towards family planning with regards to involvement of men in family planning, adoption of specific methods, household decisions and family planning, practice and view points on the National population policy.
4. Practice of contraception by the respondents and their spouses and the type of contraceptive device used.

Pretesting:

A pretesting of the questionnaire was carried out on 20 men residing in Oja-Oba, Aare, and Odeinlo's compounds all in the inner core areas. Three male research assistants who were indigenes of Ibadan conducted the pretest. They were previously trained on the aim of the study and the process of data collection. Questionnaires were filled by those who could read and write but those who could do neither were interviewed. Each questionnaire took 10-15 minutes to complete.

After pretesting, relevant changes and modifications were done. For example, question 17b had "in years" added to duration because it was misinterpreted. In

addition, question 14 was made closed ended.

Reliability and Validity:

In order to clarify the appropriateness of the questions, advice was sought from several people to know the extent to which the questionnaires addressed the objectives of the study. Some of the questions were modified when the author presented her research proposal at a seminar. Reliability was ensured by translation of the questions which were originally in English to Yoruba language (Ibadan dialect) and a back translation into English to be sure that they were consistent. In addition, the same research assistants were used for pretesting and actual data collection to ensure uniformity in the mode of questioning.

Pretesting guaranteed validity. In addition, clarity of the questions and the assurance of confidentiality to the respondents ensured that they gave appropriate answers. Furthermore, repeatability of some questions ensured validity. For example questions 16 and 17, 18 and 20b and 23.

Data Collection Procedure:

Prior to data collection, permission was sought and granted from the local government office at Mapo. In addition, each head of compound or the eldest person available was informed about the aim of the data collection.

Five hundred and four (504) questionnaires were administered to the selected compounds in February 1992 between the hours of 9 to 12 noon and 4 to 6 p.m. daily for 3 weeks. All completed questionnaires were returned daily and verified.

In all, four hundred and sixty (91.3%) questionnaires were duly completed and

deemed fit for statistical analysis. The remaining 44 questionnaires had a lot of missing data hence they were not considered good enough for analysis.

Method of Data Analysis:

Data collected were manually sorted out, edited, coded and entered into the computer for statistical analysis. Frequency distribution, means and percentages were computed for data description. In addition to the computer, the hand calculator was used for statistical tests (Chi square) of association and significance in order to draw inferences as well as give meaningful description to the data analysed.

Limitations of the Study:

Limited time and finance for the study did not allow for a very large sample. However, the sample size was statistically adequate for the study.

CHAPTER FOUR

PRESENTATION OF RESULTS

The result of this study is presented in four parts namely:

1. Demographic characteristics of respondents
2. Knowledge of family planning
3. Attitudes towards family planning
4. Practice of family planning.

(1) Demographic Characteristics of Respondents

i) Respondents Age Distribution:

The age range of respondents is from 15-80 years with a mean of 34.7 years. About half of the respondents, 218 (47.4%), were between 25-34 years, 122 (26.5%) between ages 35-44 (Table 1).

ii) Marital Status and Type of Marriage

Most respondents 338 (73.5%) were married while 105(22.8%) were never married, 8(1.7%) were divorced, 5(1.1%) were separated and 4(0.9%) were widowers. About 246(53.6%) respondents had one wife (monogamous) while 101(22%) were polygamous.

iii) Respondents Educational Level

As shown in figure 2, about half of the respondents 226(49.1%) had secondary school education, followed by 141(30.7%) with primary school education. Only 50(10.9%) respondents had no formal education while the remaining 43(9.4%) had post secondary education.

TABLE 1

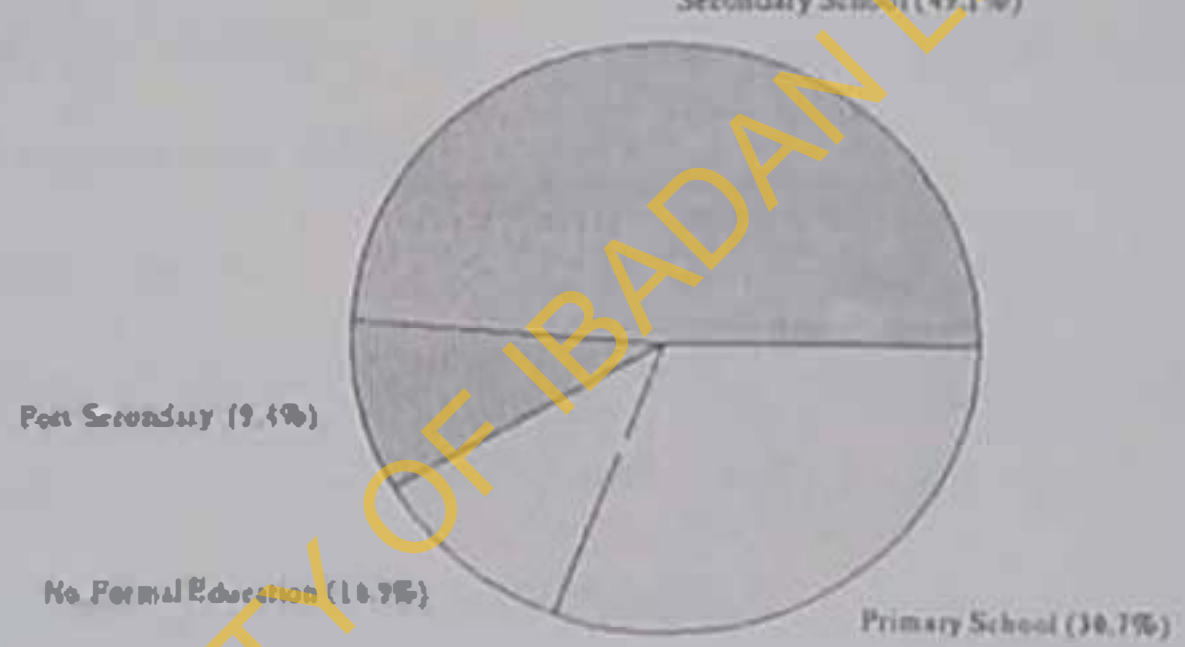
Respondents' Age Distribution

N = 460

Age (in-years)	Number	Percentage
15 - 24	19	4.1%
25 - 34	218	47.5%
35 - 44	122	26.5%
45 - 54	53	11.5%
55 and above	48	10.4%
Total	460	100.0%

FIGURE 2

Respondents Educational Qualification



N = 460

iv) Respondents Occupation:

As regards respondents occupation, majority 300(65.2%) were skilled workers (carpenters, auto-motor mechanics, welders, artisan), 60(13%) were unskilled workers, and 35(7.6%) were professionals (Table 2).

v) Respondents Religion:

Figure 3 shows the religious distribution of the respondents. Majority 350(76.1%) were mosleins, 100 (21.7%) were christians and 5(1.1%) were of African traditional religion. The remaining 5(1.1%) respondents did not disclose their religion.

vi) Ethnic Groups:

Almost all the respondents 452(98.3%) were Yorubas, 4(0.9%) were Nupes, 3(0.7%) were Ibos and 1(0.2%) was a hausa man.

vii) Respondents Number of Living Children:

Although 208(45.2%) respondents had 5 children and above, a substantial number 147(32.0%) had either 4 or less. One hundred and five (22.8%) respondents did not specify the number of their children.

(2) Knowledge of Family Planning:

i) Awareness:

Out of the 460 respondents majority 398 (86.5%) have heard of family planning; and 326 (81.9%) listed the radio as the most important source of information on family planning followed by the television 193(48.5%). Religious institutions were not credible sources (Table 3).

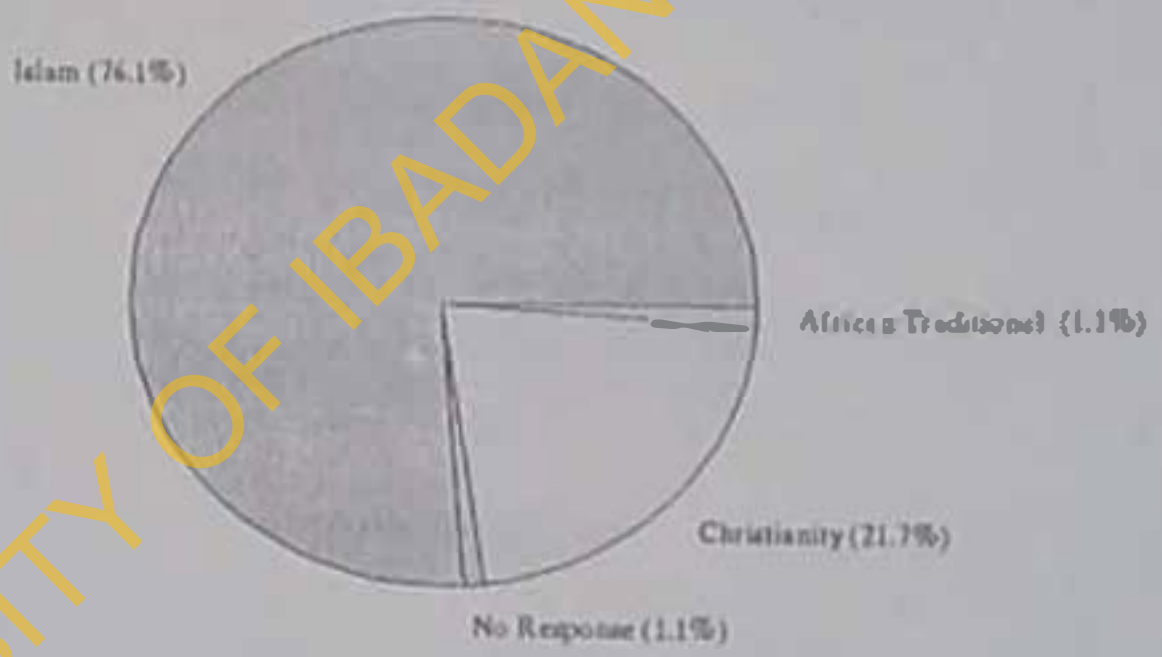
TABLE 2

Respondents' Occupation

Occupation	Number	Percentage
Skilled (Tailor)	300	65.2%
Unskilled (Farmer)	60	13.0%
Professionals (Engineer/Civil Servants)	35	7.6%
Unemployed	52	11.3%
Not Specified	13	2.8%
Total	160	100.0%

FIGURE 3

RESPONDENT'S RELIGION



N = 160

TABLE 3

Source of Information on Family Planning

N = 398

Medium	Number	Percentage of N
Radio	328	81.9%
Television	193	48.5%
Health Workers	110	27.6%
Friends	92	23.1%
Family Leaders	20	5.2%
Peers	14	3.5%
Mosque	14	3.5%
Social Clubs	11	2.7%
Church	10	2.5%

* MULTIPLE RESPONSES HENCE PERCENTAGE ADDS UP TO MORE THAN 100%

ii) Knowledge of Family Planning Methods:

Respondents knowledge on traditional methods of family planning was low as 88(22.3%) respondents reportedly knew about them. The use of the ring topped the list of the traditional methods mentioned by 80(20.1%) respondents. This was followed by medicinal herbs which was identified by 21(5.3%) respondents (Table 4).

In contrast to the low knowledge of traditional methods, a very high proportion of the respondents 349(87.7%) knew about the modern methods (Table 5). The condom was most frequently cited by 312 (78.4%) respondents followed by the pills, 176(44.2%) and injectables 82(20.6%).

iii) Knowledge of Advantages and disadvantages of Family Planning Methods.

Out of the 398 respondents who have heard of family planning, 237(59.5%) could mention at least one advantage. The most cited reason was avoidance of unwanted pregnancies mentioned by 166(41.7%) respondents followed by prevention of diseases (STD's including AIDs) by 69(17.3%) respondents (Table 6).

With regards to disadvantages of family planning, 135(33.9%) of the respondents who answered this question said it encourages promiscuity and 77(19.3%) said it causes bareness (Table 7)

TABLE 4

Respondents' Knowledge of Traditional Family Planning Methods

N = 398

Methods	Number	Percentage of N
Rings	80	20.1%
Waist Beads	13	3.2%
Medicinal herbs	21	5.3%
Scarification	8	2.0%
No Response	310	77.9%

* MULTIPLE RESPONSES

TABLE 5

Respondents' Knowledge of Modern Family Planning Methods

N = 398

Methods	Number	Percentage of N
Condom	312	78.4%
Pills	176	44.2%
Injectables	82	20.0%
Female Sterilization	16	4.3%
Withdrawal	9	2.3%
Intrauterine Device (IUD)	4	1.0%
Others (abstinence, Rhythm Foaming Tablets, D & C)	8	2.0%
No Response	57	14.3%

* *MULTIPLE RESPONSES HENCE TOTAL ADDS UP TO MORE THAN 100%*

TABLE 6

Respondents' Knowledge of Advantages of Modern Family Planning Methods

N = 398

Advantages	Number	Percentage of N
To avoid unwanted pregnancy	166	41.7
To prevent diseases	69	17.3
To space and limit children	35	8.8
It is reliable,safe and reversible	35	8.8
Don't Know	161	40.5

- *MULTIPLE RESPONSES.*

TABLE 7

Respondents' knowledge of disadvantages of modern contraceptive devices

N = 398

Disadvantages	No	%
It encourages promiscuity	135	33.9
It causes bareness	77	19.3
Sometimes not reliable	16	4.1
It causes irregular bleeding	6	1.5
Not aware of any disadvantage	29	7.3
Don't Know	183	46

* MULTIPLE RESPONSES

(3) Attitudes of Men Towards Family Planning:

Attitudes of men towards family planning was measured by 9 items on a Likert scale of agree, undecided and disagree. Other attitudinal variables relate to family decisions and responsibility, use of modern contraceptive devices and ideal number of children.

Assessments were only done on respondents who have heard of family planning (N = 398).

i) General attitudinal Assessment (Table 8)

Most respondents, 366(92.0%) agreed with the statement that men should be involved in family planning programmes. In addition 287(72.1%) respondents were of the opinion that men should be in a position to recommend family planning services to others.

Although most respondents, 316(79.4%), agreed that contraceptive devices are very effective if used correctly, and 234 (58.8%) supported its use by their wives/girl friends. 274(68.8%) would not approve of use because of adverse effects. For instance, 310(77.9%) respondents felt women are likely to be promiscuous if allowed to use contraceptive devices.

About 192(48.2%) respondents felt traditional methods of contraception are not effective

140(35.2%) were undecided and only 66 (16.6%) were certain of the efficacy.

Majority of the respondents 354(88.9%) were of the opinion that women

needed their husbands approval to use modern contraceptives.

With regards to self-use of the condom, most respondents 206(51.8%) agreed that the condom should be used by men because it is safe and effective; 191(48.0%) disagreed while 1(0.3%) was undecided.

In order to determine the overall men's attitude towards family planning, the 9 items on the Likert Scale were grouped into positive statements (Questions 1,4,7,8,9)and negative ones (Questions 2,3,5 and 6) Table 8. Each positive statement had a score of 3 for agree, 2 for undecided and 1 for disagree. The reverse was the scoring for negative statements (appendix 5). The possible highest score is 27 indicating a highly positive attitude while the lowest score is 9, an indication of a highly negative attitude.

The overall group mean is 21.4. This suggests that respondents have a favourable attitudinal disposition towards family planning.

ii) <u>Family Planning Decisions:</u>

Responsibility to use contraceptives devices were reportedly shared by 206(51.8%) respondents with their spouses. The major reason for this behaviour by two-fifths of the respondents was for co-operation and understanding among couples (Table 9). However, 87(21.9%) maintained that this responsibility was that of the wife/girl friend because the burden of child bearing is solely that of the woman (Tables 9). In addition, 72(18.1%) respondents will take such decisions because women are likely

to be promiscuous or as heads of the family, they are responsible for all decisions. About 33(8.3%) respondents did not respond to this question because their religion (Islam) is against use of contraceptive devices. The decision on whether or not the wife uses contraceptives was male-dominated (65.5%) (Table 10). This confirms the earlier result of the 354 (88.9%) respondents who said that women needed their husbands' approval to use modern contraceptive devices (Table 8). Few respondents 86(21.6%) felt the decision should be that of both partners.

iii) Ideal Number of Children:

Although slightly more than half of the respondents 217(54.5%) reported that their ideal number of children for a family was 4 and below for improved family wellbeing, a considerable proportion 106(26.6%) wanted 5 and above due to the prevailing economic situation in the country (18.3%), and fear of repeated deaths of children from childhood diseases (8.3%) Table 11. About 67(18.8%) respondents wanted as many as possible for fear of repeated childhood deaths (10.3%) and cited religion (Islam) (6.5%) as being against a small size family.

iv) Religion:

Although most respondents 246 (61.8%), reported that their religion approved of the use of contraceptive devices for adequate family care, a considerable number 147(36.9%) said their religion (Islam) was against it mainly for reasons bordering on adultery and fornication.

TABLE 8

Respondents' Attitude Towards Family Planning

N = 398

S/No.	Questions	Agree	undecided	Disagree
1.	Men should be involved in family Planning programmes	366	1	31
2.	Men should not support the use of modern contraceptive devices by their wives.	140	24	234
3.	Men should be reluctant to approve of modern contraceptive use by their wives because they are very likely to be promiscous.	310	14	74
4	Men should be in a position to recommend family planning services to others.	287	15	96
5.	Women can adopt and use modern contraceptive devices without their husbands approval or consent.	37	7	354
6.	Traditional family planning devices are much more effective than the modern devices and its use should be supported by husbands.	66	140	192
7.	Men may not approve of modern contraceptive use by their wives/ girlfriends because of the adverse effect of these devices.	274	60	64
8.	Family planning devices are very effective if used correctly	316	54	28
9.	Condoms should be used by men because they are safe and effective.	206	1	191

TABLE 9

Respondents perception of who should take major decision on contraceptive use

Perception of who should take major decision on contraceptive use	Reasons	No	Percentage %
Both Partners	For co-operation and understanding among couples	204	51.3
Wife/girlfriend	The burden of childbearing is solely that of the woman	86	21.6
Men	1 I am the head of the house and make all decisions	54	13.6
	2 Women are likely to be promiscous	18	4.5
No response	1 It is against my religion	31	7.8
	2 No response	5*	1.2
	Total	398	100.0%

* *Out of the 5 respondents who did not respond 2 were for both partners, 1 for wife/girlfriend, and 2 for those who did not respond at all. (Some did not respond to decision maker because it is against their religion).*

TABLE 10

Key decision–makeron contraceptiveuse in Respondents Household.

Decision maker	No	%
alone	261	65.6
My wife and i	86	21.6
Health worker	23	5.7
Wife / girlfriend	18	4.5
No response	10	2.6
Total	398	100.0%

TABLE 11

Respondents' Ideal Number of Children and Reason Given

Number of children	Reasons	No	%
4 and below	for improved family well being	217	54.5
5 and above	1 Due to prevailing economic situation in the country	73	18.3
	2 I am afraid of repeated deaths of children	33	8.3
As many as possible	1 Fear of repeated deaths of children	41	10.3
	2 my religion does not preach a limit number of children	26	6.5
Not Decided and No response		8	2.1
	Total	398	100.0%

v) National Population Policy:

About 266 (66.8%) respondents have heard of the national population policy and felt it was a laudable programme given the present economic situation in the country. The rest 132(33.2%) either have not heard of it 125(31.4%) or were not certain if they have 7(1.8%).

(4) Respondents Family Planning Practices:

Out of the 398(86.5%) respondents who were aware of family planning, 24(6.0%) and 190(47.7%) have ever used traditional and modern methods respectively.

i) Condom Use:

Of the 190 respondents who reported ever use of male contraceptives, 179(94.2%) have

ever used the condom mostly to prevent unwanted pregnancies (52.6%) Table 12.

Current users of the condom were few as evident by only 77(19.4%) respondents who indicated so mainly to prevent unwanted pregnancies (85.7%) and diseases (STD's including AIDS (58.4%) Table 13.

Of the 77 current users, 27 (35.1%) use condoms often, 22(28.6%) always, 20(26.0%) sometimes and a few 7(9.1%) rarely. Married men 53(68.8%) reported current use more than never married 24(31.2%). Of the 53 married respondents who reportedly use condoms, 46 were in monogamous marriages while 7 were in polygamous.

Majority of the current users, 58(90.6%) were between ages 25-44 years

(i.e. 52 were between ages 25-34 and 18 between 35-44 totalling 70). Few 5(6.5%) were between ages 45-54 and the least 2 (2.6%) between ages 15-24.

Duration of Condom Use:

Of the 179 who have ever used a male contraceptive, majority 106 (59.2%) started using contraceptive methods a year ago, 33 (18.4%) for the past 2 years, 24(13.4%) for 3 years, 10 (5.6%) for 4 years and 5(2.8%) for 5 years.

Adoption of Vasectomy as a means of Contraception:

None of the respondents mentioned vasectomy as a method of contraception and non reported use for contraception.

Reported Practice of Modern Family Planning by Respondents Spouses

Out of the 398 respondents who have heard of family planning, only 94 (23.6%) reported the use of contraceptives by their wives/girl friends. Table 11 shows that most women 62(15.6%) were said to be using oral pills while 18(4.5%) preferred injectables and only 6(1.5%) were using IUD.

With regards to when a woman should start using contraceptives, many respondents 122(30.7%) either cited after the fourth child or having had the desired number of children. Reasons given for delaying contraceptive use till this time were fear of contraceptive - induced bareness, to ensure survival of more children and for religious reasons. Fewer respondents

TABLE 12

Condom Use by Men

N = 398

Condom Use	Number	%
Never Used	219	55.0%
Ever Used: but stopped	102	25.6%
Ever Used: Still continued	77	19.4%
Total	398 (86.5%)	100.0%

$\chi^2 = 55.1$, df = 2, $P<0.05$

62(15.6%) felt a woman should use contraceptives before the first pregnancy to avoid unwanted pregnancies; 137(34.4%) respondents preferred the use of contraceptives for birthspacing between the 1st, 2nd or 3rd child. However, 11(2.8%) respondents did not approve women's use of contraceptives because they are likely to be promiscuous.

Reasons For Non-use of the Condom:-

For those who reported non-use of any family planning method, the most cited reason was not knowing how to use the condom 72(37.5%), followed by religious reasons 43(22.4%) and that the condom interfered with sexual satisfaction 40(20.8%) (Table 15).

Source of Condom Supply:

Most condoms were reportedly purchased at the chemist 56(72.7%) followed by hospital and family planning clinics, 17(22.1%). The rest 2(2.6%) respondents did not state point of purchase.

TABLE 13

Ever Use: Reasons For Condom Use

N = 179

Reasons	No	%
To prevent unwanted pregnancy	92	52.6
It is reliable, safe and easy to use	49	28
To prevent disease (STDS & AIDS)	32	18.2
Recommended by the Doctor	1	0.5
No Reasons given	18	10.2

* MULTIPLE RESPONSES.

TABLE 14

Current Users: Reasons For Condom Use

N = 77

Reasons	No	%
To prevent unwanted pregnancy	66	85.4
To prevent diseases (STD & AIDS)	45	58.4
It is safe and easy to use	14	18.2
No response	2	2.6

*MULTIPLE RESPONSES

TABLE 15

Family Planning Methods Used by Respondents' Spouses

N = 398

Methods	No	%
Pills	62	15.6
Injectables	18	4.5
IUD	6	1.5
Foams & Jelly	3	0.75
Sterilization	3	0.75
Safe Period	1	0.3
Abstinence	1	0.3
No Response	304	76.3
Total	398	100.0

TABLE 16

Reasons for Non–Use of the Condom

N = 192

Methods	No	%
I do not know how to use the condom	72	37.5
My religion does not permit use of contraceptives	43	22.4
It interferes with sexual satisfaction	40	20.8
Until I have my desired number of children	30	15.6
Inappropriate answers	7	3.7
Total	192	100.0%

HYPOTHESES:

Hypothesis 1: This hypothesis states that there is no relationship between educational status of respondents and their level of awareness to family planning. Results show that the highest level of family planning awareness was recorded among those with secondary school education 253(55.0%), followed by 117(25.4%) respondents with primary school education (Table 16). Out of the 62(13.5%) respondents who were not aware, 24 (5.2%) had primary school education, 22(4.8%) had no formal education and 16(3.5%) had secondary school education. A test of statistical significance an showed an association between educational status and level of awareness ($P < 0.05$).

Hypothesis 2: Hypothesis 2 compares respondents educational status with their knowledge of modern contraceptive methods. Table 17 shows that 196(49.2%) respondents with secondary school education had correct knowledge of contraceptive methods as compared with 95 (23.8%) with primary school education and 15 (3.8%) with no formal education. However, all respondents with post secondary education had correct knowledge of at least one contraceptive method. A total of 49 men from all educational level had no knowledge. These differences were statistically significant ($P < 0.05$).

Hypothesis 3: (Table 18) compares the respondents educational status and their use of contraceptives. A breakdown of result shows that out of 77 respondents who are current users of condoms, 49(63.6%) had secondary school education. This was followed by 18(23.4%) respondents with post secondary education and 9(11.7%) with primary school education. Results were statistically significant ($P < 0.05$).

Hypothesis 4: States that there is no relationship between respondents knowledge of contraceptive methods and the use of contraceptives. A total of 77(19.3%) respondents who had correct knowledge of contraceptive methods were current users while 272(68.3%) who had knowledge and 49(12.3%) who had no knowledge were non-users (Table 19). These differences were found to be statistically significant, ($P<0.05$).

Hypothesis 5: This hypothesis states that there is no relationship between number of respondents living children and their use of contraceptive method (Table 20). A total of 40(51.9%) respondents with 4 children or less used the condom and 27(35.1%) with 5 and above number of children also used the condom. A total of 225 (77.1%) were non-users. These differences were statistically significant $P<0.05$.

Hypothesis 6: Relates religion with respondents use of contraceptives. Findings showed that 52 (67.5%) respondents who were current users were moslems. 24(31.2%) were christians and 1(1.3%) respondent was of the African traditional religion. No statistical relationship between religion and use of contraceptives was observed ($P>0.05$) (Table 21).

Hypothesis 7: Relates socio-economic status of respondents (as measured by occupation of respondents) with the use of contraceptives by their spouses. Results showed that more of the spouses of skilled workers 60(15.1%), than those of professionals 19(4.7%) were current users of contraceptives. Findings showed a statistical relation between socio-economic status and use of contraceptives ($P<0.05$). (Table 22)

TABLE 17

Respondents' Educational Status and Awareness of Family Planning Programme

Educational Status	Awareness of Family Planning Programme		
	Aware	Not Aware	TOTAL
None	28(6.1%)	22(4.8%)	50(10.9%)
Primary	117 (25.4%)	24 (5.2%)	141 (30.6%)
Second/Post Secondary	253 (55.0%)	16 (3.5%)	269 (58.5%)
Total	398 (86.5%)	62 (13.5%)	460 (100.0%)

$X^2 = 55.1$, $df = 2$, $P<0.05$

TABLE 18

Respondents' Educational Status and Knowledge of Contraceptive Methods

Educational Status	Knowledge of Contraceptive Methods		
	Correct Knowledge	Incorrect Knowledge	TOTAL
None	15 (3.8%)	13 (3.3%)	28 (7.1%)
Primary	95 (23.9%)	22 (5.5%)	117 (29.4%)
Second	196 (49.2%)	14 (3.5%)	210 (52.7%)
Post Secondary	43 (10.8%)	0 (0.0%)	43 (10.8%)
Total	349 (87.7%)	49 (12.3%)	398 (100.0%)

$X^2 = 46.94$, $df = 3$, $P<0.05$

TABLE 19

Respondents' Educational Status and Use of Modern Contraceptives Devices

Educational Status	Use of Modern Contraceptives		
	Users	Non-Users	TOTAL
None	1 (0.25%)	26 (6.5%)	27 (6.8%)
Primary	9 (2.3%)	108 (27.1%)	117 (29.4%)
Second	49 (12.3%)	162 (40.7%)	211 (53.0%)
Post Secondary	18 (4.5%)	25 (6.3%)	43 (10.8%)
Total	77 (19.4%)	321 (80.6%)	398 (100.0%)

$\chi^2 = 36.6$, $df = 3$, $P < 0.05$

TABLE 19

Respondents' Educational Status and Use of Modern Contraceptives Devices

Educational Status	Use of Modern Contraceptives		
	Users	Non – Users	TOTAL
None	1 (0.25%)	26 (6.5%)	27 (6.8%)
Primary	9 (2.3%)	108 (27.1%)	117 (29.4%)
Second	49 (12.3%)	162 (40.7%)	211 (53.0%)
Post Secondary	18 (4.5%)	25 (6.3%)	43 (10.8%)
Total	77 (19.4%)	321 (80.6%)	398 (100.0%)

$X^2 = 36.6,\ df = 3,\ P<0.05$

TABLE 20

Respondents' Knowledge of Contraceptive Methods and Use

Knowledge of Contraceptives	Users of Contraceptives		
	Yes	No	TOTAL
Knowledge	77 (19.3%)	272 (68.3%)	349 (87.7%)
No Knowledge	0 (0.0%)	49 (12.3%)	49 (12.3%)
Total	77 (19.3%)	321 (80.7%)	398 (100.0%)

$\chi^2 = 15.03$, df = 1, $P < 0.05$

- Those without children were excluded from the table

TABLE 21

Respondents' Number of Living Children and Use of Modern contraceptives Devices

Number of Living Children	Use of Contraceptives		
	Yes	No	TOTAL
1 – 4	40 (13.7%)	75 (25.7%)	115 (39.4%)
5 and above	27 (9.2%)	150 (51.4%)	177 (60.6%)
Total	67 (22.9%)	225 (77.1%)	292 (100.0%)

$X^2 = 13.4$, $df = 1$, $P < 0.05$

* Those without children were excluded from the table

TABLE 22

Respondents' Religion and Practice of Contraception

Religion	Practice of Contraception by Respondents		
	Yes	No	TOTAL
Christianity	24 (6.2%)	73 (18.8%)	97 (25.0%)
Islam	52 (13.4%)	239 (61.6%)	291 (75.0%)
Total	76 (19.6%)	312 (80.4%)	388 100.0%)

$X = 2$, df = 1. $P > 0.05$

* Respondents of African faith and those who did not indicate their religion were excluded from the table

TABLE 23

Respondents' Socio-Economic Status and
Use of Contraceptives by their Spouses

Occupation of Respondents	Practice of Contraception by Spouses		
	Yes	No	TOTAL
Unemployed	4 (1.1%)	38 (10.1%)	42 (11.2%)
Skilled	60 (15.9%)	194 (51.5%)	254 (67.4%)
Unskilled	11 (2.9%)	36 (9.5%)	47 (12.4%)
Professional	19 (5.0%)	15 (4.0%)	34 (9.0%)
Total	94 (24.9%)	312 (75.1%)	377 (100.0%)

$X^2 = 22.91$, $df = 3$, $P<0.05$

* Those without wives/girlfriend were excluded from the table

CHAPTER FIVE

DISCUSSION OF RESULTS

This chapter describes the implications of the results under the following headings:- demographic characteristics, knowledge of family planning, attitudes towards and use of contraceptive devices. In addition, family planning educational strategies and recommendations for improved participation in family planning by men are suggested.

Demographic characteristics:

Majority of the respondents were between the ages 25-44 years. This has implication for use of condom or other means of male contraception. Since people in this age group are said to be in the sexually active age bracket, there is an increasing need to aggressively promote condom use among them in order to control fertility.

Although most men were married with one wife, a considerable number were never married. This also has implications for condom use as never married men are said to engage more in unplanned sexual encounters (Stokes 1980) with consequences such as unwanted pregnancies and STD's including AIDS (Liskin et al 1990). In view of this finding, this group of respondents should be included or targeted in the AIDS education programme. In addition, group discussions should be organised by health educators for them on why condoms should be used and consequences of non-use.

Results also showed that most respondents were skilled workers (teachers, artisans, tailors) with few professionals - civil servants, engineers. The implication of this finding relates to cost of condoms and the financial capability of respondents to purchase them - in the light of other competing demands - for example, most skilled workers may

prefer to use their money on food than contraceptives.

Respondents were predominantly moslems and of the Yoruba ethnic group. This is probably due to the study location.

Inspite of the fact that more men had more than 4 children, a substantial number had 4 children or less.

Knowledge of Family Planning:

Awareness to modern family planning was high in these traditional areas with the radio being the most credible source of information. This finding is in line with studies by Brieger (1990), Adamchak and Mbizvo (1991) and Chaudhury (1987), where the radio was cited as the most used media for receiving information on health/family planning matters especially in rural areas.

The 62(13.6%) respondents who were never aware of family planning is a little surprising. This is because the Fertility Research Centre at UCH Ibadan had a network distribution of contraceptives and a boosted mass media family planning promotion between 1985-1988. However, similar findings have been reported in similar cities like Harare (Boohene et al 1991) in which a total of 414(64.0%) out of 647 male respondents were not aware of family planning; Ibadan in 1986 among adolescents (Nichols et al 1986) in which less than 10% of secondary school students and non students were not aware and in Khartoum, Sudan (Khalifa 1988) where 5.8% of the male respondents out of a total of 1,500 were not aware. That these respondents have not heard of family despite intensive media promotion in Ibadan (1985-88) may be due to the fact that television was the medium mostly used to disseminate family planning

messages. The television is an expensive commodity which artisans and other low income urban dwellers may not be able to purchase. Although family planning messages are also disseminated through the radio, the respondents media habits may be at variance with the broadcast period. In addition, they may not pay attention to the messages as they are always directed to women. Furthermore, it has been said that having a radio in Nigeria sometimes signifies a status symbol and not necessarily for listening to any specific programme (Brieger 1990).

The results on knowledge of contraceptive method was surprising. In contrast to a low knowledge level of traditional methods of contraception was a very high level of modern methods. That the condom (rubber, "roba", durex) was cited by most respondents, followed by the pills and injectables suggest that family planning promotion of these products are reaching the desired target group. These products have been acclaimed as highly effective means of contraception if used correctly (Hogan 1985). It is worthy of note that none of the respondents mentioned vasectomy which is the most effective male method of contraception. This maybe attributed to the little publicity given to this method.

Out of those respondents who have heard of family planning, a considerable number cited avoidance of unwanted pregnancies and prevention of diseases (STD's including AIDS) as advantages of using contraceptive devices. This knowledge level could create a positive attitude to use and needs to be emphasised in family planning promotion.

With regards to disadvantages, most respondents related contraceptive use by

women to promiscuity and secondary infertility (causes bareness). This finding is in line with those of demographic and health surveys from Ghana, Egypt, Zaire (1990) and studies by May et al (1990) in which the respondents attributed non-use of contraceptive by their spouses to fear of bareness and promiscuity. These beliefs can act as a serious drawback for the success of family planning programmes. However, most of these misconceptions or real fears can be allayed through the provision of appropriate health education strategies such as interspousal communication and group counselling.

Knowledge of family planning methods was very high but very few respondents reported current use of the condom. This seems to confirm the health education principle that states that knowledge does not necessarily lead to practice (Kasl and Cabb 1966). However, since differences between respondents knowledge of family planning and practice were statistically significant, the hypothesis is rejected.

Furthermore, education is one of the most important variables affecting awareness, knowledge and use of contraceptives. This is evident as majority respondents with secondary school education and all post secondary school respondents who were aware had correct knowledge and use the condoms.

Number of living children was related to contraceptive use by the respondents ($P < 0.05$). This might relate to the expressed fears on high infant mortality rate and side effects of contraceptives.

Socio-economic status was also found to affect use of contraceptives by respondents' spouses. This may be due to the finding that most of the respondents were artisans, tailors and other skilled workers in the low income group. They may not have

the money to purchase contraceptives (condoms, pills, injectables).

Attitudes Towards Family Planning:

Generally, respondents had a positive attitude towards family planning programmes and contraceptives use by their spouses. This is contrary to the belief that male opposition is a major obstacle to family planning programmes especially in Africa (Gallen et al 1986). In addition, the respondents had a favourable attitude towards condom use but inspite of this, reported usage was low probably due to lack of skill on how to use the condom or because it interferes with sexual satisfaction. Most men irrespective of their number of living children preferred to have 4 children or less because they are concerned about household finances in view of the present economic situation and the health of their families, both of which can be addressed through family planning. This attitude might have just been created recently since the study was conducted at a period when the economic situation of most families is glaringly lower than ever before due to the deregulation of the Nigerian currency. However, inspite of these positive attitudes which have also been documented by studies of Olukoya (1985), Oni and McCarthy (1991), men do have concerns about contraceptive devices. One major fear is that of losing their children to ravages of diseases. This may make them to disapprove the use of contraceptive devices which are believed to harm their users such as inducing secondary infertility. In addition, they are likely to object to women's use of contraceptives without their (husbands) approval probably due to the already held belief that it encourages promiscuity and probably correctly too, that it may change the balance of social control between men and women (Gallen et al 1986). These problems

can be addressed through group discussions with respondents about benefits of contraceptives in their various associations.

That men are aware that family planning can ease their economic load and contribute to a healthier family is a good premise for health education to build upon. In order to improve upon the existing attitudes, problems associated with infant mortality must be addressed through expanded programme on immunisation (EPI) and those of side effects of contraceptives through repeated researches and trials to lessen identified adverse effects. In addition, the cost of condoms must be subsidised so as to make it affordable to potential users.

The finding that the decision to use contraceptives should be a joint responsibility by both couples in order to promote co-operation and understanding is desirable. This attitude can further be explored to promote and improve discussions by satisfied couples on family responsibilities toward family planning. Using this approach, couples will be able to enhance their relationship built on trust and thus allay the fears of female promiscuity. In addition, the females can encourage their husbands to use condoms. However, that some of the respondents favoured women taking full responsibility for family planning because the burden of childbearing rests on them has the potentials of making men relinquish some of their family responsibilities (Musa 1988). To tackle this problem, opinion leaders including satisfied users should be organised for group discussions on men's role in the family. In addition, group counselling of men at association meetings on men's family role can be helpful.

In this study, the decision on whether or not the wife uses contraceptives was

male-dominated. Similar findings were reported in studies by Joesoef et al (1988) and Gallen et al (1986). This has implication for use of contraceptives by women as they will need their husband's approval to adopt and use any method. Invariably, it is only those women whose husbands approve of use that are likely to practice contraception with modern devices - In view of this, finding, there is need to involve men in family planning programmes through group counselling of men in their community on methods and benefits of use of contraceptives. Group discussions using opinion leaders (mostly men) with positive attitudes to be aired on the radio in the evenings. Furthermore, the other implication is that with this attitude men can decide not to use condoms or obtain sterilization since no one can impose any sanctions on them if they fail to do so.

Practice of Family Planning:

The finding revealed that few respondents reported ever using condoms and much fewer reported current use regardless of the finding that more married than never married men were current users of condoms. Since this study could not accurately determine the extent of condom use in matrimony through observation, the proportion of married men who reportedly use condoms might have been exaggerated. It is possible that most condoms used were outside marriage as most of the respondents relate its use to illicit sex of which unwanted pregnancies and STD's could adversely affect their marriages.

Most condoms were purchased at the chemist and only a few mentioned clinics. This may be due to unavailability of family planning clinics in the study location or embarrassment experienced when respondents want to buy condoms at some community

based distribution points. Besides, the cost of the condom in the chemist is ₦4.50k compared to that of the social marketing which is 50 kobo for the same pack of 3.

Reason for Non-use:

Lack of adequate and specific instruction on condom use was one of the major reasons given for non-use. This may be due to the fact that respondents have not been taught the skill. Besides, teaching skills require return demonstration and practice which the radio cannot effectively teach, and television cannot assure return demonstration. This skill can be taught at training workshops where selected men who use condom always from the study location are brought in as motivators; taught aims of condom use, points of purchase and how to put on the condom using bananas or wooden phallus. They should repeat demonstration on how to put on and when to remove the condoms. Having been trained, they can teach their peers alongside condom distribution. Film shows and posters can complement the training workshops. Painphlets demonstrating how to use the condom can also be distributed in workplaces like mechanic garages and artisans shops. Demonstrations can also be carried out in these areas.

Reported Practice by Respondents' Spouses:

Results revealed that few respondents' spouses use contraceptives. This is not surprising as only few respondents use condoms.

Implication For Health Education:

Health education focuses on peoples' knowledge, attitude and practices with the intent of discouraging human behaviours detrimental to health and reinforcing existing ones that enhance health, or encourage new forms that are believed to promote health.

From findings and discussions, the following problems in relation to family planning were identified:

a) Problems related to knowledge as some of the respondents were not aware of family planning and could not mention at least one contraceptive method.

b) Problems related to attitude in respect to female contraceptive use and condom use by men which seemed to be affected by fear of side effects, religion, fear of promiscuity by women and a belief that males should dominate family planning decision - making.

c) Problems related to self-use of condoms: Low condom use was reported despite the recorded positive attitude and knowledge of benefits. This appears to be largely due to lack of skill on how to use the condoms; its interference with sexual satisfaction and religious reasons.

Problems Related to Knowledge:

Interpersonal communication in addition to the mass media can be used to raise awareness and improve the level of knowledge of contraceptives. For example, group discussion methods involving men from all interest groups in the study location (landlord association, artisan, carpenters, mechanics, medicine dealers), some opinion leaders and family planning practitioners on aims of family planning and various methods with emphasis on male types should be used. In addition, people who are eligible to use various types of contraceptives and contra indications should be discussed. This can be aired on the radio in the evenings since most respondents have it in their homes.

Television and film shows can be used as supplements.

Interpersonal communication can be done through home visits and engaging the men at work or at home in discussions on family planning.

Community campaigns can be organized using local media like songs, drummers, and drama with a session for question and answer for community members. Films, posters, pamphlets can be used to enhance comprehension.

Problems Related to Attitudes:

Group counselling can be used to address male-dominated decision-making, fear of side effects, and promiscuity. For example, satisfied users (couples) of contraceptives in the study area should be used for counselling on methods used, benefits achieved and complimentary roles of husbands and wives in achieving their objectives. Other methods like, role play, and film show can be employed. These strategies can be used in the community during meetings of associations or clubs.

For religious reasons, a training workshop should be organised for Imams, arabic teachers and representatives of Islamic associations. Content of workshop can include methods, uses of family planning methods, benefits and desired family size in the light of the present economic situation. In addition, modalities of incorporating the contents into their preaching will be taught. Since moslems have very high regards for their preachers (Deen 1992), it is believed that they can influence their flock to change their negative attitudes to positive ones. Seminars and conferences are other strategies that can be used.

Problems Associated with Contraceptive Use:

Factors which appear to be contributing to low contraceptive use include lack of skill to use condoms, fear of infant mortality, and interference with sexual satisfaction. Lack of skill to use the condom can be addressed through home-to-home or ward-to-ward training for males in the study area (males working in patent medicine stores, mechanic garage, carpenter, artisan and tailoring shops, civil servants, etc.). Representatives of each group and those who are using condoms should be trained on correct use of condoms, benefits of use and possible undesirable outcome like breakage and leakage. Wooden phallus or banana should be used for demonstration on how to put on and remove the condom and also where to dispose of it. Participants should perform return demonstration. Having acquired the skill, they in turn would be requested to teach men at workplace like garages, carpenters and tailoring shops. Posters and pamphlets can be used to enhance skill acquisition training and free condoms should be distributed.

The respondents fear about infant mortality can be addressed through enlightenment campaigns that promote factual information about current low-level of infant mortality as a result of mothers increased vaccination of their children. They can be targeted through community discussions and group counselling.

With regards to the condom interfering with sexual satisfaction, group/individual counselling is also a desirable strategy to use to convince respondents that benefits of the condoms like prevention of unwanted pregnancies and diseases outweigh the interference. In addition, they should be told that thinner condoms are now available

which enhance sensation and manufacturers are already trying out new condoms made from plastic.

Finance is a factor in condom purchase since most respondents were of low income group. Resource and external linkage with the fertility research unit in the University College Hospital (UCH) to assist in establishing more distribution points and involve more men from the inner core in their market project will help. In addition, since the respondents reportedly purchase condoms at the chemist, the patent medicine dealers should be involved in the social marketing of condom which will drop the price from ₦4.50k to 50 kobo for a pack of 3.

CONCLUSIONS AND RECOMMENDATIONS

The findings in this study show that there are high levels of awareness and knowledge of modern contraceptive methods among men in the study area but a very low level of contraceptive use. In addition, the study highlighted factors that could be explored to enhance acceptance of contraceptive methods such as the positive perception of shared responsibility for use of contraceptives, the expressed benefits of family planning and the desire to limit births to 4 children.

Factors that militate against success of family planning for men include lack of detailed and specific instruction on condom use, its interference with sexual satisfaction, religious objection, infant mortality, fear of side effects and promiscuity by women and a male-dominated decision-making on whether or not a woman should use contraceptives. In the light of these findings health education strategies are suggested and the following recommendations are made:

1. Family planning promotions on radio, television and other visual aids used should be sustained by the government so that people especially men are constantly reminded of family planning.

2. Family planning programme promotion should target men, stressing their responsibilities towards family planning through group discussions, demonstrations counselling on radio, television and rallies at places where men work or congregate.

3. The Oyo State government in conjunction with the Fertility Research Centre UCH should explore avenues of increasing family planning clinics and both CSM and CBD retail outlets in the inner core area. This will make contraceptives more widely

available at a cheaper rate.

4. Family planning practitioners in Oyo State and UCH should organise training workshop for peer groups on condom use. In addition, chiefs, heads of house holds, religious leaders and head of social organizations should be organised for group discussions on family planning because they are in a position to influence people's behaviour towards use of contraceptives.

5. Manufacturers, researchers and donor agencies (USAID, PPFN, Africare) should take cognisance of the complaints associated with poor use such as interference with sexual satisfaction with a view to improving the quality of the condom.

6. Evaluation of health education components of the family planning programmes should be embarked upon by the Federal Government of Nigeria in collaboration with donor agencies. For this exercise, the evaluation expertise of the African Regional Health Education Centre (ARHEC), College of Medicine, University of Ibadan should be tapped and used.

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110

APPENDIX I

QUESTIONNAIRE

This questionnaire is designed to assess the knowledge, attitude and practice of family by men.

It would be appreciated if you provided truthful answer to the questions. Name are not required and confidentiality is guaranteed.

Please put a [_/] or supply the answer as appropriate.

Ase eto awon ibere yi lati mo nipa tabi wa imo. ibuwasi ati ise yin lori awon eto ilana feto si.

Inu wa yio dun bi e ba awon olito si ibere wa. A o fe lati mo oruko yin, gbogbo nkan ti e ba si ba wa so yio ni bonkele.

Ejowo e fi ami si awon idahun yin.

SECTION A : DEMOGRAPHIC CHARACTERISTICS

1. Ward/Agbegbe..... Compound/Agbo ile .....

2. Age/Ojo ori [ ]

3. Marital status/Ipo wo ni o wa nipa loko laya

   a. Never married/Ko ti ni Oluwa

   b. Married/O ti loluwa

   c. Separated/Otu pin ya pelu Oko/Iyawo

   d. Divorced/Ott ko oko/Iyawo

   e. Widower/Opo [ ]

   f. Other (Specify)/Omiran so pato .....

4. If married state type of marriage/Bi o ba ti gbe yawo tabi loko lru Igbeyawo wo ?

   a. Monogamous/Oniyawo kan

   b. Polygamous/Oniyawo pupo [ ]

5. Educational qualification/Iwe melo ni o ka ?

   a. No formal education/Nko lo si ile iwe rara

b. Primary School/Ile iew alako bere

c. Secondary School/Ile iwe ise owo

d. Post Secondary (Nursing, NCE, University, Polytechnic etc. specify.....

Ilo iwe giga ti ati niko ise Nurse, Ise Olokoni, NCE, we giga university [ ]

6. Occupation/Ise Ojo

a. Unemployed/Ko ni ise

b. Skilled worker/Ise owo

c. Unskilled worker/Ise ti ki se ise owo

d. Professional/Ise imo ijinle

[ ]

e. Others (specify)/Omiran se pelo.....

7. Religion/Esin re

a. Christianity/Esin omo lehin Jesu

b. Islam/Esin omo lehin anabi

c. Traditional Religion/Esin ibile [ ]

d. Others (specify/Awon omiran so pato .....

8. Ethnic Group/Eya wo ni yin .....

9. Number of Wives/Girl friends/Iyawo tabi orebinrin melo ni o ni.

a. 1/Okan

b. 2/meji

c. 3/meta

d. 4/merin [ ]

e. above 4/Ju merin lo

10. Number of living children/Omo yin melo ni o wa laye [ ]

11. Have you ever heard of family planning/Nje o ti gbo nipa rele ni awon bibi

a. Yes/Beni

b. No/Beko [ ]

12. If Yes, what was your source of information/
Bi o ba je beni. bawo ni o se gbo

1. Family leaders/Olori ile
2. Peers/Egbe
3. Social clubs/Elegbejegbe
4. Church/Ile isin
5. Mosque/Mosalasi
6. Radio/Ero gbohungbohun
7. T/V Ero mobuomaworan
8. Health workers/Osise ilera
9. Friends/Ore [ ]
10. Others (specify) .....

13. Name the various methods of family planning that you know for men and women
Daruko awon ona feto si ti o mo fun okunrin ati obinrin.

a. Traditional/Ti ibile

_____

_____

b. Modern/Ta ode oni

_____

_____

14. Have you ever used family planning methods/Nje o ti lo ona feto ri bi?

a. Traditional/Ibile 1. Yes/Beni 2. No/Beko [ ]

b. Modern/Ti Ibile 1. Yes/Beni 2. No/Beko [ ]

15. If No. Give reasons:

_____

_____

_____

16. If yes, list all the methods you ever used and indicate duration/
Bi o ba je beni daruko awon ona eyili o ti lo ati se fun akoko wo

Method	Duration in Years

17. Out of the listed methods which do you prefer most?
Nisu gbogbo awon ona wonyi ewo ni owu o ju lo?

18. Give reasons for this preferred method/wo idi ro?

19. Are you currently using any contraceptive device
Nje o nlo ona leto esi kankan bayi

1. Yes/Beni 2. No (move to 24) | |
Beko, keja si ibere mimalelogun

20a. If yes specify or name method/Bi o ba je beni, daruko ona ti o nlo?

____

____

____

20b. Why do you use this method/Kini idi re to o se nlo ona yi?

1. ....

2. ....

3. ....

21. How often do you use it?
Bawe ni akoko ti o nlo ona yi se pe si are won si

a. Always/Ni gbogbo igba

b. Most of the time/Ni opolopo igba [ ]

c. Sometimes/Ni o kokan

d. Rarely/Ni igba ti o ba wu ni

22. Where do you normally get supplies from [ ]
Nibo ni e ti nri awon ukan feto si yi gba

....

....

23. What benefits do you derive from using a modern family planning method/
Kini anfani ti e nri tunu hlo feto si alo oni?

1. ....

2. ....

3. ....

24a. When should a woman start using contraceptive device/
Ni igbawo lo ye ki obinrin no ti nkan feto si

a. Before 1st child/Ki o to bi omo akoko

b. After 1st child/Lehin aro akoko

c. After 2nd child Lehin omo keji

d. After 3rd child/Lehin omo keta

e. After 4th child/Lehin omo kerin [ ]

f. Having had desired number of children/
Lehin igba ti o ba ti bi iya omo to wu.

24h. Give reasons for your answer/So idi fun awon idahun re

.....

.....

25. Is your wife or girl friend using any modern family planning methods/Nje iyawo tabi orebinrin yin lo ilana feto si ti ode oni bayi.

1. Yes/Beni

2. No/Beko [ ]

26. If yes which method?/Bi beni eru ilana wo

_____

_____

27a. What number of children is ideal for a family
Omo melo lo ye ki idile kan bi?

_____

27b. Why is this number ideal/Kini idi ti iye yi fi yo?

1. _____

2. _____

3. _____

28. What are the advantages and disadvantages of using traditional and modern family planning methods/Kini awon nkan ti o dara ati eyiti ko dara ti owa ninu lilo ilana feto si ti ibile ati ti ode oni.

Advantages/Awulo	Disadvantages/Awulo
1.	
2.	
3.	

ATTITUDES AND BELIEFS TOWARD FAMILY PLANNING/
Isesi ati igbagbo si feto si

S/No.		AGREE MO GBA	UNDECIDED NKO TI LESO	DISAGREE MI O FARA M[illegible]
29.	Men should be involved in family planning programmes / Okunrin gbodo mo si eto feto si omo bibi			
30.	Men should not support the use of modern contraceptive devices by their wives. Okunrin ko gbodo fi ero mo lilo nkan feto si li ode oni pelu iyawo won.			
31.	Men should be reluctant to approve of modern contraceptive use by their wives because they are very likely to be promiscuous. Oye ki okunrin lora lati fi owo si lilo nlaru feto si ti ode oni fun iyawo won nitori ise buruku			
32.	Men should be in a position to recommend family planning services to others. Oye ki awon okunrin ki o le ma polongo eto feto si fun awon elomiran			
33.	Women can adopt and use modern contraceptive devices without their husbands approval or consent. Obinrin le mo lo awon ohun feto si laigba ase oko won.			
34.	Traditional family planning devices are much more effective than the modern devices and its use should be supported by husband. Ilana feto si ti ibile munadoko ju ti ode oni lo, o si ye ki awa oko fi owo si			
35.	Men may not approve of modern contraceptive use by their wives/girl friend because of the adverse effect of these devices. Okunrin le ma fe fi owo si lilo ilana feto si ti ode oni fun iyawo tabi orebinrin won nitori awon ohun ti o tele lo jade.			
36.	Family planning devices are very effective if use correctly. Ilana feto si maa daa ba a ba lo o bi o se ye.			
37.	Men should use condoms because it is safe and effective			

38. In a family, whose responsibility should it be to use family planning methods.
Ninu idile, eto ta ni lati lo ilana feto si
a. Respondent/Emi o nikan nikan ( )
b. Wife (wives/girl friend)/Iyawo tabi orebinrin. [ ]
c. Both partners/Awon mejeji

39. Give reasons for 40 above/so idi fun

_____

_____

40. Who usually decides whether or not your wife/girl friend uses contraceptives
Tani alase lori ati lo ilana feto si

a. I alone/Emi nikan

b. Wife/girl friend/Iyawo tabi erebinrin

c. My wife and I/Iyawo mi ati emi [ ]

d. Health workers/Awom osise ilera

e. Others (specify) .....

41. Does your religion permit the use of modern family planning devices by:
Nje esin yin fi aye sile fun lilo ilana feto si ti oda ona fun

a. Men/Okunrin 1. Yes/Beni 2. No/Beko [ ]

b. Women/Obinrin 1. Yes/Beni 2. No/Beko [ ]

42. Gives reasons for 45 above/So idi fun No. 45

1. .....

2. .....

43. Have you ever heard about the National Population Policy?
Nje o ti gbo nipa ofin iye ona ti o gbobo wa lori lo ede yi bi?

a. Yes/Beni [ ]

b. No/Beko

c. Not sure/Ko daju

44. If Yes what are your views on the National Population Policy?
Bi o ba je beni kini ero yin lori eleyi

1. .....

2. .....

3. .....

APPENDIX 2

IBADAN SOUTH EAST LOCAL GOVERNMENT AND DIVISIONS INTO WARDS

S/No.	WARDS	DISTRICT (AREAS)
1.	C1	Bere-Ogunmola Compound, Oke Dada Oleyo.
2.	S1	Oja oba, Isale Jebu, Idi arere, Omiyale,
3.	S2A	Oranyan, Ita-agbakin Kobomoje,
4.	S2B	Oranyan, Kobiowu, Ita-Ege
5.	S3	Elcia, labo, Olukoyi
6.	S4	Labo, Elckuro, Orita aperin, Oniyere-
7.	S5	Odinjo, Academy
8.	S6A	Kudeti, Elcia, Olunloyo Area
9.	S6B	Molete, Felele, Oke Oluokun
10.	S7	Orita Ikere Kudowu to Express.

APPENDIX 3

SELECTED WARDS WITH NUMBER OF COMPOUNDS AND HOUSES

S/No.	WARDS	COMPOUNDS	
1.	C1 Bere	1. Ogunmola' Compound	120 houses
		2. Laamos "	15 "
		3. Oniro's "	20 "
		TOTAL	155 houses
2.	S1 Oja-Oba	1. Oluwo's Compound	110 houses
		2. Kure "	80 "
		3. Omiyale "	100 "
		4. Abas Olubadan "	60 "
		5. Ile Ode "	45 "
		TOTAL	395 houses
3.	S2A	1. Kobomojo Compound	350 houses
		2. Inakoju's "	8 "
		3. Bamgbose "	10 "
		4. Maye's "	40 "
		TOTAL	408 houses
4.	S2B Kobiowu	1. Ita apete	25 houses
		2. Ita kooto	25 houses
		TOTAL	50 houses
5.	S6A Olunloye area	1. Olunloyo Compound	100 houses
		2. Adeniyi "	15 "
		3. Ali's "	80 "
		4. Ala adorin "	100 "
		5. Bola's "	75 "
		6. Adebiopon "	30 "
		7. Alagbede's "	28 "
		8. Oluokun "	120 "
		9. Onilu's "	10 "
		TOTAL	488 houses
		23 compounds =	1,496 houses

APPENDIX 4

SELECTED 50% OF COMPOUNDS IN SELECTED WARDS

1.	C1 -	Ogunmola Compound	120 houses
2.	S1	Oluwo Compound Kure "	110 houses
3.	S2A	Kobomoje compound Bamgbose "	80 houses 350 "
4.	S2B	Ita Apete Compound	10 houses 25 "
5.	S6A	Olunloyo's Compound Ademuyi " Oluokun " Ali " Ogidi " Total	100 houses 15 " 120 " 80 " 10 " 1120 houses

APPENDIX 6

ATTITUDE OF MEN TOWARDS FAMILY PLANNING

N = 398

	STATEMENT	Type	Agree		Undecided		Disagree			
			F	Score	F	Score	F	Score	Total	SCORE
1	Men should be involved in family planning programmes	P	336	1008	1	2	31	31	1041	2.62
2	Men should not support the use of modren contraceptive devices by their wives	N	140	140	24	48	234	702	890	2.24
3	Men should be reductant to approve of modern contraceptive use by their wives because they are likely to be promiscous	N	310	310	14	28	74	222	560	1.41
4	Men should be in a position to recommend family planning services to others.	P	287	861	15	30	96	96	987	2.48
5	Women can accept and use modern contraceptives without their husbands approval or consent.	N	37	37	7	14	354	1062	1113	2.8
6	Traditional family planning devices are much more effective than the modern devices and its use should be supported by husbands.	N	66	66	140	280	192	576	922	2.32
7	Men may not approve of modern contraceptive use by their wives/girlfriends because of the adverse effects of these devices	P	274	822	60	120	64	64	1006	2.53
8	Family planning devices are very effective if used correctly	P	316	948	54	108	28	28	1084	2.72
9	Men should use condoms both use it is safe and effective.	P	206	618	1	2	191	191	811	2.04

Expected mean score = 27 Overall Group mean = 21.16

= 21.2

Attitudinal disposition is high (positive)

APPENDIX 6