



Thesis

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**FACULTY OF
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OBAFEMI AWOLOWO
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**MALE REPRODUCTIVE BEHAVIOUR,
SPOUSAL COMMUNICATION AND
FAMILY SIZE AMONG THE YORUBAS OF
SOUTH-WESTERN NIGERIA**

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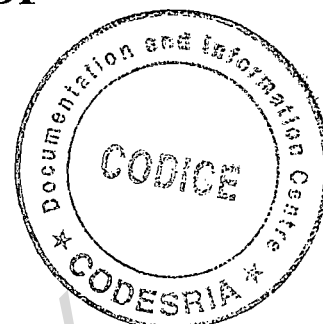
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SOUTH-WESTERN NIGERIA**



BY

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**A THESIS SUBMITTED TO THE FACULTY OF SOCIAL
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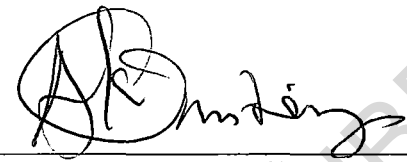
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CERTIFICATION

This dissertation has been read and certified as meeting the requirement of the University for the award of the degree of the Doctor of Philosophy


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Date 5/2/2001

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DEDICATION

TO ALMIGHTY GOD AND MY MENTOR

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Abstract

Very little is known of the dimensions of male contribution to the problem of high population growth in Nigeria vis-a-vis fertility preferences and contraceptive use. Therefore with the recognition of male involvement as essential for the success of programmes aimed at reducing population growth, it becomes imperative to investigate the interrelationship between male reproductive behaviour, spousal communication and family size as well as the interplay of factors affecting them.

Primary data was used in this study. Data were collected from respondents selected from Osun, Oyo and Ondo states of Southwestern Nigeria. In each state, a sample size of 200 men and their wives were selected. On the whole 585 males and 715 females were interviewed in the three states. Statistical techniques used ranged from frequency distribution for all variables, bivariate analysis (cross tabulation) to multivariate analyses (logistic regression analysis and recursive path analytic technique). Data obtained from focus group discussion were used to supplement the quantitative information on individual as well as couples reproductive behaviour.

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The results of the study revealed that conservative attitudes and behaviours of men with respect to reproductive issues are now changing. For instance, more than 50 percent of the male respondents are now involving their spouses in reproductive decision making and about 37 percent of them are adopting family planning methods. The results further showed that generally, among the Yorubas, while knowledge of contraceptive is high, usage is still relatively low. As high as 60 percent of males and 54 percent of female respondents claimed knowledge of at least one contraceptive method, but the proportion of males and females using any of these methods was 32.3 percent and 27.6 percent respectively. The study thus showed that contraceptive prevalent rate among males is higher than that of females.

The results of our findings further indicated that 26.1 percent of male population and 23.1 percent of female population in South Western part of Nigeria still showed preference for large number of children. Educational attainment of respondents was found to be the most important variable affecting desired family size. While respondents with no education desired as many as 5.6 children, their counterparts with secondary education and post secondary education reported mean desired family size of 3.5 and 2.5 children respectively. The results of the

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multivariate analysis also portrayed education as having a depressant effect on family size. The study also showed a tendency towards closer relationship among married couples in Southwestern Nigeria. For instance, about 57 percent of the respondents claimed that they ate together, 69.5 percent slept together, 16.9 percent usually had leisure together and 78.6 percent usually shared confidence. It was also observed that more than 30 percent of the spouses with spousal communication had a mean family size of 4 children; whereas only 18.5 percent of spouses without spousal communication had a mean family size of 4 children.

The study therefore concludes that there is need to increase male knowledge of the need for women to participate in reproductive decision making in the family set-up. This will definitely encourage greater communication between spouses and thus will lead to joint decision making on reproductive issues. It will also remove the alienation men often feel towards family planning programmes and consequently will arouse their interest, cooperation and involvement in such programmes.

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study:

The population of any nation has been recognised to be, the most valuable resource both as an instrument and objective of national development. Despite this, rapid population growth has been identified as the most important factor with the most deleterious effects on the efforts to improve the quality of life for the common people. This realisation led to the adoption in 1988 of a National population policy tagged "National Policy on Population For Development, Unity, Progress and Self-Reliance" with the main objective of reducing population growth which has risen from 2.5 percent estimated in the 1960s to nearly 3 percent (2.83%) in the recent time. In the policy, government hopes to lower fertility by a number of measures which include "boosting the availability of family planning methods to the population of reproductive age through both the public and private sectors; a vigorous population education campaign to reduce the likely completed family size from six to four by the year 2000; and to achieve a birth interval of at least two years for 80 percent of the country's mothers by the year 2000" (Federal Republic of Nigeria, 1988).

After almost a decade of the take-off of the policy document, most of the basic goals are yet to be realised. One of the shortcomings of the policy

has been the lack of effective male involvement in reproductive health issues. For instance, the policy stipulates the average number of children per woman to be four without due consideration to the role of men in achieving the reproductive target. This was a serious omission considering the fact that men are still the decision makers even in matters affecting family size and the health of their wives and children. Men can participate in family planning by supporting their partners' decision to use family planning and/or by practising a male method of family planning themselves - Condom, vasectomy, withdrawal or periodic abstinence. Men's support affects the choice, adoption, continuation and correct use of female methods. However, there is still not enough evidence of how men themselves view the connection between contraceptive use and their involvement in other aspects of reproductive responsibility (Awusabo-Asare and Anarfi, 1997; Schneider and Schneider, 1991).

Conventional approaches to fertility reduction have focused primarily on altering women's sexual and fertility patterns while neglecting male sexual and contraceptive behaviour (Bruce, 1994). Thus family planning programmes are primarily targeted at the females, with emphasis on the acquisition of knowledge concerning family life and reproduction. The consequence of the female-only approach to the fertility control has been that some men view family planning with suspicion, regarding it as being aimed at undermining

their authority in the family. Failure to involve men in family planning programmes can, therefore, have serious implications. Men are the dominant decision-makers in Nigerian families, including matters relating to reproduction and family size. The male-dominant and patrilineal traditions encourage large families (Donavan, 1995).

Recently, however, there has been a move toward recognizing the important role of men in fertility, family planning and reproductive health. Attention is now being paid to including men in fertility and family planning studies as well as in policy and programme formulation. The reasons for the new interest in men according to Bankole and Singh (1998) are not hard to find. They include (i) information that has become available from surveys conducted over the past decade suggests that men and women do not necessarily have similar fertility attitudes and goals; (ii) the scope of fertility and family planning research has expanded to include such broader reproductive health issues as sexually transmitted diseases, on which data from both men and women are needed (Becker, 1996; Bankole, 1995; Ezeh, 1993; Degraff and de Silva, 1996). Donavan (1995) further observed in a survey of five urban areas of Nigeria that, men and women respondents agreed that men decide whether the couple will have sexual relations, the duration of postpartum abstinence, and whether the couple will practice family planning. Thus with the encouragement of a growing number of family planning

programmes around the world, men are showing a new concern over family size and child spacing (Gallen *et al.*, 1986). They also are recognising the benefits that they as well as their wives and children can derive from family planning.

However, one of the unresolved issues in demographic research is whether certain systems of gender power dynamics or particular socio-economic conditions systematically differentiate women's and men's demand for children in developing countries (Manson and Taj, 1984). Overwhelming majorities of Nigerian men and women believe that men wanted more children than wives. Donovan (1995), however, found that men who are educated, who marry at a later age, who are monogamous, who discuss family size with their wife, and who plan to rely upon investments or savings, instead of upon their children, for old-age support, were significantly more likely than other men to prefer small families and to have fewer children.

The relatively high fertility levels in most of sub-Saharan African countries therefore point to the need for a closer examination of the mechanisms of spousal communication about fertility decision making among couples in different family settings. One factor deriving emphasis on couple over the individual, as observed by Biddlecom and Fapohunda (1998), has been the increasing number of studies that demonstrate the influence of man's preferences and power on reproductive outcomes such as contraceptive use

(Mbizvo and Adamchak, 1991), childbearing (Bankole, 1995; Isiugho-Abanihe, 1994), and views about family planning (Ezeh, 1993). Becker (1996) further posited that, based on these studies, one could argue that reproductive health programmes which attempt to reach women will have a higher probability of success if they also involve the husband or at least encourage such involvement. Such programmes should be broadened and sufficiently directed at the males as very important partners in matters of reproduction.

1.2 Justification of the Research:

Large-scale demographic surveys have focused on collecting data from women. As a result, much of what is known about fertility, fertility preferences and contraceptive use is based solely on women's responses. Men have often been perceived as having a more pronatalist view than women and as acting as barrier to contraceptive use (Bankole and Singh, 1998; Stash, 1996). Recently, however, it is realised as a serious misplacement to focus on women alone in major issues on family decision. There has therefore been a move towards recognizing the important role of men in reproductive issues. The international conference on Population and Development in Cairo specifically called for equal participation of men and women in reproductive health. The conference further emphasised men's shared responsibility in reproductive health and the importance of men's active involvement in

responsible parenthood and reproductive behaviour.

Furthermore, various studies have shown important effects of the husband's desires on a couple's fertility (Thomson *et al.*, 1990). A low level of communication between spouses about family size and family planning have also been reported in many studies (Shah, 1974; Lozare, 1976; Mott and Mott, 1985; Ezeh, 1991) and women with low levels of contraceptive use also report little spousal communication (Lozare, 1976; Mott and Mott, 1985; Kane and Sivasubramaniam, 1989). From family perspective, the first step in a rational process of fertility decision making involves communication between spouses (Hollerbach, 1983; Mott and Mott, 1985). Interspousal communication should therefore be among the most important factors leading to lower desired family size and increased use of contraceptives. Traditional roles generally accorded the males in our societies show the male to be paramount in family decision making. Such decisions include determination of family size.

Though, it is realised that the target group in family planning are the females, and especially, women of child bearing age, it is averred that the male is an important factor with far reaching positive or negative implications for the practice. In this context, the decision to have or not to have children is male's and invariably his decision is usually in favour of having children, as more and more children further enhance his status as a man in the society. Isiugo-Abanihe (1994) and Raimi (1994) noted that male dominance is

particularly profound in matters of reproduction. They generally view reproduction as their prerogative, an issue in which the compliance of their wives is taken for granted. Men will, therefore, act as models of change by encouraging the utilization of family health services and discouraging negative socio-cultural practices.

In addition, statistics show that male literacy rate in many developing countries is higher than that of females (Health and Population, 1978; Omideyi, 1990; Bankole and Olaleye, 1993). Again, since men in Africa, were noticed to be dominating and controlling many of the structural, behavioural, and cultural dimensions of the family and its fertility processes (Adamchak and Adebayo, 1985), an understanding of their attitudes, preferences, and behaviour concerning reproduction becomes an important area for demographic investigation.

Finally, programmes and researches on reproductive matters are currently undergoing fundamental shift from a focus on women only to an interest in both partners in sexual relationships (Biddlecom and Fapohunda, 1998). The first step in rational process of fertility decision-making has been recognised to involve communication between spouses (Hollerbach, 1983). Such communication should be among the most important precursors of lower desired family size. This study will therefore bring to focus the importance of dialogue between husband and wife and an understanding of gender

differences in reproductive orientation may shed light on the course of demographic transition. The differences that may exist between married partner's fertility desires and preferences will also be brought to focus.

1.3 Objectives of the Study:

The study has as its primary aim to examine the relationship between male reproductive behaviour, spousal communication and family size among the Yorubas of South Western Nigeria. The study would provide opportunity to gain an insight into male fertility aspirations, factors and the intricacies that are involved in decision-making process which affect desired or actual family size. Specifically, our objectives in this study would include:

- (1) Examination of the interrelationship between male reproductive behaviour and family size.
- (2) Examination of the influence of spousal communication on actual and desired family size.
- (3) Examination of the extent to which spousal communication and other socio-economic variables influence male sexuality and contraceptive use.

1.4 Literature Review:

1.4.1 Men's fertility preferences, contraceptive use and family size

A longitudinal assumption about men's fertility preferences is that men want more children than do women. As observed by Isiugho-Abanihe (1994), African men generally desire larger families than do their wives, in part as a result of the institution of polygyny and in part because children enhance men's status and the prestige of their lineage. One other argument has been that men do not bear physical or economic costs of repeated childbearing that women bear. They, generally, do not take responsibility for their sexual and reproductive behaviours. Thus they are more pronatalist than women.

There have been conflicting views on men fertility preference and most studies on fertility preferences show substantial disagreement existing among couples (Mott and Mott, 1985). For instance, studies in Malaysia and Taiwan showed a high congruence between men and women on overall family size preferences but low agreement among couples (Coombs and Chang, 1981; Coombs and Fernandez, 1978). Becker (1996) found that spousal agreement on subjective matters ranged from 60 percent to 70 percent in developed and developing countries respectively. Manson and Taj (1987), reviewing men's and women's fertility preferences in developing countries, found that when gender differences occurred they were typically small. Bankole and Olaleye (1993) study equally showed that there seems to be a high degree of

disagreement concerning fertility preferences among Kenyan and Ghanaian couples, with about 58 percent of wives in Kenya wanting no more children, compared with 4 percent of their husbands. The corresponding figures for Ghana are 29 percent and 19 percent for females and males respectively. Pool (1970) however, concluded from a study of urban males in Ghana that the overwhelming majority of the men preferred small family size and therefore showed a positive attitude towards contraceptives, though the proportion using contraceptives was low. Kritz *et al.* (1992) found that Yoruba men want more children than do their wives.

Recent survey also point to the direction that majority of African women want more children. A review of findings of the World Fertility Survey (WFS) shows that 60-90 percent of women in nine countries wanted another child. In his assessment of the contribution of family planning programmes to fertility decline in Africa, Odile (1983) concluded that fertility rates in Africa are high not because of deep rooted desire to continue childbearing among African women but for preference for high family size by men. Thus Danforth and Jezowski (1994) observed that in most countries, DHS surveys show that men are more likely than women to want another child. Various studies indicate that the average desired family size is highest in Africa with 6.5 children, followed by Asia with 4.2 and Latin America with 4.0 children (United Nations, 1995). Men's ideal family size ranged from

around 9 children in West Africa to 5 children in East Africa to about 3.5 in North Africa and Asia.

However, the desired family size does not lend itself to easy measurement because of the high degree of non-numeric responses to the question on the subject. In a survey of fertility, family, and family planning carried out in Nigeria (1978), it was observed that almost half (49.2%) gave non-numeric responses though there were variations according to status, level of education, religion, urbanity and age (Adeokun, 1979). Those who intend to procreate as many as their capacity can bear tend to give non-numeric responses. One can therefore conclude that non-numeric response is an indication or pointer of preference for large family size.

Ezeh *et al.* (1996) in a review of 17 Demographic and Health Surveys of men and women observed a wide variation in both men's and women's fertility preferences. Women's fertility preferences and behaviour are strongly influenced by their husband's reproductive motivation (Ezeh, 1992). This influence is a function of both men's dominance and women's financial dependency on their husbands. Marris (1966), however, observed that women in Yorubaland enjoy considerable social and economic independence. They trade on their own, albeit often with money or goods borrowed from their husbands. This long-standing tradition of independent marketing is thought to provide them with a stronger basis for emancipated status than exists

elsewhere. There is a rather widespread assumption that men intuitively possess all of the knowledge and skills needed to live a satisfactory, healthy, and responsible sex life. This assumption is false and closely related to the popular image of man as the initiator of sexuality and being in control of it (Ketting, 1996).

However, when it comes to question on family decision making, men play an important role in decisions pertaining to family size and family planning. Due to the fact that wives depend on their husbands, socially and economically, men have great influence on them in family decisions (Isiugo-Abanihe, 1994). A number of cultural and institutional factors favour men in matters related to marriage and family life. Men, as the head of households, are viewed as the protectors and providers of their families (Bankole and Singh, 1998).

Among the Yorubas of Western Nigeria, by tradition, men's decision is final. In the context of marriage, the man is recognized as the one who marries the woman and therefore regarded as a father of all offspring of the marital union. In this context, the decision to have or not to have children is his. Invariably his decision is usually in favour of having children, as more and more children further enhance his status as a man in the society (Adeokun, 1979; Orubuloye, 1979; Ottong, 1985; Ebigbola, 1987; Olusanya, 1989; Raimi, 1994).

Bankole and Singh (1998), however, argued that the perception that men will necessarily have more influence on reproductive decisions because they typically control the family assets; they are accepted as the household head and are older, may be an exaggeration. The actual situation is likely to depend on other factors and to vary over time and by location (Bankole and Singh, 1998). For instance, among the Yorubas of Nigeria, the fertility desires of both marriage partners are important predictors of the couple's fertility. However, whereas the husband's desire is dominant in predicting the couple's behaviour when the number of living children is small, the wife's desire becomes more important as the number of children grows (Bankole, 1985). The socioeconomic groups to which parents belong also shape family size goals. The responsibility of family size decision-making may rest, for example, with grandparents, until western values of individuality and independence weaken parental control over their offspring (Caldwell, 1981).

Apart from the number of children, sex of children is also an important determinant of male fertility behaviour. In many parts of Nigeria, the presence of at least a male child is regarded as necessary, since to have a son is a sign of social completeness first and economic investment second. It is not that daughters are not important, but as Orubuloye (1987) observed, sons are traditionally expected to maintain the family "tree" and make financial contribution towards the support of their parents. In a study in Eastern

Nigeria, Nsudoh (1994) concluded that the desire for more children seems to be influenced by the preference for sons at all levels of education.

Several studies have noted the tendency for son preference to influence family size (Williamson, 1976; Coombs and Sun, 1978; Park, 1983; Ali, 1989; Rahman and Davanzo, 1993; Raimi, 1994;). These studies have shown son preference to be partially responsible for parents' desire for additional children. Some families have exceeded preferred size because the sex composition of children was not right for them. It was hypothesised that when parents already have one son or more among their offspring, they are more likely to use contraceptives in order to delay or stop childbearing (Davanzo and Starbird, 1991; Das, 1987; Chaudhury, 1979). Having sons who survive induces parents to adopt more effective or permanent methods of birth control or to have abortions (Rahman et al, 1997; Arnold and Liu, 1986; Robey, 1985). Not only does the number of surviving sons trigger contraceptive use among non-users, it also reinforces continuation among contraceptive users (Gadalla *et al.*, 1985; Sun *et al.*, 1978).

Preferences for children of a certain sex, usually boys, are also argued to make men more pronatalist than women. There is tendency for men to prefer sons over daughters (Manson and Taj, 1987), but this varies across countries. Pebley and his colleagues (1980) found that the predominant preference among both men and women in Guatemala was for equal numbers

of sons and daughters. In a study in India, couples for most part shared preferences for additional children and the ideal number of sons and when there was disagreement, husbands tended to be less pronatalist than wives, mainly due to men's lesser dependence on sons for old-age support (Jejeebhory and Kulkarni, 1989). Stash (1996) in a study found that while husbands and wives did not differ significantly in their preference for sons, when asked to consider hypothetical situations of family size and gender composition, more husbands than wives were willing to pursue larger family size than their ideal in order to reach their desired number of sons. He further observed that husbands are consistently more willing than wives to pursue the birth of sons at the expense of larger family size, and that the birth of daughters is not pursued to a similar degree by wives or husbands. Male children are regarded as the pillar of the family and object of perpetuation of family lineage. For instance, if a woman has only four living daughters, she stands the risk of total neglect from a husband who needs at least a living son for perpetuating the family name. Modernisation has not yet weakened this deeply rooted traditional trait. Therefore, the potential of this cultural fact for unlimited procreation should not be under-estimated in population policy implementation strategy (Stash, 1996).

From the foregoing, there is ample evidence that socio-cultural differences play an important role in reproductive behaviour. It should

however be noted that preference for a particular sex or large family size does not imply a desire for an unlimited number of children. In large part, it is a rational decision which takes cognisance of the survival chances of each child. Ware (1975) and Olusanya (1967) have demonstrated this in their study in Western Nigeria. A contraceptive prevalence survey in the rural area of the Belgium and Gulbarga district of Karnataka State in India in 1990 found that the use of contraceptive was almost nil among couples with one or no living children, only one-fourth were using method; for those with three or more living children, nearly two-thirds were using a method (Rajarenam and Desphande, 1994). In a related study of rural Manchok in Southern Zaria, Nigeria, Ottong (1976) concluded that fertility rates were high on account of high mortality rates. He submitted that fertility control could be achieved much faster through the control of child mortality.

Patriachal authority relations in the family is very pervasive in Nigeria such that in many homes, a son could assume control of the family in the fathers's absence. This position of the male in the traditional social structure is further strengthened by the principle of inheritance. Generally, inheritance is determined by the male, as children, especially sons, normally inherit from the father. Thus both men and women look at male children as highly prized treasure (Ottong, 1985) and a family or couple without at least a son feels insecure. This has in some instances, resulted in couples having more than

normal family size desire, in the quest for at least a son among their offspring. As observed by Ottong (1985), male chauvinism is overtly or covertly promoted by customary practices. It can therefore be asserted that the more dominant the male position in society and/or the more patriarchal the authority relations in society, the higher the probability that the decision on the timing and number of children would remain a male prerogative.

Raimi (1994) submitted that Nigerians in general and the Yorubas in particular are so much interested in the idea of children surviving parents especially to give them befitting burial when they die. He further noted that, the Yoruba believe that the number and type of people that will be present at their burial ceremony depend not only on quality of their children but also on quantity. Both Yoruba men and women desire and actually produce many children so that at least some would survive them (Raimi, 1994).

Other factors like employment, household accommodation and use or non-use of family planning have been used to explain the persistently high fertility among the Yoruba (Kritz *et al.*, 1992; Isiugo-Abanihe, 1994; Renne and Bankole, 1996). However, such findings are in almost all cases significantly different from the findings of the studies conducted in developed parts of the world (Raimi, 1994).

Bankole (1995), found that if there were four or fewer children, a subsequent birth was likely if the husband wanted it, and if there were five or

more children, another birth was likely if the wife wanted it. The proportion of men who want another child is a meaningful predictor of future childbearing. Fertility has remained high in many countries in Africa in part because the demand for children is high.

Caldwell (1978, 1981) states that pre-transition societies, where fertility is high and stable, are characterised by the existence of net wealth flows that go from the younger to the older generations. Therefore the extent to which parents will depend on their children for old age support is an important determinant of fertility in Nigeria. Men who plan to depend on their children are likely to have higher family size goals than are those who will depend on their personal resources when they are old. High fertility levels and their direct association with per capita income in developing economies, where children work in rural industry, have equally been attributed to the utilities of offspring (Lindert, 1980). Knodel *et al.* (1984) also found that, in Thailand, when urban industrial employment and education became more accessible to villagers, rural parents perceived large families as an unnecessary drain on the family's economic resources, and fertility began to decline. Caldwell (1981) similarly stressed the importance of how the industrialisation process is perceived, and he focuses on the changing usefulness of children in supporting their parents. As the family mode of production is transformed into the capitalist mode of production through a labour market that operates outside the family, children's

utilities decline and desired family size is influenced accordingly.

Though the age of the woman at marriage has been more commonly studied in demographic survey, the age of the man, and the difference between the ages of the spouses, also reflect social expectations and affect marital and other social relationships. Larger age differences between husbands and wives reinforce gender stereotypes of wifely dependency and powerlessness (United Nations, 1995). Zaky (1992) also observed that the larger the age difference between spouses or the greater number of children ever born, the higher the probability that they would not agree on the desired number of children.

In many cultures, misunderstandings and myths about female sexuality and reproductive systems persist. Though there are indications that male attitudes towards a range of taboos are changing (Omideyi, 1990), a woman still needs to get her husband's consent before she can receive any contraceptive services. Traditional societies often invest power and authority in males to make decisions and to control valued resources, especially in the case of patriarchal societies (Cain *et al.*, 1979; Caldwell, 1981; Dyson and Moore, 1983). However, such powers may not necessarily be utilized because individual convictions differ from norms. This intimate relationship notwithstanding, personal opinions of males within their familial context becomes the overriding factor (Simons, 1990; Ajzen, 1988).

Data from the Zimbabwe 1988 Male Fertility Survey, comprising a

representative sample of 711 currently married men aged 20 and above, showed that men play a major role in the decision to use family planning and in determining the number of children a couple should have. Male knowledge of various family planning methods was high, as well as the approval and ever-use of family planning (Mbizvo and Adamchak, 1991). However, findings from the same survey revealed that men still believe women are responsible for fertility control (Mbizvo and Adamchak, 1992). In a study of 100 married men aged 15-39 years, from the Via society of Liberia, Campbell (1985) showed that the husband's desire for large family size had a dominant influence on fertility decision. Among the Yorubas of Western Nigeria, it has been established that men wanted more children than their wives. Indeed, it has been shown that women's reproductive preference and behaviour are strongly influenced by their husbands reproductive motive. This influence is a function of both men's dominance and women's financial dependency on their husbands (Olusanya, 1969; Orubuloye, 1987; Isiugo-Abanihe, 1991; Kritz *et al.*, 1992; Bankole and Olaleye, 1993).

Studies of fertility and mortality in relation to status of women (Mason, 1983; Dyson and Moore, 1983; Omideyi, 1986) have consistently highlighted in their causal models variables relating to egalitarianism of husband/wife decision making as important conditioning, if not determining factor (Omideyi, 1990) accounting for changes in fertility levels. A greater understanding of

male attitudes and the role they play in decision-making can throw better light on mechanisms through which egalitarianism of husband/wife decision-making as an indicator of women's status, influences fertility. In certain settings, especially in developing countries, male attitudes regarding the status of wives may become critical in achieving the ultimate objective of improvement in women's status so as to influence the desired reduction in fertility levels (Omideyi, 1990).

In Nigerian societies, where average family size is traditionally large, and where the male input is very significant in determining family size, the change towards the small family norm depends on the adequacy of family planning education programmes targeted not only at the females but also at the males. Though the burden of fertility falls on the females who, consequently, constitute the main targets of family planning practice, the males as breadwinners are also important targets that should be sufficiently recognised in family planning education.

Men make most family-related decisions and because their status is directly related to the size of their family, population has continued its rapid growth (Popoola, 1994). Despite the recognition of the important implications of women's and men's social roles and power relations for fertility levels (Caldwell, 1981; Manson, 1984; Feyisetan and Togunde, 1988; Omideyi, 1990) it is, however, not yet clear through what mechanisms gender affects

reproductive and contraceptive decision making in Nigeria. Isiugo-Abanihe (1994) study also confirms the generally held view in Nigeria that as husbands and household heads, men control the sexuality of their wives. Wives are bound to comply with their husband's sexual demands as refusal is a major source of strife, the taking of other wives or the keeping of "outside wives" (Wa Karanja, 1987). Hollander (1997) in a study conducted in the districts of Masaka and Lira in Uganda, even observed that approximately 50 percent and 25 percent of men and women respondents respectively, feel that a woman has no right to refuse sexual intercourse with their husbands either to avoid pregnancy or because she knows that he has AIDS. However, it is realised that husbands' desire for more children and their perception of their wives' desire to have more children both play important roles in decisions leading to family planning use.

1.4.2 Effects of spousal communication in modifying male's fertility preference:

Discussion between spouses of sexual matters, family planning, or number of children is still rare in Nigeria, especially in rural areas and among the muslim population (Isiugo-Abanihe, 1994). United Nations (1997) reports also indicate that husband and wife may want the same thing, but they don't tell each other. Hollander (1997) in Uganda study, also found that men and

women generally believe that they know their partner's family size desires even though couples rarely discuss the number they want to have. A large proportion of men still considers sexual and reproductive health to be exclusively women's concern.

Sabakati, a project director with UNFPA, while counselling couples on family planning in Malawi, overheard women pointing their accusing fingers at men saying "we are willing to use contraceptives, but these people (i.e. their husbands) prevent us from doing so". Studies have however shown that men have all along been showing serious concern for women reproductive health and are willing to participate in making decisions (UN, 1997). The problem however, may be communication. Contraceptive use is affected by the level of communication between husband and wife (Alcantara, 1988). Failure to communicate about sex and other reproductive matters can lead to a failure to act on commonly held preferences (Van de Walle and Maiga, 1991).

Numerous studies show a positive association between spousal communication and contraceptive use (Oni and McCarthy, 1991; Salway, 1994; Lasce and Becker, 1997; Omondi-Odhiambo, 1997). Where there is a negative association between communication and agreement on reproductive behaviour, it becomes apparent how little we really understand about couple communication. For example, Coombs and Fernandez (1978) found in a Malaysian study, that agreement between husbands and wives on fertility

preferences was higher among couples who, according to wife had never discussed the number of children they wanted.

Spousal communication has been recognised as an important channel for reproductive change (Nyblade and Menken, 1993, Hardee-Cleaveland, 1992), and strong determinant of family planning adoption (Phillips *et al.*, 1997; Rutenberg and Watkins, 1996). Opinion is unanimous concerning the strong positive effect of husband-wife communication about family planning behaviour in both Kenya and Ghana. Nyblade and Menken (1993) show that, irrespective of household structure, spousal communication is associated with greater contraceptive use in Kenya. Hardee-Cleaveland (1992) also documents this effect of spousal communication in Ghana.

Husband and wife communication about family planning has been improving over the past few decades, but a large minority of men still consider sexual and reproductive health to be exclusively women's concerns. Omondi-Odhiambo (1997) noted that spousal disagreement may be more related to the lack of communication between spouses rather than being a meaningfully articulated opposition of one spouse to the other's desires.

The conventional wisdom of recent family planning research considers men's negative attitudes toward fertility control as one of the most serious causes of women's unmet need for family planning (Bongaarts and Bruce, 1995; Casterline *et al.*, 1997). This consideration, according to Ngom (1997)

has been the origin of strong recommendations that programmes fostering husband-wife communication about reproductive issues be implemented. He noted that where men and women experience substantial unmet need and discrepancies occur between spouses' levels of unmet need, husband-wife communication may be expected to include large increases in contraceptive use, possibly as large as might be achieved by targeting men's or women's demand for children.

Several problems face the spread of the knowledge and practice of family planning in Nigeria, including lack of funds, inadequate equipments, insufficient personnel and sheer human problem. One dimension of the human problems is male factor which the Planned Parenthood Federation of Nigeria (PPFN) has identified as 'the husband problem'. Men as obstacles to fertility regulation is a widely held view. This is reflected in the low use of modern contraceptives by men. For instance, Van de Walle and Van de Wyk (1982) in a study of black males in urban community of Daveyton in South Africa, found that out of 227 men, only two percent were using male contraceptives. Ezeh in another study conducted in Ghana in 1993 observed that the wife's attitude toward contraception is strongly influenced by her husband's attitudes and background characteristics, especially education, but the husband's views are not similarly influenced by his wife.

The justification that men serve as barriers to women's contraceptive

use seems to be unfair. The literature tends to be grounded in the assumption that men block their wives lower fertility desires. More recent research has even found that African men actually support family planning and may even be more favourable to and use contraception more than women. Despite these positive findings, Kumak *et al.* (1994) note the lack of spousal communication as barriers to greater male involvement in family planning. Survey data also indicate extraordinarily high levels of approval of contraception among men in most developing countries and differences between men's and women's approval of contraceptive use tend to be small (Ezeh *et al.*, 1996). Westoff and Bankole (1995) in a study noted that only a small proportion of women who want to delay or limit childbearing state that their partner's opposition is the main reason that they do not intend to use contraception. It must be understood that many men are interested in learning more about and practising family planning as an equal partner with their wives. Men are far from being a monolithic group opposed to family planning (Green, 1991). Some researchers even argued that in the demographic transition in many developed countries, men were the key elements to smaller families, using condoms and coitus interruptus prior to the widespread use of the pill in the 1960s.

Resurgence of interest in male contraceptives has led to intensification of efforts towards the development of safe, effective, reversible and acceptable methods of male fertility regulation. However, in spite of a decade of

considerable investment of time, money and effort on a global basis on family planning programmes, the goal continues to remain elusive (Herndon, 1992). Introduction of new technologies has long been seen as one important way of expanding contraceptive use (Simmons *et al.*, 1997) and addressing unmet need, especially that of men. More recently, introduction of new methods has also been regarded as a means of improving quality of care by making available a wider choice of contraceptives. However, in practice, the benefits of technology have not always materialized. The availability of contraceptives alone will not expand use or broaden choice unless the existing constraints faced by programmes in delivering adequate services are addressed (Simmons, 1997; Soni, 1984; Simmons *et al.*, 1994; Lubis *et al.*, 1994; Snow and Chen, 1991). Social dynamics and economic compulsion have provided strong motivation for men to accept their share of responsibility in family planning programmes. A scientific breakthrough in the field of male contraception, is likely to be much more acceptable in the present milieu (Bajaj and Madan, 1983). These advantages of males over females may help to reveal new areas hitherto unknown in the study of fertility and fertility regulation.

Apart from the above, there are several reasons for the lack of progress in male contraceptive technology. An incomplete understanding of male reproductive physiology and fewer modes of fertility control are two factors inhibiting progress (Chaudhuri, 1988; Bremner, 1984). The lack of

contraceptive methods available for men is probably the primary reason for the failure of men to assume more responsibility for fertility control. Development of reversible methods of suppression of male fertility remains in a preliminary stage. With the availability of a variety of safe and acceptable male contraceptive methods, men can undertake more effective partnership in contraceptive practice (Health and Population, 1978). Reliable methods of male fertility control would lead to greater cooperation by males in family planning and a more equitable distribution of the risk involved in fertility control (Chaudhuri, 1988). Nieschlag and Quazi (1982) however observed that although the need for development of new male methods of fertility control is unquestioned, such methods will probably not be available for some time.

1.4.3 Socio-economic factors in spousal communication, contraceptive use and family size

Despite the shortcomings of various programmes, recent studies have shown that male attitudes are more positive than originally thought, though significant obstacles remain in some countries (Ezeh *et al.*, 1996). A study of males in four Nigerian cities indicated a more positive perception and attitudes towards family size. It was found that factors that influence men's reproductive outcomes and intentions include education, age at first marriage, type of union, inter spousal communication about family size and intentions to rely or not on

children for old age support. Men living in urban areas are more likely to engage in greater spousal communication than those living in rural areas. This is in part because people in urban areas have better access to information, and in part because they are more likely to be educated (Roudi and Ashford, 1996). Better educated men are far more likely than their less educated peers to practise or have a spouse who practises family planning. Men who expressed male-dominant views have higher family size intentions than do those with more egalitarian attitudes. Males with more broader outlook are more liberal in matters of family life, and are more favourably disposed to family planning practice and the small family norm than males with less broad outlook. To the former, wives are more likely to be treated as equal partners in the family, while to the latter, male dominance and strong patriarchal authority as sanctioned by custom and tradition are likely to be strongly upheld, and at times invoked, to demonstrate superiority over the wife (Ottong, 1985). Monogamously married men have lower family size desire and desire fewer children than do men in polygynous unions. Communication may appear to be somewhat more extensive in monogamous as compared to polygynous units (Mott and Mott, 1985). Also men who have discussed family size with their wives have lower family size goals as do men who are currently using family planning methods with their wives. Popoola (1994) also suggest that in order to increase direct and active male participation, programmes

should seek an attitudinal and behavioural change to a small family norm, should encourage joint husband-wife decision-making regarding family size and contraception, and should provide relevant family planning services for men.

Family planning programmes traditionally have focused on women as the primary beneficiaries of service provision. Men have been considered 'silent partners', whereas research on contraceptive acceptance has concentrated on the methods' effect on women and factors affecting method choice (Cosminsky, 1982; Sargent, 1982). Furthermore, few studies examine the broader social, economic, and cultural forces affecting individual fertility regulation decisions or the decision-making dynamics within couples (Pieteraz, 1983; Browner, 1986; Handwerker, 1992; Stark, 1993, Tucker, 1986). Indeed, a consideration of the potential for invoking men in family planning and contraceptive decision-making is a recent concern that has developed largely as a result of efforts to prevent the transmission of HIV/AIDS (Edwards, 1994). Moreover, a recent review of studies of couple's behaviour indicates that reproductive health interventions targeted at couples demonstrate greater impact than those aimed at a single sex (Becker, 1996).

Unfortunately, perspectives on male involvement are often rooted in negative assumptions. Programme planners view men as gatekeepers, potential obstructionists who, if involved in decision making, will defeat women's efforts to regulate fertility. Yet, the limited evidence to date suggests that the

most successful family planning programmes target men as well as women (Ezeh, 1993; Chaturved, 1986; Pieterasz, 1983) and promote communication about contraception between spouses (Jolly, 1976). Nevertheless, Edwards (1994) cautions that important questions about men and contraception remain unanswered and that these can affect acceptance of family planning.

In countries where national family planning programmes have been effective, there has been a trend towards male preference for relatively smaller family sizes and an increase in contraceptive use such as was reported in Kenya where two successive surveys have shown substantial increases in the use of family planning methods (Omondi-Odiambo, 1989).

Findings from recent studies have indicated increasing awareness of contraception though its use remains very low in some countries (Meekers and Oladosu, 1996). The recent trends could be attributed to improved socioeconomic conditions such as education, occupation, increased income and rapid urbanisation, all of which seem to have a weakening effect on traditional norms of reproduction. Another important factor, perhaps, is the economic crisis that started from the 1980s (Ebigbola 1997). The recent insurgence of AIDS and the increasing promotion of condom as the only means of protection so far, could have an impact on the overall contraceptive usage.

Lampthey *et al.* (1978) and Feyisetan and Adewuyi (1988) observed that there was a significant correlation between literacy and acceptance of family

planning by men. They observed that literate men were prone to favour the adoption of modern family planning. Such men, Pool (1970) indicated, may have more liberal attitudes towards family planning than do their wives. Education has also been found to be critical in bringing about the shift from non-numerate to numerate thinking about children. It provides an alternate model of gender relations which promotes spousal discussions of desired family size and fertility (Renne and Bankole, 1996).

Another aspect of fertility having to do with men is the existence of polygyny in tropical Africa (Adewuyi, 1988). Monogamously married men have lower family size than those who are polygynous (Isiugho-Abanihe, 1994). Men who desire a large family take a greater number of wives, even though the fertility of each wife may be lower than that of women in monogamous unions. Ukaegbu (1978) observed that the wide age differential between polygynist and their wives was responsible for the association between reduced fertility and polygyny in rural Eastern Nigeria. Garenne and Van de Walle (1989), also concluded from a study in Senegal that the low fertility among the Serer polygamists was as a result of lower fecundity of the older men.

Polygyny is common among the Yorubas, especially among Muslims and those practising traditional religions, but even among those professing Christianity (Marris, 1966). A man's motives for polygyny include the prestige

and demonstration of virility, associated with having many offspring (Fortes, 1978). One legitimate alternative to a lengthy period of sexual abstinence is to take a second wife. Traditionally, however, the most important reason for marrying several women was to be able to have more children and many parents still bear pressure on their sons to take additional wives for the sake of extending the family's sphere of influence (Raimi, 1994; Marris, 1966). Besides prestige, there are practical and moral advantages to having more than one wife. Many Yorubas consider it improper to have sexual relations with a woman from the time she becomes pregnant until the time the child is weaned (Lloyd, 1971; Dow, 1977). It is still widely believed among the Yorubas that semen harms the child in the womb and spoils the mother's milk (Marris, 1966).

According to Phillips (1969), all traditional African marriages are potentially polygynous and, in fact, polygyny is held as the ideal. Husbands in monogamous unions were much more likely than their wives to indicate that they would use modern contraceptive methods. Though monogamous unions are still prevalent (Fapohunda, 1981), not much difference exists between the fertility of women in polygynous unions and those in monogamous unions.

Polygyny may lead to differential reporting of contraceptive use between husbands and wives. When one wife in the polygynous circle is a user, both she and her husband may report the use but her cowives may not

(Ezeh and Mboup, 1997). Also, a polygynous husband may use condoms or practise abstinence with only one of his wives. Certain criteria are required in establishing an effect of polygyny on the gender gap in contraceptive use reporting. First, the reported level of contraceptive use has to be higher among polygynous husbands than among their wives; second, the polygyny level has to be high enough to influence the overall gap (Ezeh and Mboup, 1997).

The reporting of contraceptive use by only one partner of a couple may result from several factors, such as multiple sexual partnerships, secret use by one partner, or differential perceptions of what constitutes a contraceptive action. A woman whose husband is polygynous is not considered a user simply because one of her cowives uses a method. One spouse's secret use of a method is another possible source of the gender gap in the reporting of contraceptive use. Methods such as injections, vasectomy, and tubal ligation can be used without one's partner's knowledge. Even when a spouse knows of a partner's secret use, he or she may fail to acknowledge or report such use, because the acknowledgement may serve to legitimize the use or imply approval of the action (Renne, 1993). One partner's secret adoption of a contraceptive method may be the result of spousal differences in childbearing motivations. Furthermore, with the exception of prolonged abstinence, a husband can use some of the contraceptive methods without his wife's knowing. Even when the wife knows, she may not associate the use with

contraception. Husbands may use condoms, for example, for extramarital relations only, both as a contraceptive and as a protection against sexually transmitted diseases. Also periodic abstinence can be practised within union without the wife's associating the action with contraception (Blanc *et al.*, 1996). Some studies have also shown that men can undergo vasectomy without their wife's knowledge (Kerra *et al.*, 1997).

One dominant explanation for the gap in contraceptive use between men and women is that individual responses are likely to be influenced by perceived cultural norms and taboos regarding the discussion and practice of contraception (Koenig *et al.*, 1984). These norms are assumed to operate more for women than for men (Renne, 1993, Mott and Mott, 1985). The strength of these norms in influencing reported behaviour is amplified when others, especially those with an interest in maintaining the norms, are present during individual interviews (Ukaegbu, 1978; Koenig *et al.*, 1984).

The disparity between men and women in their reporting of contraceptive use has long been documented in demographic literature (Yankey *et al.*, 1965; Stoeckel and Choudhury, 1969; Koenig *et al.*, 1984; Mitra *et al.*, 1985). The nature of this discrepancy is also well established, with men or husbands generally reporting greater use of contraceptive than do women or wives (Mott and Mott, 1985; Coombs and Chang, 1981). Ezeh *et al.* (1996) recently found current contraceptive use to be higher among currently married

men compared with currently married women in twelve of fourteen countries they studied. A difference of only two percentage points separates the reports of the men and the women in two countries where women reported greater contraceptive use than men did. The observed inconsistencies in contraceptive use status of husbands and wives might be as a result of respondent-related errors, and in particular, as under-reporting by wives (Koenig *et al.*, 1984). The inconsistencies might not be unconnected with the fact that spouses use contraceptive exclusively with their marital partners. An extension of this assumption is that sexual activity among married men and women occurs exclusively within marriage (Ezeh and Mboup, 1997). The treatment of wives' reports as mis- or underreporting assumes that spouses have equal knowledge of the use of a method and that both partners have the same definition of what constitutes contraceptive practice.

Extramarital relations are another form of multiple sexual partnership. As observed by Karanja (1994), unlike polygyny, where all the wives may share a residence and each knows what the others are doing, extramarital partners generally meet outside the residence and may be unknown to the spouse. The association between extramarital relations and higher incidence of condom use among men has received some attention in the literature (Wandera-Nadaho, 1990; Havanon *et al.*, 1993), and this finding is often assumed to explain the gender gap in contraceptive prevalence rate among

couples (Ezeh and Mboup, 1997). However, it is acclaimed by many authors that men use condoms for extramarital relation primarily as a protection against AIDS and STIs, but not for contraception.

The gender gap in contraceptive use may also result from gender differences in perceptions of what constitute contraceptive practice (Ezeh and Mboup, 1997). For instance, a man may report current use of condoms if he used the method recently, whereas a woman may report it only when her partner uses it at every sexual encounter. Again, a man who periodically abstains from sex for either religious, health, or cultural reasons may report that he practises periodic abstinence, whereas a woman may only report such abstinence if she practises it during her most fertile period to avoid pregnancy.

Roudi and Ashford (1996), report that a wide gap exists between African couples' knowledge of and attitude toward contraceptives and their use. They observed that although the majority of married couples in Africa know about family planning, it is estimated that on average only about 22 percent of couples use either a modern or traditional method. AIDS epidemic in most of the developing countries has been an important factor in bringing male involvement in family planning to the forefront of policy agendas (Roudi and Ashford, 1996). The spread of sexually transmitted diseases (STDs), including HIV/AIDS, challenges policymakers to develop strategies to promote condoms and other male and female methods of sexually transmitted disease

and HIV protection (Roudi and Ashford, 1996).

Many men are directly assuming responsibility for preventing pregnancy through coital-dependent methods such as condoms, withdrawal, and periodic abstinence. Coitus-dependent methods are usually preferred to coitus-independent methods, especially by men. However, studies of men's acceptance of vasectomy and condoms are presently receiving a boost (Grady *et al.*, 1993; Pleck *et al.*, 1990; Ringheim, 1993; Ross and Huber, 1983). Also because condom protect against pregnancy and STDs, it may be the ideal method of choice among those engaging in extramarital relations. However, studies in Uganda, Tanzania and Thailand found little support among men for condom use within marriage (Knodel and Pramualratana, 1995; Blanc *et al.*, 1996; Pool *et al.*, 1996). While they think that condom use is good generally, their views of using condoms in sexual relations with spouses may be negative because of the association between condoms and promiscuity, disease and commercial sex (Knodel and Pramualratana, 1995). Sexual contact is the main form of HIV transmission in sub-Saharan Africa. In many parts of the region, the custom of men having multiple sexual partners has contributed to the spread of HIV. Condom is the only known method that can effectively prevent the spread of HIV among the sexually active population. While knowledge of condom among men is widespread, not all of them know where to obtain them.

Despite the long histories and widespread use of traditional methods, less attention has been devoted to understanding men's use of such methods as withdrawal, periodic abstinence, and postpartum abstinence. In a number of sub-Saharan African countries, more than 50 percent of current use is of traditional methods, periodic abstinence being predominant (Ezeh, Seroussi and Ruggers, 1996).

1.4.4 1988 Nigerian National Population Policy and the Issue of Family Size

The second half of the 1980s witnessed further deterioration in the living standards of the masses as a result of the introduction in 1986 of the Structural Adjustment Programme which was regarded as an economic reform in the light of the prevailing ailing economy. It is thus not unexpected that the first Nigerian National Policy for Development, Unity, Progress and Self-Reliance launched in February, 1988, was perceived as timely and appropriate. The objectives and modalities of implementing the programme were clearly spelt out with the overall goal of reducing the growth of the population from 3.3 percent per year in 1988 to 2.5 percent per year in 1995 and to 2.0 percent per year by the year 2000 (Federal Republic of Nigeria, 1988).

The desire to minimize the negative impact of rapid population growth underscores the timely launching of the Nigeria's National Population Policy

(Ebigbola, 1988). The document lists a number of programmes to be undertaken. The policy document spells out implementation procedures as well as the implementation strategies. The policy, in a nutshell, is well conceived and all mechanisms are put in place on paper (Federal Ministry of Health, 1988). The policy is now over ten years old and certain socio-cultural and other constraints are found to have militated against effective implementation of the policy programmes (Ebigbola, 1997).

First among the faults identified in the 1988 National Population Policy by Ebigbola (1997) is the voluntary nature of the policy. According to the policy document, "couples will only be encouraged to have the number of children that they can adequately cater for, since all couples have the basic right to decide freely and responsibly the number and spacing of their children". Since there are no incentives or disincentives for those who flout the provisions, it may be difficult for the policy to achieve its demographic goal. For instance, the desire to have at least one living son is a major factor that has continued to influence family size and the use of contraceptives in Nigeria. There is prevalence of polygyny in Nigeria. For instance, in the Muslim North, polygyny is not merely a tradition but it is regarded as a religious injunction. Under this religious-traditional context, the concept of four children per woman will not yield any serious demographic impact. Furthermore, early marriage appears to have a religious tint in Nigeria. It is a common feature in

the Muslim North to withdraw girls from schools for marriage to much older and wealthy men who in most cases have harems where the major responsibility of the women is child bearing and rearing. Under this situation, the minimum age at first marriage may be difficult to be enforced. It is however said in the Muslim community that it is against Islamic principles to fix marriage at 18 years and therefore such program cannot be implemented (Ebigbola, 1997).

On a final note, the relatively high fertility levels in most of the sub-Saharan Africa call for a closer examination of the mechanisms of fertility decision making among couples in different family settings. But since the husband is very important in family decision making, it is very essential that the male should be adequately informed on population issues. This is necessary in order to increase his understanding and enhance his encouragement and support for the wife who is the main target of contraceptive innovation. Male acceptance of contraception is at least as effective in preventing pregnancy as female acceptance, and perhaps more so, as reflected in the higher continuation and use-effectiveness rates (Lamptey *et al*, 1970). The male partner may be highly motivated to obtain contraceptives. This may be related to his desire to control the use and choice of the contraceptive or to assure himself that the objective of avoiding an unwanted pregnancy is achieved, particularly in an extramarital relationship.

Furthermore, reproductive behaviour and family planning practices in females have been identified as two factors influencing fertility and consequently population growth. These two factors are therefore the appropriate indicators for understanding how fertility is formed (Lightbourne and MacDonald, 1982). Hence, various researches on fertility have the tendency to emphasize fertility control from the point of view of the female. This is mainly because women bear a greater burden in procreation than males. Yet men's control over the affairs of women in the traditional African societies remains indisputable (Ntozi, 1993). The males as husbands, family heads and chief bread winners are important targets that should be sufficiently recognised in family planning education.

Emphasis should be placed on the dynamics of family keeping, child bearing and on parental aspirations for the children. Reference to the economic conditions and demands of modern society, and indeed, the hardships a father faces in the process of bringing up his children is very likely to appeal to males, and should be effectively used in increasing population awareness including family size regulation through the acceptance and adoption of family planning in the country.

1.5 Conceptual Framework

It has long been realised that socio-economic factors do not influence

fertility directly but only operate through a number of demographic, physiological and behavioural factors known as the intermediate or proximate determinants of fertility. As early as 1956, Davis and Blake, identified eleven of such intermediate variables which they grouped under three broad categories which include: (1) factors affecting exposure to intercourse (or the intercourse variables); (2) factors affecting exposure to conception (or conception variables); and (3) factors affecting gestation and successful confinement (or parturition variables).

For Davis and Blake (1956), variables like age at marriage, length of breast feeding etc. for instance, can have direct effect on fertility through an indirect determining factors like education. Thus the higher the level of education, the longer the delay in marriage or on the other hand, the lesser the intensity and duration of breast feeding, hence the shorter the birth interval.

Since the initial effort by Davis and Blake (1956), a number of authors have come up with analytic models for quantifying the effects of the different intermediate variables on fertility. For instance, Freedman (1963), in his monograph on the sociology of human fertility, incorporates the Davis and Blake scheme within a broader sociological context. Working outward from the intermediate variables towards more encompassing societal concepts, Freedman discusses ways in which social norms and aspects of social organization operate through the intermediate variables to affect fertility.

A conceptual scheme giving equal weight to person variables and family variables was developed by Mishler and Westoff (1955) in the course of early planning for the Princeton studies (Westoff *et al.*, 1961; 1963). In this framework, person and family variables interact to produce effects on the dependent variables of specific pregnancy desires and availability of contraception. These variables, in turn, operate through contraceptive to influence fertility.

Smith (1969) also developed a conceptual map similar to those mentioned above. A special feature of this map which deserves attention is that it depicts behaviour as a joint function of the immediate situation and the personality processes and dispositions of the individual. The relevance of this conceptual framework is apparent for the study of attitudes and values related to marriage, children and contraception and for ways in which these person variables are influenced by the immediate situation.

In another study, Hobcraft and Little (1984), found that (a) the difference in age at marriage between groups with different education are the major determinants of the observed differences in fertility; (b) the better educated spend less time in periods when there are no regular sexual relationships; (c) the effects of contraception are low for no education; (d) education reduces the degree of protection against conception from breast feeding.

Yankey (1961) in his book "Fertility Differences in Modernizing Country" described the complex pattern of large fertility differences based on rural and urban residence, education, religion, among 900 women in Lebanon. He further attempted to show that the immediate causes of these fertility differences were linked with contraception, induced abortion, age at marriage, prolonged nursing of children, separation of partners and other such related causes.

Caldwell (1971) further demonstrated that female education does not only delay age at marriage but also contribute to the use of contraception, especially among those with higher socio-economic status.

Age at marriage, proportion married, and duration of marriage are found to be important factors affecting fertility. It was also found that marital fertility and proportion marrying and staying in marriage have influence on birth rate (Olusanya, 1981; Durch, 1980). Awareness of birth control was also observed to be varied with urban background or residence (Howthorn, 1970).

One important theoretical model for predicting whether marital partners have similar fertility goals is the demand framework (Bulatao and Lee, 1983; Cleland and Wilson, 1987). This model states that the number and sex of children desired by couples are functions of the perceived value of children or of sons versus daughters. Whether women and men differ in fertility desires is consequently a result of the balance between child costs and benefits that

each partner perceives. The model made important contributions in stressing parental decision making regarding the quantity-quality tradeoff in raising children. For instance, Bulatao and Lee (1983) observed that once within the calculus of parental choice, fertility responses to change in parents' demand for children. Caldwell (1981) similarly stressed the importance of how the industrialisation process is perceived and focuses on the changing usefulness of children in supporting their parents. As the family mode of production is transformed into the capitalist mode of production, children's utilities decline and desired family size is influenced accordingly (Caldwell, 1981).

The theme of this study, therefore, is to examine the direct and indirect relationships between male reproductive behaviour, spousal communication and family size. This is highlighted in figure A1 below.

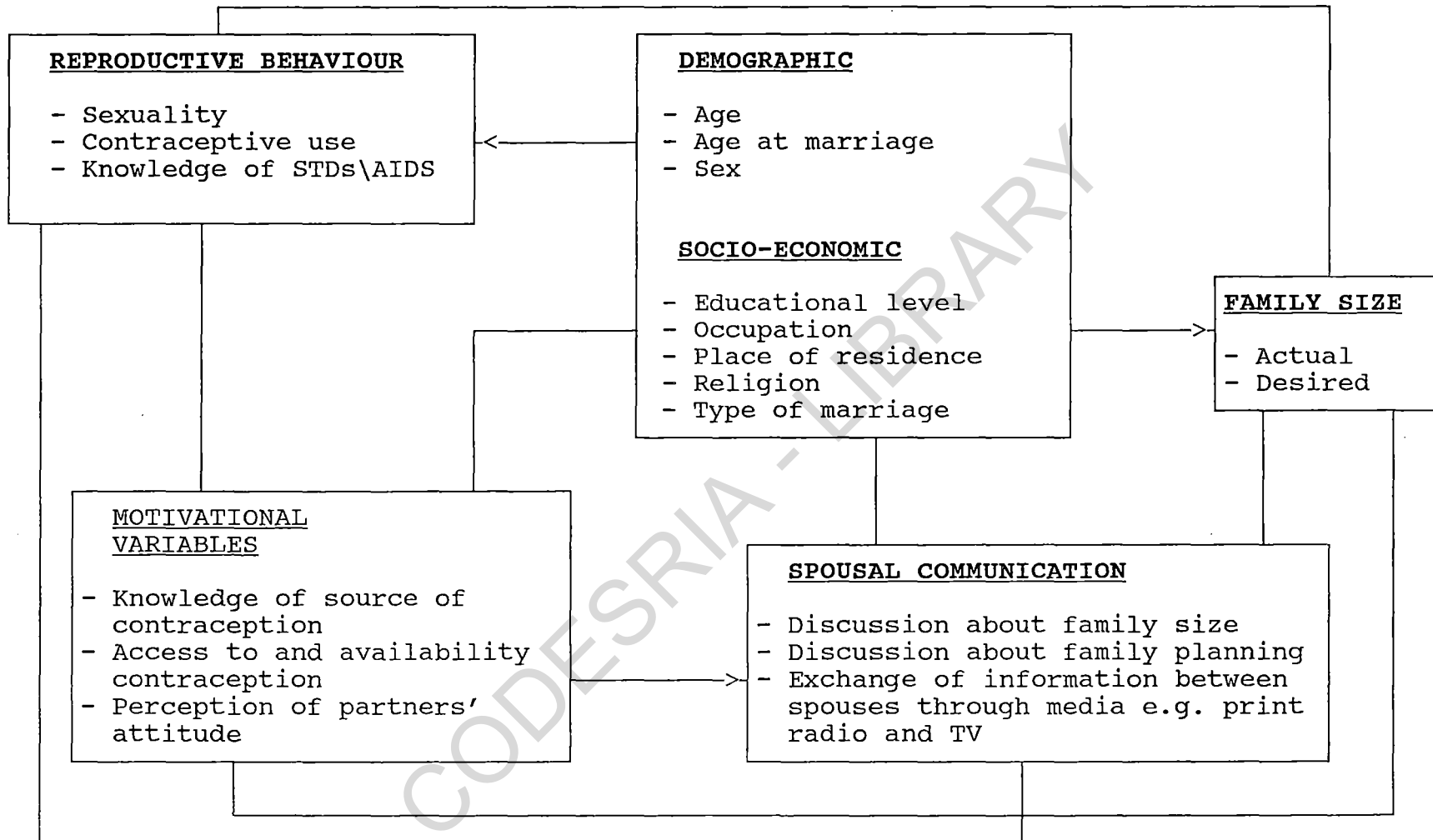


Figure 1: Conceptual Framework Showing the Interrelationship Between Male Reproductive Behaviour, Spousal Communication and Family Size.

Figure 1 shows a conceptual model distinguishing four types of factors that may likely affect family size. These are the background variables among which are the demographic and socioeconomic variables such as age, sex, age at marriage, level of education, occupation, place of residence etc. Salaff (1985) observed that as developing countries undergo their fertility transition, socioeconomic differences in family size and in attitude toward childbearing persist. Understanding of these differences, as well as the reasons for them, is essential for anyone involved in a study of this nature. Socioeconomic variables like education, occupation, place of residence, type of marriage etc. tend to have direct relationship with family size. For instance, education has been found to have a stronger negative impact on desired and actual family size (Olusanya, 1967; Nsudoh, 1994; Ottong, 1985). Knodel *et al.* (1984) found that in Thailand, when urban industrial employment and education became more accessible to villagers, rural parents perceived large families as an unnecessary drain on the family's economic resources, and fertility began to decline. Other factors that may have direct link with family size include motivational variables in which factors like knowledge of source of contraception, access to and availability of contraception and perception of partner's attitude will be considered; spousal communication and reproductive behaviour by which the influence of male sexuality, their contraceptive use and knowledge of STDs\AIDS on family size will be examined. The conceptual

framework in figure 1 shows that family size is directly influenced by all these factors.

Apart from direct relationships, certain other relationships are visible in the framework. For instance, we observed in the literature that married couples together sometimes make household decisions of various kinds. Such decisions include decision on family size and contraceptive use. Whether couple discusses such matters affect family size. Spousal communication may therefore be an important factor in the rapid increase in contraceptive use, raising level of awareness of STDS\AIDS and thus cause a change in the unwholesome sexual habit of men. Thus spousal communication may through its impact on reproductive behaviour of men influence both actual and desired family size. This study will focus on three dimensions of communication. One, discussion between husband and wife about family size; two, discussion about family planning and three, the exchange of information between spouses through media, most especially printed matters. This third dimension recognises that communication can be non-verbal, especially where there is no tradition of discussion between spouses about sexual intercourse, contraception or sexual play (Balmer *et al.*, 1995).

To initiate a fertility transition, family planning programmes would have to increase awareness of fertility control and knowledge about ways to achieve it. To accelerate a transition towards lower family size, a family planning

programme would have to increase contraceptive availability. Lowering the cost of contraceptive use to those with weak motivation is one acceleration mechanism (Coale, 1967). Those who are indecisive about using contraceptive or allowing their spouse to use it will not travel long distances, pay high fees or use inconvenient methods. The impact of these motivating factors on family size will be examined using both direct and indirect approaches. Apart from this, we will examine the influence of these factors on male reproductive behaviour and spousal communication.

Finally, family size would be measured by the actual and desired number of children by men while spousal communication would mainly be determined by whether couples ever discuss family life issues.

1.6 Research Hypotheses

The expectation is that a spouse who discusses family size with his partner would be better able to predict the partner's approval than would a spouse who would not engage in such discussion. Communication between spouses about reproductive matters will prevent couples from having unwanted children and might encourage contraceptive use. Based on the review of relevant literature and from the theoretical point of view, it is hypothesised that:

- (i) Couples with effective interspousal communication will have smaller family size than their counterparts with no interspousal

communication.

- (ii) Spousal communication among couples who have knowledge of contraceptive will affect contraceptive use more than couples with no such knowledge.
- (iii) The educated males will show greater willingness to discuss reproductive matters with their partners than their non-educated counterparts and they are more likely to have smaller family size than the less educated.

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CHAPTER TWO

RESEARCH METHODOLOGY

2.1 The Study Area:

The study location for the present research project is South Western Nigeria. The region is largely inhabited by the Yoruba speaking people; however, there are ethnic groups from other parts of Nigeria and neighbouring countries in the region. The Yorubas constitute more than 80 percent of the resident population in this region. The ethnic group exclusively occupies eight of the thirty-six states of Nigeria namely, Lagos, Oyo, Ogun, Osun, Ondo, Ekiti, Kwara and Kogi states. Although other people from virtually all ethnic groups in Nigeria (e.g. Igbo, Hausa, Ebibira, Edo etc.) have found their ways into the region. South western region is highly urbanised having the largest number of urban centres with 100,000 or more inhabitants (NPC, 1991). Although less than one-fifth of the total national population lived in the South West in either 1952 or 1963, yet for each of these two years, well over two-fifths of the people residing in the urban centres were found in this part of the country (Farooq and Adeokun, 1976). The same pattern was observed in 1991. The crude birth rate of the region compares with the national rate of 45 live births per 1000 population while the total fertility rate is 5.7 live births per woman (NPC, 1991).

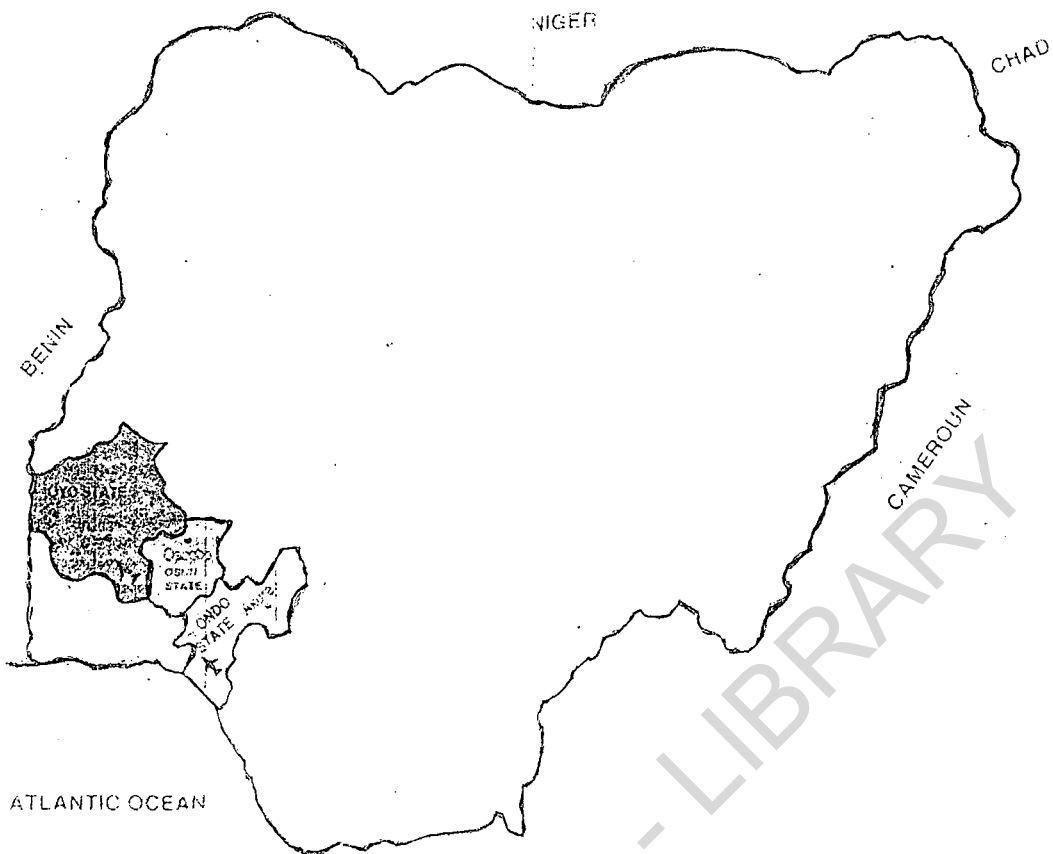
The people inhabit an agriculturally fertile and undulating thick forest which in effect makes the economy dominantly agrarian. The region has a climate which has in diverse ways influenced the way of life of the people. Farming activities for example reflect both the seasonality of rains and the overall amount of precipitation received on an annual basis in the area. The cultivation of food crops such as maize, cassava and yam is done with due consideration of the sequencing of the dry and wet seasons. Also, the success of tree crop culture particularly with respect to cocoa, kolanut and oil palm in the area is associated with the characteristics of the climate.

The region is blessed with both physical and human resources in large quantities including rich forests, good agricultural land, medium industrial base, a large labour force, well developed health and educational sectors and a rapidly evolving strong private sector. The people of the region are mainly traders, artisans and farmers. Other occupations they engage in include making of hand woven textiles, tie and dye-clothes, leather works, calabash carving and mat-making. The basic rural population is directly dependent upon the land, and it includes those engaged in agriculture, forestry and fishing. The secondary rural population serves the needs of the primary population. Such includes shop keepers, official transport workers and teachers. Women play a very significant roles in the social and economic organization of the region. Apart from child care, they contribute meaningfully to the socio-economic

growth of the area.

Traditional music and dancing are two important features of the culture of the people of the region. Christianity and Islam are the principal religions. There is also strong belief in natural objects such as seas, hills, mountains, rivers and trees among others. For these reasons, the Yoruba communities in the region, regularly pay homage to the "Spirits" of these natural phenomena. They also worship 'Ogun' the god of iron and 'Sango' the god of thunder and lightning and other gods and goddesses annually.

The study covered three states of South-Western Nigeria. These are Osun, Oyo and Ondo states. By 1991 census, Osun state has a population of 2,158,143 inhabitants, Oyo state, 3,145,720 while Ondo state has 3,785,338 inhabitants. Specifically, these states have been chosen for the study because they broadly represent the custom and tradition of the Yoruba ethnic group. Secondly, there have been dearth of data on demographic information especially those relating to male status and attitudes.



*MAP OF NIGERIA SHOWING THE THREE SELECTED STATES-
OSUN, OYO AND ONDO STATES*

2.2 Sampling Design:

Selection of eligible respondents in urban areas followed a multi-stage stratified random sampling design. In the first stage, each selected urban centre was divided into four district residential zones reflecting their settlement patterns namely the traditional area; the migrant area; the mixed residential areas (i.e traditional and migrant) and the elite residential areas. Within a stratum, five major streets were randomly selected from the listing of all major streets.

In the second stage, a listing of all houses in each stratum was compiled out of which 50 houses were selected using systematic random sampling approach. The four strata yielded 200 houses. Then from each house a household was selected using lottery method and the male head and his wife/wives of each selected household were interviewed.

In the rural areas, selection of the 200 houses was by simple random sampling technique since each rural area consists of a largely homogenous group. Each of the two selected rural areas in the state constituted the Enumeration Areas. However, the random selection was made in such a way that all the different parts of the locations were represented. A household was selected from each house also using lottery method. In each household, one currently married man aged 59 or younger and his wife/wives were interviewed.

Following the above sampling design, the following are the selected urban and rural areas:

Location of selected Urban and Rural Areas

State	Urban Area	Stratum	No of Eligible male Respondents	Rural Area	No of Eligible male Respondents
Osun	Osogbo	1	50	Kajola	100
		2	50	Awo	100
		3	50		
		4	50		
Oyo	Ibadan	1	50	Olodo	100
		2	50	Afijio	100
		3	50		
		4	50		
Ondo	Akure	1	50	Oba-Ile	100
		2	50	Owena	100
		3	50		
		4	50		
		Total	600		600

2.3 Sample Size:

Available demographic data are grossly inadequate for a comprehensive analysis of study of this nature in Nigeria. This is inspite of the fact that majority of the demographic studies in Nigeria were conducted in the Western part of the country. More compounding is the absence of vital registration system from which a reliable estimation can be made. For the present study, fresh data were collected through sample survey. The data needed for this

study were collected at the individual level. A target sample size of 200 men and their wives were selected in each state. On the whole 1,396 respondents were interviewed. But after data cleaning we found only 1,300 of the returned questionnaires useful and these were made use of in our analysis.

2.4 Research Tool:

The research tool for the study was specially designed and prepared to compile information relating to the objectives of the study (see Appendix II and III). In this regard, the interview schedules were constructed using simple questions to elicit information on the background characteristics of household members, socio-economic characteristics, fertility attitudes, husband/wife relationship, spouse reproductive history, spousal communication, value of children, family size preference, knowledge of, attitude toward and practice of family planning, family decision making etc. The interview schedules were administered by trained and carefully selected interviewers. The interview schedules were processed by employing relevant computer programmes.

Pretesting of interview schedules involved translating the questions into Yoruba. Pretesting was on a small scale and it lasted about four days. The adequacy and intelligibility of the interview schedules in relation to the responses received were assessed through pretest.

While structured interview was employed to collect information on

social, demographic and reproductive-related variables that could be quantitatively measured, focus group discussions (FGDs) were used to collect additional information on the cultural practices of the people. We conducted twelve focus group discussions, that is four per state. One male group and one female group were selected in the urban location, and one male group and one female group from the two rural locations respectively. Each focus group discussion consisted of eight members. The researcher served as moderator for each discussion session while one clerical assistant took note.

Specifically, interviews were conducted for diverse categories of rural and urban respondents such as highly educated, the moderately educated and the non-educated, the young adults (20-34 years) and adults (35+) and of various occupational categories. We specifically collected information on reproductive behaviour, knowledge, attitude and practice of family planning, spousal communication, myths surrounding female sexuality, decision making process etc.

2.5 Field Work and Problem Encountered on the Field:

The field work lasted two months and was completed in June, 1999. Four interviewers and one supervisor who were conversant with each of the study locations in each state and who spoke Yoruba fluently were taught how to administer the questionnaires. On the whole, services of twelve interviewers

and three supervisors were engaged in the conduct of interview.

Before the main interview, a pretest was conducted in the month of March, 1999 with a view to ensuring that questions were in logical sequence, properly worded and also noting questions that should be included in the final survey.

The usual period of visits for the interview was in the evening during the week and between 3.00 and 6.00 p.m. during weekends. Questionnaires were left to be filled and collected later only when it became very necessary, particularly for the educated respondents who so desired. This was done to prevent the problem of wrong timing of the visits as well as the problem of incomplete questionnaire and non-response.

Some serious problems were encountered in the course of this study with respect to data collection. These include outright refusal of interviews, inability to sustain respondent's cooperation throughout the interview and non-response to certain questions. This was in spite of making use of all known demographic techniques (e.g. rapport) in collecting information from respondents. Some of the respondents could not entertain enough patience to answer all the questions; some of them complained that some questions were too private and so were not ready to answer them; some complained that our questionnaire was too lengthy. May be because of economic hardship in the country some of the respondents were asking for inducement or wanted to be

motivated by giving them money or some other things before they could entertain any question from our interviewers. A good number of the respondents could not give accurate information on past events either as a result of memory lapse or out of sheer unwillingness to provide information on past sad occurrences.

Apart from the problems listed above, the field work suffered from lack of finance to foot the bill of the field expenses. The supervisors were put in charge of all aspects of the study in their respective areas; this was after they have been effectively trained by the investigator. They were responsible for checking of the completed interview schedules of their interviewers and ensured that the interviewers complied with the field instructions. Despite the training, one of the supervisors still could not do efficient job. He did not devote enough time for the supervision. So the interviewers allocated to such areas where we had this problem had to wait for the investigator for clarification on some important questions.

At the end of data collection, only 1300 interview schedules were found to have been efficiently completed and these were the ones used in the analysis.

2.6 Data Processing

Information from focus group discussions was transcribed by person

employed to do it. The transcribed information was organised under broad headings that depict different aspects of the discussions. The transcribed information was analysed descriptively (qualitatively) and also used to explain results of quantitative analysis where and when necessary.

With respect to information collected through the structured interview, codes for responses to close-ended questions were entered directly from survey materials into computer. For open-ended questions, responses were organised under few headings and codes were assigned to these headings. These codes were also entered into the computer.

Specifically, data from the field were edited and entered into the computer using EPI INFO version 6.0. Analysis of quantitative data was done using SPSS PC+ version 4.0. The qualitative data were categorised and were also subjected to computer analysis.

2.7 Method of Analysis

Generally, the data collected were analysed at three levels and each level requires a different analytic procedures.

The first level involved an examination of the distribution of the respondents according to each of the selected characteristics. On the basis of the assumption that the sample was representative of the population from which it was drawn, a knowledge of the composition of the respondents with

respect to their characteristics provided an insight into the structure of the population. In order, therefore, to know the structure of the population, data summarising procedures such as frequency distributions and associated statistics were adopted.

The second level involved the examination of the patterns of association between the dependent and independent variables. The bivariate analysis that was carried out at this level was able to discover the existence of a relationship between the dependent and one or more independent variables, first without control for the influences of other variables, and second, when one or two variables were held constant. In addition, there was the desire to know the strength and form of relationships through which the proposed hypotheses would be tested.

Level three of the analysis involved the use of advanced statistics to examine the patterns of association between the dependent and independent variables. The technique of causal modelling was used to measure the direct and indirect impact of some socioeconomic variables, motivational variables, spousal communication and male reproductive behaviour on family size. The recursive path analytic technique was used to examine the causal connections among these variables. For instance, the direct and indirect effect of (i) socioeconomic variables on male reproductive behaviour, motivational variables and spousal communication respectively; (ii) spousal communication

on male reproductive behaviour; and (iii) motivational variables on male reproductive behaviour and spousal communication respectively. Basically, path analysis was used in this study to estimate the magnitude of the linkages between the variables and the estimates obtained, provided information on the underlying causal processes. The technique decomposes the relationships in the models into a sum of simple and compound paths thereby providing a more adequate interpretation of an independent variable's impact and thus makes explicit the relationships among the prior variables. A more adequate interpretation of a given independent variables' impact on the dependent variable is, consequently made more plausible. The heuristic value of causal modelling makes it more appealing than ordinary correlation and regression models. While correlation and regression models are mere estimates of direct effects, path analysis goes beyond this level to examine the indirect effects of the independent variables on each of the dependent variables hitherto not exposed by correlation and regression analyses. Also the degree of spurious correlation that would have been concealed by ordinary correlation and regression analyses were brought to light.

Path estimates are obtained by a variety of procedures. The simplest being the ordinary regression techniques once certain regression assumptions are met. Thus path analysis based on causal modelling would only be visible if these restrictive set of conditions are met:

- (i) that there must be concomitant variation or covariation between X and Y
- (ii) that there must be a temporal symmetry or time ordering between X and Y and
- (iii) that the covariation between X and Y should not vanish when the effects of confounding variables (i.e. other unmeasured possible causal factors that may be producing the observed relationship between X and Y) are removed (Asher, 1976) .

It should be noted however that the use of path analytic procedure is not without limitations. Like all other statistical techniques, causal modelling cannot, according to Uslamer (1976) deal with final causes of anything responsible for change, motion or action. This is because the nature and limitations inherent in causal modelling are those of inexact, non deterministic and flexible model. In addition, where the number of independent variables entered into the model are too many, it becomes more difficult for the model to have an accurate decomposition of the relationships between the independent and dependent variables, a limitation not suffered at least relatively and to a point by the regression and correlation analyses (Feyisetan and Adewuyi, 1988).

2.8 Variables to be analysed

For the purpose of this analysis, the dependent variables were the actual and desired family size. These dependent variables were related to a number of motivational, demographic and socio-economic independent variables.

The following independent variables, because of their theoretical relevance and their statistical significance, were included in the analysis. These are:

- (i) Demographic and socio-economic variables some of which are age, age at marriage, educational attainment, religion, rural/urban residency, occupation, income, media exposure among others, ;
- (ii) Knowledge of source of contraception, access to and availability of contraception, cost of transportation to the source and perception of partners attitude which together are referred to as motivational variables;
- (iii) Spousal communication measured through the discussion about family size and family planning as well as exchange of information between spouses through media. It is assumed here that there may be occasions when spouse will not have formal discussion about reproductive issues. However through media, especially print media, messages can be passed across.

- (iv) Male reproductive behaviour proxied by sexuality, contraceptive use, and knowledge of sexually transmitted diseases (STDs) and AIDS.

Some of these variables were measured at the ratio scale (for instance age, income, number of children) while others were only measured at the ordinal or nominal (for instance, education, occupation, type of household etc.).

Cross-tabulation analysis was used to identify patterns among the study variables, as well as to select for inclusion in the multivariate analysis the variables significantly associated with dependent variables.

2.9 Organisation of the Study:

The study is divided into nine chapters. The first chapter deals with the background to the study, the statement of the problem, justification of the study, objectives of the study, literature review, conceptual framework and research hypotheses.

Chapter two discusses the research methodology. This chapter contains the brief background information on the study area, sample design, field work, data analysis and organization of the study.

Socioeconomic and demographic characteristics of respondents were dealt with in chapter three. In this chapter a description of the study population according to such variables as age, place of residence, education, current

marital status, religion, economic activity, number of children etc were examined. Chapter four looked at the determinants of male reproductive behaviour as well as the relationship between male reproductive behaviour and spousal communication and family size controlling for the effects of demographic/ socioeconomic variables. Chapter five was concerned with the analysis of spousal communication.

Chapter six deals with the determinants of family size. Here the influence of some selected background variables on family size were examined.

Chapter seven concentrates on the discussion of determinants of fertility preference among couples. Chapter eight concentrates on using both logistic regression analysis and the path analytical approach to examine the interrelationship between the three major variables i.e. male reproductive behaviour, spousal communication and family size.

Chapter nine, which is the last chapter deals with the summary of the study, highlight the major findings and it outlines the policy implications and presents recommendations.

CHAPTER THREE

SOCIOECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF THE SAMPLE SIZE

Introduction

The understanding of background characteristics of respondents is necessary for the analysis and interpretation of our survey findings. The main objective of this chapter is, therefore, to highlight some basic demographic and socioeconomic characteristics of the respondents, especially those that have relationship with reproductive behaviour, spousal communication and family size. This is necessary in that the information derived will help a great deal in the effort to explain the interrelationship between the three key concepts. In addition to this, description of some of these characteristics will prove very useful in later analysis in this study.

The variables considered more relevant and analysed in this chapter are respondents' socioeconomic variables such as education, occupation, working status, religion, marital status etc; the demographic and other motivational variables considered in the study include age, age at marriage, type of marriage, media exposure, children ever born, ideal family size, desired family size, contraceptive practices and value placed on children.

3.1 Age Composition

Responses to the question on present age of the respondents were obtained from the sampled population and the result is presented in Table 3.1. The table shows the distribution of the age structure of the population covered in five-year age groups.

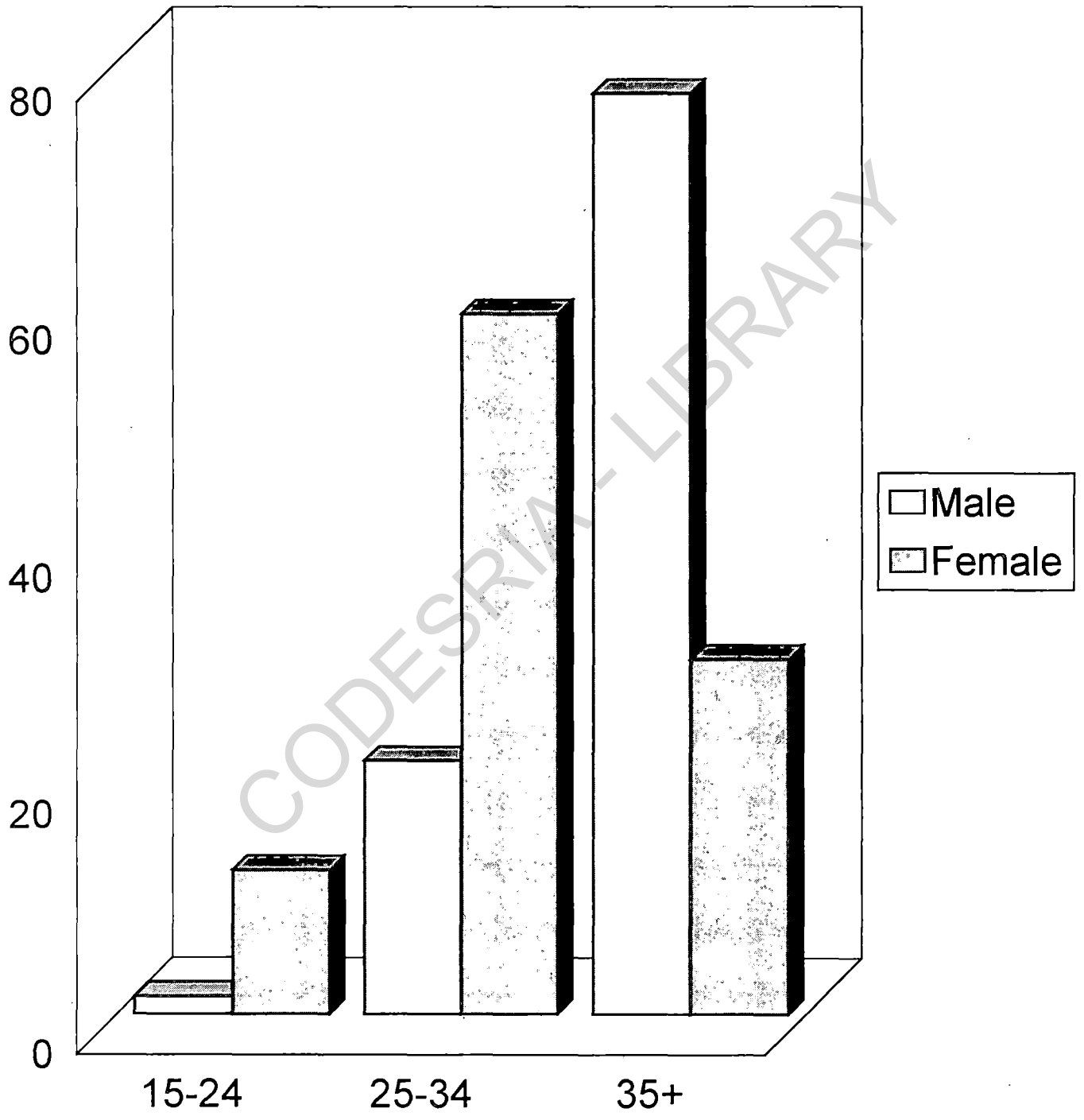
Majority of the respondents fell within age range 25-39 (60.3 percent). Whereas males outnumbered females in ages 40 and above, the females were more than males at lower ages. It may be said that the dominance of the highest age groups by males should be expected considering the age interval between couples.

Table 3.1: Percentage distribution of respondents by Age and Sex

Age	Male (N=585)	Female (N=715)	Total (N=1300)
15 - 24	1.4	11.9	6.9
25 - 34	21.2	58.8	40.1
35+	77.3	29.3	53.3
Mean	37.4	29.2	

Note: The variation from the expected sample size is due to the exclusion of non-response for questions to this variable- Age

Figure 3: Percentage distribution of respondents by Age and Sex



3.2 Place of Residence

Type of place of residence refers to whether the individual lives in an urban or rural community. Urban-rural differences could be attributed mainly to the glaring disparity in the distribution of socio-economic infrastructures in favour of urban communities. The implication is that the urban dwellers have a much greater advantage over the rural dwellers in obtaining the necessities of life and therefore have a much higher chance of improving their socio-economic status which may have implications for family size and contraceptive use. Indeed, many studies have also shown that residence in urban or rural areas is related to fertility preference and practices. Implicitly, therefore, changes in residential patterns can lead to change in fertility. Most socio-cultural trends begin in urban centres and because of urban centre's backward linkages to the rural areas, this "impulse" trickle down to the rural areas. This socio-cultural trend influences age at first marriage, fertility preference and contraceptive use leading to different fertility levels at both sides of the continuum. South Western Nigeria is highly urbanised and over two-fifths of the people reside in the urban centres (National Population Commission, 1997).

The distribution of respondents according to rural-urban residence is as shown in Table 3.2. The table shows that a higher percentage of the respondents interviewed reside in urban area (56.4 percent). This pattern is

observed for both the male and female populations. However, the table shows that a significant proportion of the respondents (43.6 percent) still reside in the rural areas. The implication of this finding is that fertility will persistently remain high in the near future since the reproductive aspirations of the rural, and agrarian population are those that favour large demand for children.

Table 3.2: Percentage distribution of respondents by place of residence and sex

Residency	Male (N=585)	Female (N=715)	Total (N=1300)
Urban	60.0	52.7	56.4
Rural	40.0	47.3	43.6
Total	100.0	100.0	100.0

Figure 4: Percentage distribution of respondents by place of residence and sex



3.3 Level of Education

The level of education constitutes an important socio-economic variable. It has generally been regarded as a major determinant of individual demographic behaviour (Omideyi, 1987; Feyisetan, 1982; Arowolo, 1979). Education is often used as an index of measuring the level of modernisation. It is widely held to broaden people's horizon and makes people more receptive to "innovations". Increases in education have often been cited as one of the major avenue through which reductions in fertility trend have been achieved. It also affects the acceptance of contraception, especially among women. Some studies in Africa have also shown that the level of education of males have significant influence on their perception and attitude towards family size and contraceptive use. Therefore, education may affect fertility decision in various ways. For instance, education may affect the efficiency of fertility control by increasing knowledge and use of birth control methods.

In this study therefore, education is one of the important socio-economic variables considered in the analysis because of its effect on male reproductive behaviour, spousal communication and family size decision. To determine the level of educational attainment of respondents, their responses were categorised as none (or those without formal education), primary, secondary and tertiary. These levels are represented in Table 3.3 and it shows a high level of literacy among respondents in South Western Nigeria. The

introduction of free primary education in South Western Nigeria on January 15, 1955 might have been responsible for the higher level of literacy (Ebigbola and Omideyi, 1988). It may be because of the 1976 adjusted national policy of Universal Primary Education (UPE), which gave every child the right to free primary schooling. Finally, the higher literacy level may be due to the impact of 1979/83 free education programme in the Western part of the country. The table shows that more than 90 percent of male population and 86.2 percent of female population had received formal education. The highest being secondary for both male and female respondents. However, males were seen to have been better educated than females (18.8 percent with no education among females as against 6.7 percent among males). While 24.4 percent of males had post secondary education, less than 20 percent of the female population went beyond secondary school. It can be said that the level of education of the respondents appears to follow the general pattern in South Western Nigeria where more males have relatively higher education.

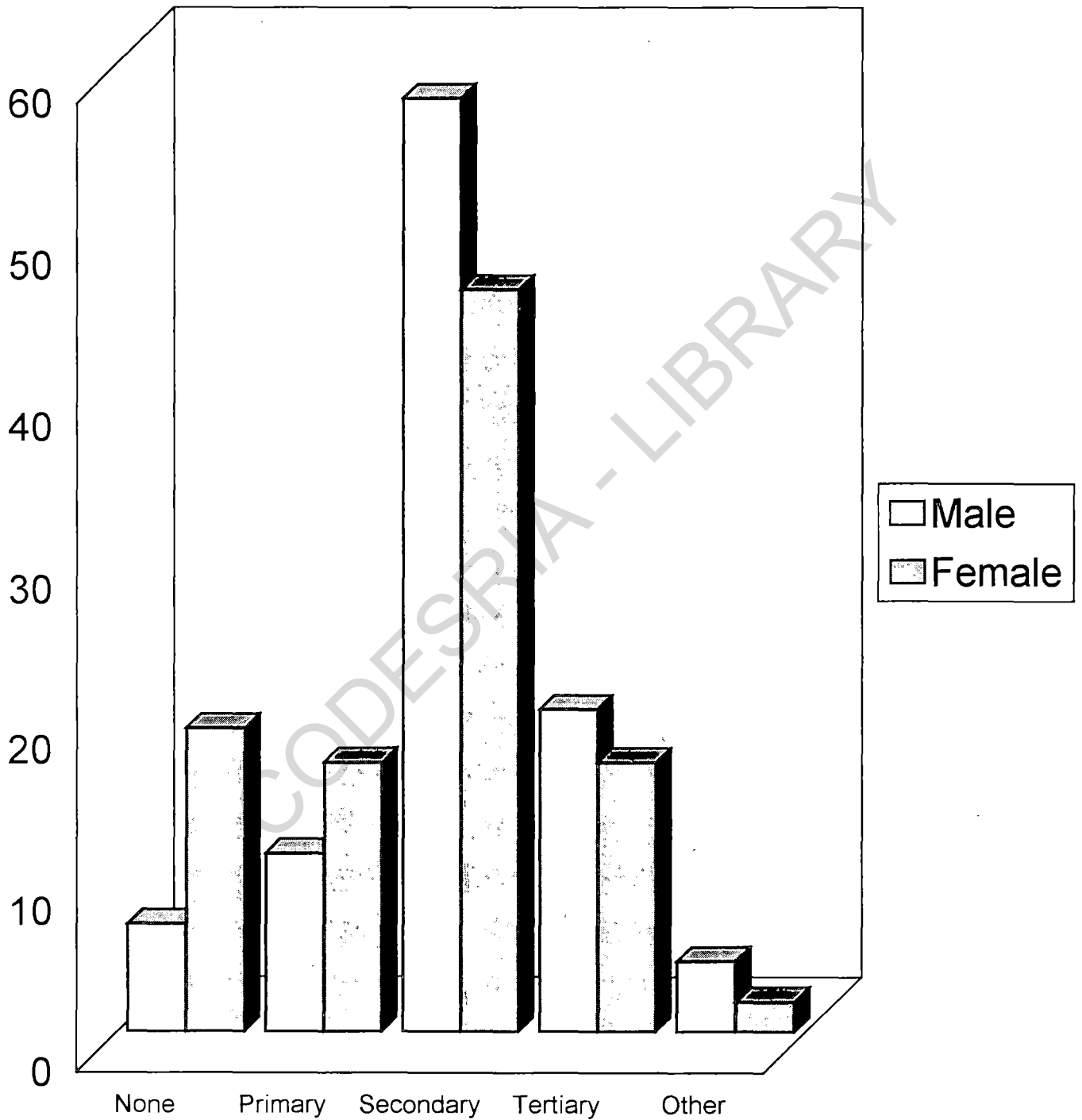
The overall level of education of 87.2 percent is higher than the 40 percent reported for urban dwellers in Nigeria Fertility Survey (NFS) in 1981/82.

Table 3.3: Percentage distribution of respondents by educational attainment and sex

Educational Attainment	Male (N=545)	Female (N=642)	Total (N=1187)
None	6.7	18.8	12.8
Primary	11.1	16.7	14.1
Secondary	57.8	46.0	51.9
Tertiary	20.0	16.7	18.2
Other	4.4	1.9	3.0
Total	100.0	100.0	100.0

Note: *The variation from the expected sample size is due to the exclusion of non-response for questions to this variable- Education*

Figure 5: Percentage distribution of respondents by educational attainment and sex



3.4 Marital Status

The universality of marriage in Nigeria is incontestable, and family formation is generally carried out within marriage. Table 3.4 shows the percentage distribution of the current status of the respondents. As shown in Table 3.4, marriage was largely universal and stable among respondents in the survey area. The table shows that majority of the female respondents (92.7 percent) were still in their first marriage while about 73.4 percent of them were first wives of their husbands. This finding implies that marriage in South-West is relatively stable and may account for the high fertility regime in the sub-region.

Table 3.4: Percentage distribution of respondents by marital status and sex

Marital Status	Male (N=527)	Female (N=698)	Total (N=1227)
Position among husband's wives			
Ist wife	-	73.4	-
2nd wife	-	17.9	-
3rd wife or higher order wife	-	8.9	-
Total	100.0	100.0	100.0

Note: *The variation from the expected sample size is due to the exclusion of non-response for questions to this variable- Marital Status*

3.5 Religion

Religion, though, is not exactly an ascribed characteristics, but its influence on reproductive behaviour is not in doubt. Different surveys have shown that differentials in terms of fertility preference by religion exist, but there is no general consensus on which religion can universally be held to cause lower fertility. Gaisie (1984) found that Muslims in Ghana had a lower fertility than the Christians. The Kenya Contraceptive Prevalence Survey of 1984 held same to be true of Kenya. Studying the Nigerian situation, Isiugho-Abanihe (1994) noted that Muslims have mean ideal family size of 7.7 children while Christians have a mean ideal family size of 5.13. These studies and others have shown that the demographic importance of religion on reproductive behaviour, couples' decision-making as well as contraceptive use may not be disregarded. In the first instance, it serves as a guidance as to what method of family planning should or should not be adopted. Second, the survey area being a Christian dominated area could reflect a particular trend in the adoption of contraception. Religion can have profound effects on people's belief, attitude and practices and these have been shown to have influence on fertility and fertility regulation.

Information on religion was obtained by asking each respondent to what religion he or she belongs. The religion was classified as Catholic, Protestant, Other Christians (including pentecostal and other orthodox religion), Islam and

other religion. The results are presented in Table 3.5.

From the table, it could be observed that religious distribution of respondents shows Christianity to be the predominant religion. About 80 percent professed to be Christian as against 18.2 percent who are Muslims; while "others" make up of spiritualists, traditional religion practitioners, and those with no religion form 2.0 percent of the entire sampled population. This may be due to the effect of modernisation whereby people are abandoning indigenous religion. There appears to be no striking differences between males and females regarding religious affiliation but in general, the females appeared to be more religiously inclined than the males.

Table 3.5: Percentage distribution of respondents by Religion and sex

Religion	Male (N=427)	Female (N=675)	Total (N=1102)
Catholic	17.8	13.0	15.2
Protestant	20.0	18.5	19.2
Other Christian	40.0	50.0	45.5
Islam	20.0	16.7	18.2
Other	2.2	1.9	2.0
Total	100.0	100.0	100.0

Note: The variation from the expected sample size is due to the exclusion of non-response for questions to this variable- Religion

3.6 Type of Marriage

Type of marriage refers to whether the individual is in a monogamous or polygynous type of marriage. The distribution of men and women by nature of marital union is presented in Table 3.6. Polygyny was certainly a major demographic fact of life in this area as it is typically in tropical Africa. About twenty-three percent of men are in polygynous unions compared with about thirty-three percent of women. The reason for the predominance of monogamy in the area may be because of the predominance of Christianity coupled with high level of literacy which play high premium on monogamy.

Table 3.6 indicate that 67.2 percent of women interviewed were the first and the only wives to their husbands. The high level of education as well as the economic crunch plaguing the country and resulting to high cost of family upkeep might have been responsible for this observation. People no longer regard number of wives as thing to be proud of.

Table 3.6: Percentage distribution of respondents by type of marriage

Type of Marriage	Male (N=527)	Female (N=698)	Total (1225)
Monogamy	77.4	67.2	72.3
Polygyny	22.6	32.8	27.7
Total	100.0	100.0	100.0

Note: The variation from the expected sample size is due to the exclusion of non-response for questions to this variable- Marriage

3.7 Age at First Marriage

Since most births do occur within unions, the timing of first union is an important determinant of fertility. Age at first marriage shows the total number of years a couple would be exposed to the risk of childbearing and probable length of contraceptive use. This could however hold if there is no incidence of separation or divorce between the couples. Most developing countries is currently witnessing a move from a traditional to a modern setting. This is accompanied by nuptiality change which involves a change from early to late marriage (United Nations, 1990; Isiugho-Abanihe, 1993).

The respondents were interviewed on age at first marriage and the results are presented in Table 3.7. The table shows that men married mostly between ages 25-34 (67.3 percent). Among female respondents, it could be observed that most marriages commence between 15-24 years of age. Less than 3 percent of males and one percent of female respondents married after 34 years. The mean age at first marriage for males and females were 29.2 years and 23.8 years respectively. This indicate late marriage in the study area.

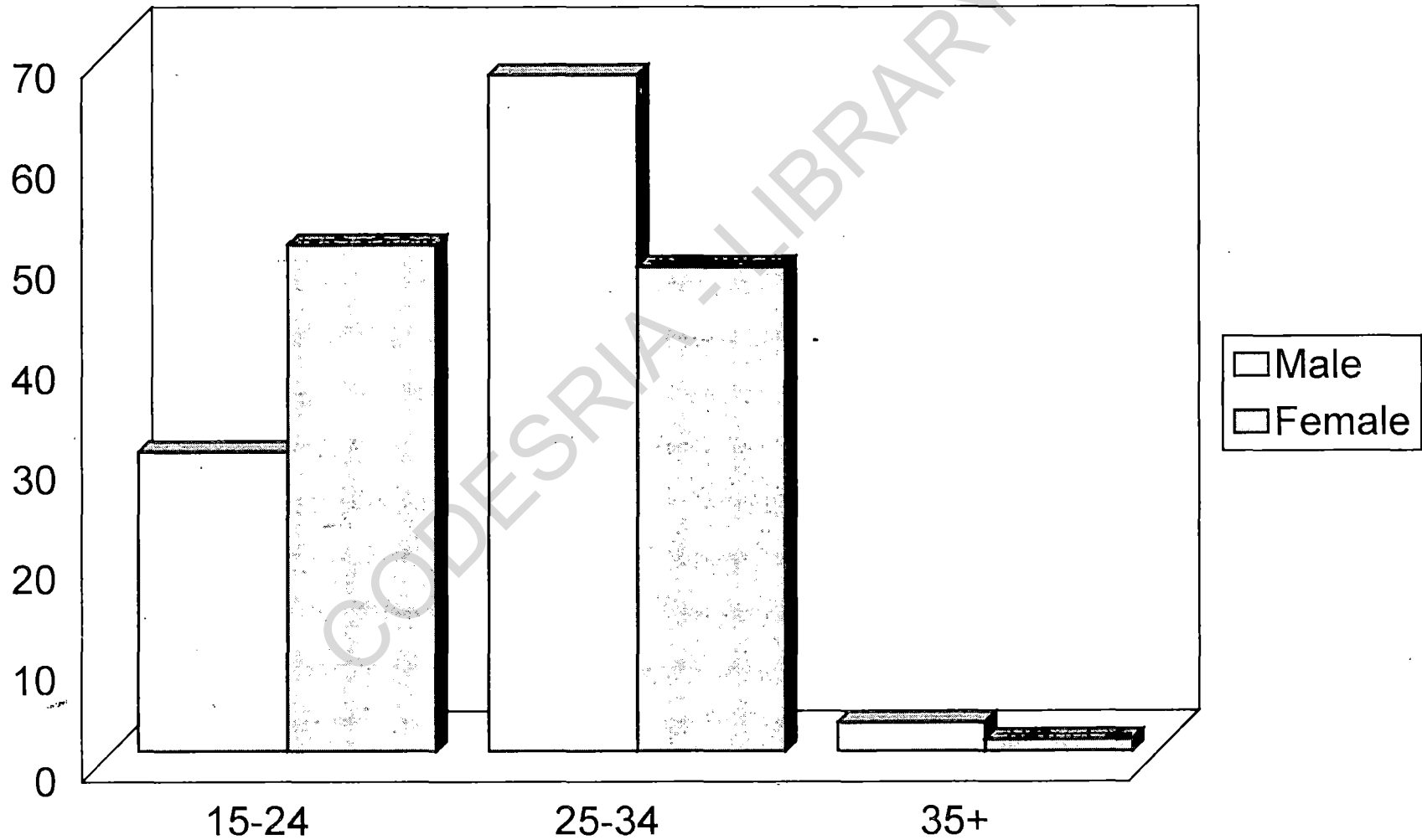
Table 3.7: Percentage distribution of respondents according to age at marriage and sex

Age at marriage	Male (N=524)	Female (N=658)	Total (N=1182)
15-24	29.8	50.5	40.2
25-34	67.3	48.3	57.8
35+	2.9	1.2	2.1
Mean	27.3	23.7	

Note: *The variation from the expected sample size is due to the exclusion of non-response for questions to this variable- Age at Marriage*

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Figure 6: Percentage distribution of respondents according to age at marriage and sex



3.8 Working Status

Respondents were asked if they were working at the time of survey. Table 3.8 shows that 79.8 percent of both male and female respondents were engaged in one employment or the other. This represents 72.5 percent of males and 87.2 percent of females. Some were employed for regular pay in government job while some were engaged in private businesses.

Table 3.8: Percentage distribution of respondents by work status and sex

Presently working	Male (N=585)	Female (N=702)	Total (N=1287)
Yes	72.5	87.2	79.8
No	28.5	12.8	20.1
Total	100.0	100.0	100.0

Note: *The variation from the expected sample size is due to the exclusion of non-response for questions to this variable- Work Status*

3.9 Occupation

Examination of the occupational distribution as shown in Table 3.9 reveals that the dominant occupation among the respondents was trading (38.1 percent). About twenty-one percent of them were engaged in farming. The table further reveals that more females than males were engaged in farming activities (23.3 percent as against 18.6 percent) and in trading (41.7 percent as against 34.5 percent). However, more males were found in other

occupations than females. It was also noted that 21.3 percent of males as against 11.6 percent of females were engaged in the public or civil service, while men in various professions account for 9.5 percent of the sampled population as against just 5.3 percent of female population. The study portrayed the socioeconomic activities of people in the South Western part of Nigeria. In this area farming, trading and crafts have always been the major occupations of the people in the area. However, in recent years, some occupations have been gaining ground. That is why we found some people engaging in occupations like teaching, banking, insurance and other professions.

Table 3.9: Percentage distribution of respondents by Occupation and sex

Occupation	Male (N=542)	Female (N=630)	Total (N=1172)
Farming	18.6	23.3	20.9
Trading	34.5	41.7	38.1
Public/Civil Servant	21.3	11.6	16.4
Professional	9.5	5.3	7.4
Artisan	11.8	8.6	10.3
Other	4.3	9.5	6.9
Total	100.0	100.0	100.0

Note: The variation from the expected sample size is due to the exclusion of non-response for questions to this variable- Occupation

3.10 Ownership of Housing Items of Property

Couples' fertility preference, spousal communication and contraceptive use are largely influenced by their socio-economic status. Respondents' socio-economic status can be determined through ownership of most of the essential household amenities.

Table 3.10 clearly shows the affordability of household amenities in the study area. The table shows that majority of the respondents claimed ownership of electricity (72.0 percent), radio (83.1 percent), and clock/watch (84.3 percent) in their households. About fifty-seven percent of both male and female respondents indicated that they have television in their households, while 57.4 percent said they have refrigerators. However, less than forty percent of the respondents claimed ownership of bicycle, motorcycle or car.

Table 3.10: Percentage distribution of respondents by Ownership of selected Housing Items of Property by sex

Housing Characteristics	Male (N=527)	Female (N=476)	Total (N=1103)
Electricity	75.6	69.1	72.0
Radio	77.8	87.3	83.1
Television	48.9	56.4	53.6
Refrigerator	62.2	52.7	57.4
Clock/watch	82.2	85.5	84.3
Bicycle	26.7	21.3	23.9
Motorcycle	33.3	36.4	35.0
Car	31.1	18.2	24.0

Note: *Excluding non-response*

Rural-Urban Differentials in Respondents' Socio-Economic Characteristics

As shown in Table 3.11, sixty percent of male and 47 percent of female respondents are residing in urban areas against 40 percent of males and 53 percent of females who reside in the rural areas. The sample shows that the urban respondents were younger on the average with male respondents mean age of 34.2 and 37.6 for urban and rural areas respectively and female respondents mean age of 29.7 and 31.4 for urban and rural areas respectively.

Table 3.11 shows that the urban sample contained a lower proportion of people with no formal education (2.6 percent male and 8.9 percent female respondents) than did the rural sample (34.1 percent males and 9.9 percent females). This is the expected pattern. The level of education is moderate as depicted by the fact that the median education for the urban and rural samples are in the category of 'secondary' level of education. This can be attributed to the UPE scheme that was launched in these states on January 15, 1955. An indirect result of this is the tendency of respondents to go into occupations demanding fairly high level of education. A significant proportion of respondents in both rural and urban areas is presently working. However, the table shows that trading was engaged in by higher proportion of respondents in both urban and rural areas. Trading has been very popular among both men and women in South Western Nigeria, as it represents a profession which can

be undertaken with little initial capital investment and its operation has little or no education restriction. The table further shows that majority of respondents in rural areas are in polygynous unions. The enquiry about the age of these respondents at the time of their first marriage shows that among female respondents, a higher proportion of the urban than rural respondents got married under age 24. The mean age at marriage among female respondents stand at 17.9 years and 21.8 years for rural and urban areas respectively. But for male respondents, a higher proportion got married between age range 25 and 34 years with a mean of 26.8 years.

Table 3.11: Percentage Distribution of Respondents by Rural-Urban Differentials in Respondents' Socio-Economic Characteristics

Characteristics	Male		Female	
	Rural (N=234)	Urban (N=351)	Rural (N=338)	Urban (N=377)
<u>Age</u>				
15-24	0.3	1.1	4.0	7.9
25-34	9.3	11.9	19.6	39.2
35+	33.5	43.8	5.6	23.7
Mean	37.6	34.2	31.4	29.7
<u>Educational Attainment</u>				
None	34.1	2.6	9.9	8.9
Primary	6.5	4.6	7.9	8.8
Secondary	21.2	36.5	21.8	24.2
Tertiary	3.5	16.5	7.9	8.8
<u>Religion</u>				
Catholic	10.7	7.1	6.9	6.1
Protestant	8.3	11.7	8.8	9.7
Other Christian	16.5	23.5	23.6	26.4
Islam	12.0	8.0	7.7	8.9
Other	1.3	0.9	1.0	0.9
<u>Type of Marriage</u>				
Monogamy	31.0	46.4	23.5	43.7
Polygyny	16.7	5.9	21.2	11.6
<u>Age at Marriage</u>				
15-24	21.3	8.5	11.6	38.9
25-34	27.9	39.4	18.9	29.4
35+	0.3	2.6	0.3	0.9
Mean	24.4	26.8	18.2	21.8
<u>Occupation</u>				
Farming	10.3	8.3	14.5	8.8
Trading	18.1	16.4	21.3	20.4
Public/Civil Servant	6.7	14.6	4.1	7.5
Professional	2.4	7.1	1.8	3.5
Artisan	4.9	6.9	3.6	5.0
Other	2.1	2.2	3.9	5.6

Summary

The understanding of background characteristics of respondents is necessary for the analysis and interpretation of our survey findings. The main objective of this chapter is, therefore to highlight some basic demographic and socioeconomic characteristics of the respondents, especially those that have relationship with male reproductive behaviour, spousal communication and family size. This is necessary in that the information derived will help a great deal in the effort to explain the interrelationship between that three basic concepts (male reproductive behaviour, spousal communication and family size). In addition to this, description of some of these characteristics will prove very useful in later analysis in this study.

Some of the demographic and socio-economic characteristics which are likely to influence male reproductive behaviour, spousal communication and family size have been examined in this chapter. These include, age, education, working status, occupation, religion, marital status, desired family size, children ever born number of living children, children ever born etc.

As expected, there are wide variations in the background characteristics of the sample being studied. For instance, the analysis reveals that 63 percent of the male and 97.2 percent of the female respondents are between ages 15 and 44 years. The study shows that 12.8 percent have never been to school, while 70.1 percent have attained secondary or higher levels of education. The

proportion of women who have never been to school is higher than that of men (18.8 percent females as against 6.7 percent of male population). Also in this study, 79.9 percent of the respondents profess the Christian faith as against only 18.2 percent who are of the Islamic religion.

The study further shows that 43.6 percent of the respondents live in rural areas as against 56.4 percent in the urban areas. Of peculiar interest is the near universality of the marriage institution where most births take place. Respondents in monogamous unions constituted 72.3 percent of the respondents. About 80 percent of the respondents are presently working. The dominant occupation among the respondents is trading. We equally observed from the study that a higher proportion of women engage in farming (23.3 percent of women as against 18.6 percent of men). While most of the respondents would either listen to radio or watch television, just a few take to reading newspaper. This may however not be unconnected with their relatively low level of education or to poor economic situation in which case most people cannot afford the cost of newspaper.

CHAPTER FOUR**SOME DETERMINANTS OF MALE
REPRODUCTIVE BEHAVIOUR**

In the last two decades, most of the countries in the developing countries have been making concerted efforts to control their rapid population growth. The primary intention is to balance the available resources and population so as to improve the standards of living of the people. The growing awareness of social, economic and health implications of high rate of population growth provided the impetus for the establishment of family planning programme in many high fertility countries. In these countries, information on contraceptive use at different levels forms an essential component of the statistical data base required for monitoring, assessing and administering population programmes (Sather and Cladambaram, 1984).

In Nigeria, family planning has been an on-going process, though on a limited scale, before the adoption of the 1988 National Population Policy. The Policy framework recognised the need to establish population planning as a multi-sectoral activity, drawing many developmental departments into the programme with the principal objective of promoting fertility regulation by means of contraception (Federal Office of Statistics, 1998).

To complement various governmental efforts to popularise contraceptive use, social researchers and demographers have become increasingly involved

in the study of the factors influencing fertility preference, reproductive behaviour and contraception (Adewuyi, 1988; Bankole, 1995; Becker, 1996; Ezeh, 1993; Hollerbach, 1983; Lasee and Becker, 1997). These studies, apart from their usefulness from the theoretical perspectives have practical implications. From such studies, planners and policy makers identify patterns and factors responsible for high fertility. Once these factors are identified and understood, family planning programmes and population policies can be appropriately designed.

We are also aware that knowledge of motives and constraints that affect both men's and women's reproductive behaviours is essential for a full understanding of the fertility dynamics of populations. Understanding men's thoughts and feeling about engendering children is crucial to finding incentives for men to participate or countenance their wives' participation in family planning. Men's participation is a promising strategy for addressing some of the world's most pressing reproductive health problems. Men can help slow the spread of HIV/AIDS and other STIs, prevent unintended pregnancies and reduce unmet need for family planning; foster safe motherhood and practise responsible fatherhood; as well as stop abusing women (United Nations, 1998).

In patriarchal societies, men play important roles as heads of their households, the custodian of the interests of their lineage and bread winners. By the nature of these societies, men control land and other economic

resources while their wives are expected to depend on them for almost all matters. In spite of modernisation factors which have facilitated the emergence of nuclear families that operate outside the confines of the traditional extended family control, family life in male dominated societies is still guided by normative principles, institutions and beliefs that vary from one place to another.

This chapter aims at examining male reproductive behaviour. The extent of and differentials in male sexuality, contraceptive need and use as well as knowledge of sexually transmitted diseases including Acquired Immunodeficiency Syndrom (AIDS) would be highlighted.

4.1 KNOWLEDGE AND PRACTICE OF FAMILY PLANNING

A necessary pre-requisite for the use of contraceptives is adequate knowledge about methods. For a high rate of use to be attained, the population has to be very familiar with at least one of the modern methods of contraception.

Respondents were asked about their knowledge of some methods of fertility control. The respondents' claim of any method was only confirmed if they could describe how it is used. They were later asked if they had ever used the method. The analysis of knowledge and practice of family planning

depends largely on the categories of 'ever used' and 'currently using'. Therefore, for the purpose of this study, contraceptive use will be examined by ever use and current use among different categories of men and women in the study area.

Table 4.1 shows the percentage distribution of respondents by knowledge of contraception. The table shows that knowledge of contraceptive is high among respondents in the area. About 65 percent of men and 54 percent of women interviewed know of at least one contraceptive method; condom being the most widely known method with 88.1 percent of men and 75.9 percent of women claiming knowledge of it respectively. This is followed by pill with almost 74 percent of men and 70 percent of women claiming knowledge of it. The least known among the modern contraceptives is the norplant with a proportion of only 6.7 percent men and 9.5 percent women. Knowledge of some traditional methods like abstinence and withdrawal is also high among the respondents in the area.

Table 4.1: Percentage distribution of respondents by sex and method ever heard

Method ever heard	Male (N=532)	Female (N=644)	Total (N=1176)
Pill	73.8	70.4	72.1
IUD	45.2	38.9	42.1
Diaphragm/Jelly/Foam	22.1	37.0	29.6
Condom	88.1	75.9	82.0
Norplant/Implant	6.7	9.5	8.1
Female sterilization	38.1	33.3	35.7
Male sterilization	38.1	31.5	34.8
Injection	61.9	48.4	55.6
Other Traditional Method (e.g. ring, charms etc.)	40.5	27.8	34.2
Safe period	48.1	64.3	56.2
Postpartum Abstinence	68.2	77.5	72.9
Withdrawal	71.4	53.7	62.6

Note:- Excluding non-response categories

Generally, a substantial proportion of both male and female populations know of at least one method of family planning, but in some countries, only a small proportion of those who know of a method are practising contraception. Husbands often report greater method use than their wives (United Nations, 1995). This position was confirmed in the study where we observed the proportion of ever used and currently using contraception among

men to be higher than that of females. About thirty-one percent of males had ever used contraceptives compared with 28.1 percent of females, while the proportion of current users is 32.3 percent among males to 27.6 percent of females. This disparity may stem from several factors such as multiple sexual partners, differential reporting of condom use by husbands and wives, differences in perception of rhythm among marital partners, and underreporting of method use because of the presence of other adults during wives' interview (Ezeh and Mboup, 1997). The difference may also be related to the type of method used, the frequency of use or the reference period (Becker, 1997).

Table 4.2: Percentage distribution of respondents by sex and method ever used and currently using

Method	Ever used		Currently Using	
	Male (N=274)	Female (465)	Male (N=169)	Female (N=390)
Pill	22.7	33.6	12.8	17.9
IUD	4.7	1.4	2.9	0.9
Diaphragm/Jelly/Foam	2.3	2.1	1.8	0.8
Condom	36.6	32.5	28.5	20.4
Norplant/Implant	-	-	-	-
Female sterilization	NA	-	NA	-
Male sterilization	-	NA	-	NA
Injection	4.9	7.9	5.2	5.8
Other traditional method (e.g. ring, charm etc.)	3.9	15.1	4.3	11.2
Safe period	9.9	8.2	7.2	3.9
Postpartum abstinence	20.1	33.8	19.6	22.7
Withdrawal	8.5	10.7	11.3	8.4

Note:- The data set is confined to respondents who have ever used methods and those currently using methods

4.2 CONTRACEPTIVE USE BY SOCIO-DEMOGRAPHIC VARIABLES

Contraceptive methods could be divided into three main categories reflecting the level of skill and, by implication, the accessibility of each method. The first consists of birth control methods requiring medical doctor's

prescription. Although the mode of spreading information on such methods exists to some extent, it is, as has been pointed out, difficult to deliver effective programme through a strained medical service (Black, 1973). Such methods are, therefore, highly localised in urban areas and attract, in the main, high status couples with sufficient motivation, access to and means for entering the high technology and high reliability market. Such method include IUD, injection, sterilization etc.

The second group consists of the non-prescription, simple and commercially distributed methods. This group is dominated by 'condom' reportedly heard by 88.1 percent male and 75.9 percent of the female respondents. The showing of other commercially distributed methods such as foam tablets and jelly is poor and not in accord with the reported sales (Black, 1973). It may be that the market is highly selective and that prices are not as low as to encourage a wide adoption that the familiarity of vaginal birth control in traditional practice may suggest (Olusanya, 1969). Although the simplicity of the commercially distributed methods may make their popularisation widespread in rural area and among uneducated people, the educated couple and urban residents with some cash income to cover the cost accruing from disposable use, will enjoy some advantage.

The third group are the traditional or folk methods. There can hardly be any man or woman who does not know that conception would not occur

without sexual relations but some did not perceive or acknowledge abstinence in the context of family planning.

The first two groups are together referred to as modern methods while the third group is also referred to as traditional methods. The contraceptive methods for this study are therefore divided into two categories. These are modern and traditional methods. The modern methods refer to such methods like the pill, IUD, injection, condom, sterilization, diaphragm/foam/jelly, norplant while the traditional methods include rhythm, periodic abstinence, withdrawal and other folk methods. A respondent is classified as a user of modern method if he or she uses any of the modern methods, while a user of traditional method is a respondent who is currently using any of the traditional methods. The practice of contraceptive methods will be reviewed with each of the following status-related variables in turn - age, education, residence, occupation and some variables relating to couples decision making etc.

4.2.1 Age and Contraceptive Use

Some studies have established that there is a close relationship between age and contraceptive use. The generally observed relationship between age and contraceptive use is that use is relatively low among young couples because most of them have not yet had the number of children they want. Also contraceptive use is less frequent among older couples partly because they are

less fertile and have less coital frequency than at younger ages. Older couples tend to be more traditionally minded (Abdulah and Harewood, 1984). Freedman *et al* (1991) also observed this pattern in their study in Indonesia where use of modern method increased from 13 percent for couples under 20 years of age to between 36 and 38 percent for couples at ages 30-34 through 40-44. Then there was a drop to 29 percent among couples aged 45-49, many of whom were subfecund. Oyediran and Ewumi (1978) observed that 23 percent of the ever-use of contraceptives were in the age group 30-34 years.

Table 4.3 shows the proportion of current users of modern contraceptives by age. The table indicates that current use of modern methods is generally low for all ages. This thus corroborate findings in earlier studies (Demographic and health survey, 1990 and Nigeria Fertility Survey, 1981/82) which all portend persistent high fertility in the sub-region. The highest level of use is found in the age group 35 - 44 (4.1 percent), followed by those in age group 35 - 39 with 5.2 percent. About nine percent of couples in age group 35 - 44 and 8 percent of those in age group 25 - 34 are currently using traditional methods. The table shows that couples in the middle age are the major users of both modern and traditional methods.

Table 4.3: Percentage Distribution of Respondents by Contraceptive Use and Age

Age Group	Number	Not Using	Using			Total
			Modern	Traditional	Modern and Traditional	
15 - 24	77	89.9	2.1	4.7	7.2	100.0
25 - 34	444	82.8	6.4	8.3	17.2	100.0
35 - 44	383	92.7	4.1	8.9	15.0	100.0
45+	220	96.7	1.7	1.6	3.3	100.0
Total	1124	89.7	3.7	5.2	8.9	100.0

4.2.2 Educational Attainment and Contraceptive use

Conventional wisdom maintains that the higher the level of education of an individual, the more knowledgeable and responsive he or she to family planning education, and the greater his or her likelihood of practising contraceptive. It has been observed from some studies (Nsudoh, 1994; Shapiro and Tambashe, 1976; Abou-Gamrah, 1981; Janowitz, 1976; Olusanya, 1969), that education enhances the use of contraceptives. Naipeng and Abdurahman (1981) found for women in Malaysian Peninsular that 58 percent of those who had seven or more years of education were using contraception compared to 44 percent of those who had no schooling. This fact has been substantiated for couples in this study.

Table 4.4 presents the percentage distribution of contraceptive use of

respondents by level of educational attainments. The table shows that the use of modern contraceptive among couples increased as the level of education increases. The proportion of modern contraceptive users being lowest among the uneducated (3.0 percent). Those who use contraceptives most are couples with secondary level of education. We also observed from the table that couples with higher level of education prefer to use more of modern contraceptives whereas those with no education prefer traditional methods more than modern methods.

Table 4.4: Percentage Distribution of Respondents by Contraceptive Use and Education

Educational Attainment	Number	Not Using	Using			Total
			Modern	Traditional	Modern and Traditional	
None	152	89.7	3.0	7.3	10.3	100.0
Primary	167	87.4	4.1	8.5	12.6	100.0
Secondary	616	83.4	9.4	7.2	16.6	100.0
Tertiary	216	87.5	8.6	3.9	12.5	100.0
Total	1151	87.8	6.3	6.7	13.0	100.0

4.2.3 Place of residence and contraceptive use

Studies have shown that contraceptive use has strong association with place of residence. The general trend that has been found in most studies is

that urban dwellers are generally more inclined to the use of contraceptives than their rural counterparts. This may not be unconnected with the low level of education of people in the rural areas and their lack of exposure to modern culture. Caldwell and Igun (1970) in their study noted that contraceptive use tended to decrease with distance from an urban centre. This may however be due to the fact that urban centres are the gateway to social change and modernization; the centre of contraceptive distribution, communication and information as well as the milieu for anonymity and break from tradition.

Table 4.5 shows the distribution of respondents by place of residence and contraceptive use. The table shows that couples in the urban area use contraceptive more than those in the rural areas (14.2 percent of urban couples against 16.2 percent of rural respondents). This result conforms with other studies (Oni and MacCarthy, 1991; Lamptey *et al.*, 1978; Pool, 1970). Also more rural dwellers tend to prefer traditional rather than modern methods.

Table 4.5: Percentage Distribution of Respondents by Contraceptive Use and Place of Residence

Place of Residence	Number	Not Using	Using			Total
			Modern	Traditional	Modern and Traditional	
Urban	733	85.8	4.4	9.8	14.2	100.0
Rural	567	83.3	2.9	13.3	16.2	100.0
Total	1300	84.6	3.7	11.6	15.2	100.0

4.2.4 Occupational Status and Contraceptive Use

Occupation as one of the indicators of respondent's socio-economic status would be expected to affect contraceptive use. Contraceptive use has been observed to be highest among skilled professionals and least among workers whose jobs do not require much skills. A closer analysis of this relationship reveals that it is as a result of the ramifying effects of education. Also the professionals earn higher incomes, have greater job security and have access to adequate old age benefits and therefore they can afford not to produce many children as a form of insurance against old age. Consequently, they would use contraceptive to avoid having too many children.

Table 4.6 depicts the variation in contraceptive use among the occupational groups in the study area. The findings conform with the earlier discussions that the professionals use contraceptives more than those in other

occupational categories. About 17 percent of the professionals are using contraceptives compared with 7.8 percent for those who are farmers, and 12.1 percent among those in the civil service. However we noticed that a significant proportion of couples who are traders are currently using contraceptives. This may be the outcome of the impact of education which, as we observed earlier, is high in the study area. For instance, it is not uncommon in the present day Nigeria to find university graduates engage in trading because of the prevailing unemployment that cuts across all educational frontiers.

Table 4.6: Percentage Distribution of Respondents by Contraceptive Use and Occupation

Occupation	Number	Not Using	Using			Total
			Modern	Traditional	Modern and Traditional	
Professional	87	83.5	8.7	7.8	16.5	100.0
Farming	245	92.2	3.3	2.5	7.8	100.0
Trading	447	87.9	8.0	4.1	12.1	100.0
Civil Service	192	83.8	7.7	8.5	16.2	100.0
Artisan	121	88.4	6.4	5.2	11.6	100.0
Others	81	86.9	6.8	6.3	13.1	100.0
Total	1173	87.1	6.8	5.7	12.9	100.0

4.2.5 Religion and Contraceptive Use

Religious belief can affect individuals perception, attitudes and practices

of family planning (Owie, 1983). Fertility regulation and contraception viz-a-viz religious moral codes have been a thorny issue that has received world wide attention. Some religious groups like the Catholics, Muslims and Traditionalists are known to be against the use of modern contraceptives and abortion in particular. Caldwell and Caldwell (1978) and Okediji *et al.* (1976) noted that the Christians were more likely to use contraceptives than Muslims or Traditionalists. The majority of the available evidence in Nigeria tends to support the claim that Christians are more likely to accept contraception than non-Christians. There appears, however, to be an uncertainty on the attitudes of different Christian denominations and sects towards contraceptive use.

Table 4.7 shows the differentials in contraceptive use among the religious groups in our sample. The table shows that the Protestants are more willing to practise modern contraception than other religious groups with a proportion of 19.4 percent of their members using contraceptives. The use of modern contraceptive is much more prevalent among Protestants (8.3 percent) relative to the Catholic (2.7 percent). About four percent of respondents of the Islamic faith are using contraceptives. We also noticed that the Muslims and the Catholic prefer traditional rather than modern methods of contraceptives with 13.6 percent and 11.8 percent usage of traditional contraceptives as against 3.9 percent and 2.7 percent respectively using modern methods.

Table 4.7: Percentage Distribution of Respondents by Contraceptive Use and Religion

Religion	Number	Not Using	Using			Total
			Modern	Traditional	Modern and Traditional	
Catholic	168	85.5	2.7	11.8	14.5	100.0
Protestant	212	81.6	8.3	11.1	19.4	100.0
Other Christian	501	88.8	4.8	6.4	11.2	100.0
Islam	201	80.5	3.9	13.6	17.5	100.0
Others	22	93.7	2.7	3.6	6.3	100.0
Total	1104	86.0	4.5	9.3	13.9	100.0

4.2.6 Number of living children and contraceptive use

The primary reason for using contraceptives is spacing of births and limiting family size. Reporting on the general contraceptive situation in Lagos and Western States of Nigeria during the first half of the 1970s, Okediji and his research associates wrote that over half (53 percent) of the acceptors of family planning did so to achieve the traditional birth interval, enabling them to improve the chances of survival of their children by proper spacing. In most African societies, the use or non-use of contraceptives would depend on the number of surviving children that a couple has. Studies have confirmed that the higher the number of children a couple has, the more likely the use of contraceptives. In their study in Malaysia, Naipeng and Abdurahman (1981)

observed that use of contraceptive increases with number of living children from 10 percent among couples with no living children to 45 percent and more after the third child. Abdulah and Harewood (1984) in their study also found that contraceptive use tends to increase with number of living children.

Table 4.8 shows that there is a relationship between extent of contraceptive use and number of living children. The table indicates that the proportion of men and women practising both modern and traditional contraception increases as the number of surviving children increases.

Table 4.8: Percentage Distribution of Respondents by Contraceptive Use and Number of Living Children

Number of Living Children	Number	Not Using	Using			Total
			Modern	Traditional	Modern and Traditional	
0 - 4	616	92.1	2.7	5.2	7.9	100.0
5+	259	85.5	5.6	8.9	14.5	100.0
Total	875	88.8	4.2	7.1	11.2	100.0

4.3 RESPONDENTS' SEXUALITY AND KNOWLEDGE OF STDS/AIDS

As HIV/AIDS spread throughout the world, along with an increase in some other STIs, the need for men to practice safer sexual behaviour is

becoming ever more urgent. Thus the need to use condoms correctly and consistently and to limit their number of sexual partners was recognised by Best (1998), Lande (1993), Ndinya-Achola *et al* (1997) and Wegner (1997). Also social change is needed in cultures that tolerate men's sexual promiscuity and condone unhealthy gender norms.

The HIV/AIDS epidemic has put men's sexual behaviour in the spotlight (Dallabetta *et al.*, 1997; Danforth, 1998; De Castro and De Castro, 1995; Leopold, 1997; World Bank, 1997). Prevention is the only solution. Yet too many men still engage in risky sexual practices. Many married men frequent commercial sex workers and do not use condoms either with the prostitutes or with their wives (Knodel and Pramualratana, 1996; Sakboon, 1996; Tangchonlatip and Ford, 1993). Consequently, men's sexual behaviour puts women at risk. For instance, in some countries, HIV is now spreading faster among women than men (UNAIDS, 1997; Mahathir, 1997; Reuters, 1998). Women are more susceptible physiologically to the viral and bacterial agents that cause HIV and other STIs (Dallabetta *et al.*, 1996; Hatcher *et al.*, 1998; UNAIDS, 1997; Mahathir, 1997). As a result, men transmit infections to women more efficiently than women do to men. For example, men are eight times more likely to transmit HIV to a female partner through repeated, unprotected sexual intercourse than women are to transmit the virus to men (Padian *et al.*, 1997)

In the recent times, researches are focusing attention on the nature of gender relations and how male-female dynamics influence sexual behaviour. Meursing and Sibindi (1995) studied 72 HIV-positive men and women. They found that women do not question their husband's extramarital affairs. They also observed that STI's and AIDS are accepted as a risk of married life, with few women standing up to their husbands to protest infection. Women who challenge gender injustice as it exists in our culture are called prostitutes and accused of failing in their duties to housekeeping in their marriages (Chitsike, 1995).

In this section, efforts are concentrated at the examination of the knowledge and attitude of Yoruba men and women about human sexuality and the kind of sexual networking that exists in the area. In this respect, we attempt to examine couples sexual behaviour and practices, the number of sexual partners a man or woman has, their reasons for having sexual relations, knowledge of AIDS\STDs and their risk reduction behaviour. However, many of the respondents would not respond to questions on sexuality because they perceived most of them to be too confidential and personal. Our analysis is therefore based on the responses of the few respondents who answered our questions on sexually-related issues.

4.3.1 Sexual behaviour and Practices

There is the general belief among the participants of focus group discussions that normal human being could not stay away from sex. They saw sex as a necessary biological need that must be met. As shown in Table 4.9, this belief and attitudes toward sex tend to affect people's behaviour. Female respondents were seen to be more likely than males to be sexually active (83.7 percent and 75.4 percent respectively in the last three months) but reported significantly fewer sexual partners than males. Sexual activity increased correspondingly over time for both males and females from last "three months" to "last year" and to "lifetime" as portrayed in Table 4.9. The table shows that the number of partners reported was significantly higher for males. Cultural restrictions may explain the differences in reporting. Traditionally a woman is expected to remain the sexual partner of one man either within or outside marriage. Therefore, a woman was more likely to report one partner at a time.

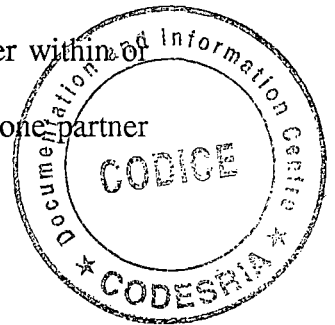


Table 4.9: Percentage distribution of respondents by sex and according to how often must one have sex and sexual activeness over specified period

How often must one have sex	Male (N=391)	Female (N=432)	Total (N=823)
Regularly	50.0	50.0	50.0
Occasionally	25.0	25.9	25.5
Depends on my mood	25.0	24.1	24.5
Total	44.9	55.1	100.0
Sexual activeness			
Last three months	75.4	83.7	74.2
Last year	71.8	82.6	71.5
Lifetime	68.5	77.4	69.4
Mean number of sexual partner			
Last three months	2.4	1.1	1.8
Last year	3.6	1.9	2.9
Lifetime	5.8	3.2	4.7

Note:- Excluding non-response categories

4.3.2 Number of sexual partners

The number of sexual partners is provided on Table 4.10. It can be seen that the number of sexual partners of the respondents increased from three months before the study through one year before the study to lifetime reporting. In the last three months prior to survey, 66.5 percent had only one partner. However, one year before the study, the figure had reduced to 65.3

percent and had further drastically reduced to 30.6 percent during lifetime. Respondents with 2-4 sexual partners was on the increase over the specified periods from 24.7 percent in the last three months to 25.6 percent in the last one year and 46.9 percent in lifetime. We also observed that those with five or more partners increased over the specified period from 8.8 percent to 9.1 percent and 22.4 percent for the last three months through the last one year and to lifetime respectively. The proportions of females who reported more than one sexual partners in the last three months call for comment. Such female respondents were most likely to be in commercial sex. For them, sex may be for survival.

Table 4.10: Percentage distribution of respondents by sex and number of sexual partners over specified period

Number of sexual partners	Male (N=398)	Female (N=432)	Total (N=830)
I. In the last three months			
1	58.9	74.3	66.5
2 - 4	34.4	12.9	24.7
5+	6.7	12.9	8.8
Total	100.0	100.0	100.0
II. In the last one year			
1	55.2	76.2	65.3
2 - 4	34.6	15.7	25.6
5+	10.2	8.1	9.1
Total	100.0	100.0	100.0
III. In lifetime			
1	20.0	47.4	30.6
2 - 4	50.0	42.1	46.9
5+	30.0	10.5	22.4
Total	100.0	100.0	100.0

Note:- Excluding non-response categories

4.3.3 Reason for having sexual relations

Given reasons for having sexual relations, majority of the males (70.5 percent) said it was for pleasure as against 43.4 percent of the females. About fifty-four percent of the respondents reported desire for more children as

reason for having sexual relations (50.1 percent of females as against 59.1 percent of males).

Another form of sexual activity of the respondents is revealed in the focus group discussion. Majority of the respondents said they had sexual encounter either between 1 and 3 times a week or daily. Again this statement brings out the difference between sex for pleasure and sex for survival.

Table 4.11: Percentage distribution of respondents by sex and reason for having sexual relations*

Reason for sexual relation	Male (N=297)	Female (N=248)	Total (N=545)
For pleasure	70.5	43.4	56.9
Want a child	59.1	50.0	54.1
No reason	9.1	11.1	10.2
Others	6.8	3.7	5.1

*Excluding non-response while multiple responses are allowed

4.3.4 Knowledge of STDs/AIDS

The respondents' awareness of STIs is high with more than ninety percent of both sexes having heard of the disease. About 12 percent reported of having been treated for STIs before; the male proportion being higher than that of females (7.1 percent and 5.3 percent respectively). It must be emphasised that venereal diseases are highly stigmatised in Nigeria and

sufferers are likely to keep the news to themselves. There is, therefore, reason to believe that the proportion which reported ever having STI is on the conservative side. Evidence to this effect came up during the focus group discussion.

Table 4.12 shows the respondents' knowledge of the mode of transmission of STIs/AIDS. Respondents were asked to indicate "true or false" against each of the causes specified in the table. However, percentages provided are for only those who indicated 'true' for the given cause of transmission. The responses show that the respondents were quite aware of the proper mode of transmission and male and female responses were quite similar. However, the level of misconceptions was disturbingly high and females were more likely than males to hold them. For example, the proportions which attributed the transmission of STIs/AIDS to witches/wizards and act of God/supernatural causes were 33.1 percent females against 16.8 percent males and 13.0 percent females versus 6.8 percent males respectively.

Table 4.12: Percentage distribution of respondents by sex and knowledge of transmission of STIs/AIDS

Knowledge of transmission of STIs/AIDS	Male (N=572)	Female (N=676)	Total (N=1248)
Through sexual contact	88.6	92.6	90.8
Through sex with prostitute	93.2	83.3	87.8
Act of God/Supernatural	6.8	13.0	10.2
Witches/Wizards	16.8	33.1	24.9
Through blood transfusion	79.5	79.6	79.6
Through kissing	48.2	50.0	49.1

Note:- Excluding non-response

4.3.5 Risk reduction behaviour

On whether there had been any modification in their sexual behaviour since hearing of AIDS, About fifty-four percent of males and 66.7 percent of female respondents indicated that they do (Table 4.13). Probing further about what they understand by modified behaviour, some focus group participants said they practised abstinence and few others said they insisted on the use of condom. What most of the respondents regarded as changed behaviour included "no sex until partner was well known", "reduction in the number of sexual partners", and "avoidance of sex with prostitute".

Table 4.13: Percentage distribution of respondents by sex and according to whether they had modified their sexual behaviour since learning of AIDS

Modified Behaviour	Male (N=572)	Female (N=676)	Total (N=1248)
Yes	53.5	66.7	60.8
No	46.5	33.3	39.2
Total	100.0	100.0	100.0

Note:- Excluding non-response

A very large proportion of the respondents knew of condoms but just a little above one-quarter of the sampled population had ever used them. Only 16.3 percent always used condom in the last three months and another 14.2 percent used it occasionally. For those who used condoms, the main reason was to prevent venereal diseases. Just about 27.5 percent mentioned AIDS specifically. Another 15.9 percent said they used condoms to prevent pregnancy. The main reason for not using condom was that they "just didn't like it" (34.0 percent). Another 7.1 percent felt that condom did not give any protection. Some 23.8 percent did not use condoms because they had faith in their partners and some others said they wanted babies (33.8 percent). Asked how they would feel if their partner wanted a condom to be used, Table 4.14 shows that 32.0 percent said they would oblige, about 21 percent of male and 19 percent of female respondents indicated that they would use it with

hesitation. Another 25.6 percent said they give up to pressure from their partner by using condom. However a higher proportion of female respondents were noticed among those who will succumb to pressure (33.3 percent against 16.3 percent of male population).

Table 4.14: Percentage distribution of respondents by sex and ever use of condom and feeling about condom use

	Male (N=321)	Female (N=347)	Total (N=668)
Ever used condom	36.6	32.5	32.9
Feeling about condom usage			
Use with hesitation	20.9	18.5	19.6
I will oblige	37.2	27.5	32.0
It may upset me	20.9	20.4	20.6
I will use if partner persist	16.3	33.3	25.6
Others	4.7	-	2.1
Total	100.0	100.0	100.0

Note:- Excluding non-response categories

Summary

In this chapter, the relationships between reproductive behaviour of the respondents and some selected demographic and socio-economic variables have been discussed.

It has been shown by our findings that the knowledge of contraceptive

is high among the Yorubas of South Western Nigeria. Sixty-five percent of males and 54 percent of females have ever heard about at least one modern method of contraception with condom and pill being the two common method ever heard of by the respondents. The respondents also claimed to have knowledge of some traditional methods like postpartum abstinence and withdrawal. However, the proportion using any of these methods (modern or traditional) was found to be relatively low compared with their knowledge (32.3 percent for males and 27.6 percent for females). Our findings showed that contraceptive prevalent rate among males is higher than that of females. The bivariate analyses indicate that some demographic and socio-economic variables like age, education, type of place of residence, occupational status, religion, number of living children etc. exert considerable influence on contraceptive use. For instance, the study revealed that generally, middle aged respondents are more likely to use contraceptives than the other age groups. Likewise, the educated and those with higher occupational status are more likely to use contraceptives than their counterparts.

Regarding respondents' current sexual practices, they were found to be sexually active. The data showed that 74.2 percent had been sexually active since they had their first sexual experience. It also emerged from the study that the respondents had a mean of 1.8 sexual partners in the last month and 2.9 in the last year before the survey. The males had higher number of sexual

partners over the specified periods probably as a result of the practice of polygyny or due to their involvement in extramarital affairs. On the respondents' sexual perception, the general opinion was that couples should regularly have sexual relation. This view was further reinforced by participants in the focus group discussions who held that 'constant or regular intercourse will prevent their partners from engaging in extramarital affairs'.

Sexual relations were maintained mainly as a source of pleasure as indicated by 56.9 percent of the respondents. However, a higher proportion of female respondents (50 percent) maintained sexual relations mainly because they wanted children. As high as 10.2 percent of the respondents (9.1 percent for males and 11.1 percent for females) could not give reason for engaging in sexual relations. This implies that a significant proportion of males have been engaged in extramarital affairs.

A high knowledge and awareness of STIs/AIDS was displayed by the respondents as more than 90 percent of them claimed knowledge of their mode of transmission. About eighty-nine percent of males and 92.6 percent of female respondents indicated that the main mode of transmission of STIs/AIDS is through sexual contact. Both male and female respondents showed the same level of awareness. However, a higher percentage of males (93.2 percent as against 83.3 percent for females) qualified such sexual contact to be one with a prostitute, thus introducing some level of misconception into their

knowledge. Another sign of misconception was shown in their belief that STIs/AIDS could be caused by witches or supernatural power. Females were more likely to hold such misconception.

On their risk reduction behaviour, although a very larger majority of the respondents knew of condoms, only 32.9 percent have ever used them. As observed in the focus group discussion, the main reason for non-use of condom was that "we just did not like it". So said some of the participants. Also as observed in the focus group discussion, the non-use of condom might be associated with their general belief that once they don't engage in extramarital sex, they could not contract STIs/AIDS. A participant in one of the locations even said: "...if one's partner is not suspected of engaging in sex outside the matrimonial home, there would be no need for one to use condom". However, we observed from our findings that a significant proportion of the respondents would still use condom if they are encouraged or being forced to do so by their partners.

CHAPTER FIVE

DETERMINANTS OF SPOUSAL COMMUNICATION

The continuing high fertility is recognised to be the result of a combination of socio-cultural and economic factors. These include gender-based inequalities, very early age at marriage, erosion of traditional long breastfeeding periods and post-partum sexual abstinence, in addition to limited use of modern contraception (Oppong, 1992). Promotion of spousal communication regarding family planning matters is a necessary component to increasing contraceptive use and reducing family size. In many studies, spousal communication has been found to be the most significant indicator of contraceptive use (Hill, Stycos and Back, 1959). These studies defined communication in various ways and these are (a) agreement in approval of family planning; (b) discussion between partners; and (c) spousal perception of the partner's approval of family planning. While some studies have used all the three dimensions of effective communication (Lasee and Becker, 1997), others have used discussion as the only measure of communication between husband and wife (Shah, 1974; Raju, 1987). Spousal communication can take several dimensions - from mere conversation, which may not be intended at influencing each other's views on issues that may not alter the structure of decision-making in the household, to an intensive discussion of issues that culminate in both partners being involved in decision-making. The main focus

of this study is on the latter. Two distinct dimensions of spousal communication that may likely influence male reproductive behaviour and family size have been identified in the study. These are discussion about family size and discussion about family planning.

5.1 Spousal communication and contraceptive use

It is observed from some studies (McDonald, 1985; Caldwell and Caldwell, 1985, 1987, 1990) that in matters relating to reproductive issues, women in several less developed societies hardly have a say. Decision on when to have another child and the number of children to have is usually made by men and their kinsmen and issues related to contraception are hardly discussed. Simply because the views of the woman who bears the burden of pregnancy and child birth are hardly sought, the number of children a woman bears is perceived most often to reflect the desired fertility of her husband and his kinsmen. In several of these studies, men's desired fertility was observed to be generally higher than those of women, implying that fertility levels would have been lower had woman's fertility desires prevailed. Ascadi and Ascadi (1990) noted that African men place high premium on children with the consequence that they generally desire larger families than do their wives. The minimal involvement of women in decision-making process regarding child bearing is one of the main reasons why fertility is still high in sub-Saharan

Africa (Caldwell and Caldwell, 1990).

Many obstacles prevent men and women from talking about sexual and reproductive issues. While research is slight, it suggests that a complex web of social and cultural factors impede such discussions (Ellertson, 1991; Meekers and Oladosu, 1996). In many societies, sex is a taboo subject for men and women to discuss. Also men and women are often afraid of rejection by a sex partner, especially at the beginning of a relationship. Consequently, they may not bring up uncomfortable issues, such as sexual history or use of contraception (Pliskin, 1997). Due to the fact that women and their husbands often do not communicate about family planning, many wives think that their husbands do not approve family planning when in fact the husbands approve (Biddlecom *et al.*, 1997; McGinn *et al.*, 1989; Oni and McCarthy, 1991; Salway, 1994). This misconception may be one reason for the widespread belief that men do not approve family planning, despite testimony from many men themselves that they favour it (Ellertson, 1991; Robey *et al.*, 1998).

Although there have been studies linking spousal communication with contraceptive use, the nature of the link is not obvious. It is not always clear whether more communication leads to more contraceptive use or, instead, couples talk more about contraception because they already use or plan to use a method. Also some couples may not have an immediate reasons to discuss family planning; for example, the wife is pregnant, the couple wants a

child/son, or they have no access to contraceptives. Partners may communicate their reproductive desires or concerns through non-verbal or indirect means (Blanc *et al.*, 1996; Fort, 1989; Hull, 1983). In Uganda, for example, most communication between men and women regarding reproductive issues took the form of suggestions, hints, and talking to friends or relatives in the hope that they would convey the information to the sex partner (Blanc *et al.*, 1996).

Many men still have negative attitudes about women choosing and using contraception. Some men fear that contraceptive use will make their wives independent of their control (Fort, 1989). They fear that their wives will have sex with other men if they no longer risk pregnancy (Fort, 1981; Oyediran, 1984; Ellertson, 1991). Some men may be unwilling to have their wives adopt family planning because they themselves know little about it, or do not want their wives talking with strangers about sex and reproduction. Some worry that contraceptive use will harm their wives' health or their own, while some oppose contraceptive use for religious reasons (Ellertson, 1991; Jordan, 1987). Some men still think that large families reflect their masculinity or their wives' faithfulness in serving men (Ellertson, 1991; Fort, 1989).

Spousal communication can be a crucial step toward increasing men's participation in reproductive health (Becker, 1996; Biddlecom *et al.*, 1997; Lasee and Becker, 1997; Mahmood and Ringheim, 1997; Omondi-Odhiambo, 1997 and Stycos, 1996). Since men, as well as women, play key roles in

reproductive health, communication is necessary for making responsible, healthy decisions. For instance, Lozare (1976) measuring communication between Filipino husbands and wives found that 44 percent of couples who frequently discussed family planning practised contraception, compared with 35 percent of those who occasionally discussed the topic and only 13 percent of those who never did so. Also Lasee and Becker (1997) observed that owing to interspousal communication, there has been a shift of attitude of Kenyan men towards lower family size and family planning.

Most studies on the causes of unmet need for family planning in developing countries point to the important influence on reproductive decisionmaking of couples', ability to communicate, as well as social factors such as husbands' approval of family planning, lack of knowledge of modern methods, and societal disapproval of contraception (Bongaarts and Bruce, 1995; Casterline *et al.*, 1997). Nyblade and Menken (1993) and Cleaveland (1992) observed that irrespective of household structure, spousal communication is associated with greater contraceptive use. These male attitudes about contraceptive use are part of some men's broader fears.

In some developing countries, husbands dominate reproductive decision making whether regarding contraceptive use, family size, birth spacing, or extramarital sexual partners (Ezeh, 1993; Fatima, 1991; Fort, 1989; Kulu, 1990; Leavitt, 1991; Magnani *et al.*, 1995; Storey *et al.*, 1997). Traditional

social norms often have required men to maintain the honour and position of their extended family, village, religious group, or other social organisation. Therefore man feels responsible for the behaviour of their wives and children and think that women have no right to make decisions for themselves (Yinger, 1998; Kim *et al.*, 1998; Gage, 1994; Ezeh, 1993; Hector *et al.*, 1990; Shaheed, 1986). Communication enables husbands and wives to know each other's attitudes towards family planning and contraceptive use. It allows them to voice their concerns about reproductive health issues such as worries about undesired pregnancies or sexually transmitted infections (STIs). Communication can also encourage shared decision making and more equitable gender roles.

Women's inferior status and lack of power limit couple communication (Diaz, 1997; Dixon-mueller, 1993; Ezeh, 1995; Gage, 1994; Hardon, 1995; Meekers and Oladosu, 1996; Salway, 1994; Worth, 1989). For many women, traditional female gender roles mean they have little say in sexual matters and lack the status to influence their partner's behaviour (Dixon-Mueller, 1993; Fort, 1989; Meekers and Oladosu, 1996; Ulin, Cayemittes, and Metellus, 1995; Van Der Straten, King, Grinstead, Serufilira and Allen, 1995; Worth, 1989). Even when men and women discuss reproductive health issues, it is usually not on equal terms (Deschutter, 1998). As women's equality with men increases, so does their ability to communicate about reproductive matters and

to participate in reproductive decisions (Beckman, 1983; Meekers and Oladosu, 1996). When a woman shares decision making power, she is better able to bring up and discuss family planning and sexual relations with her sex partner.

Traditional cultures often discourage married women from starting discussion about contraception. For their part, men may feel there is nothing to discuss or no need to take account of their wives' feelings and opinions. In countries such as Nigeria, Kenya, and India, traditional male dominance is a major obstacle to spousal communication about family planning (Isiugo-Abanihe, 1994; Omondi-Odhiambo, 1997). Also, a husband might consider his wife promiscuous or unfaithful if she tries to discuss contraception with him (Fort, 1989). In some cultures it is easier for unmarried women and prostitutes to negotiate sexual activity with men, including condom use, than for married women to do so with their husbands (Ulin *et al.*, 1995).

Many men want to know more about contraception and family planning and to be more involved. For example, in Malaysia, Nigeria, and Turkey, most men surveyed wanted to learn more about family planning (Arokiasamy, 1980; Okpere *et al.*, 1988). In Peru, men in focus group complained that false stereotypes of dominating men limited their opportunities to obtain information about sexuality and family planning (Payne Merntiti, 1993). In Tunisia, men often accompanied their wives to the family planning clinic but then waited

outside talking among themselves (Coeytaux, 1989).

Men need information about contraceptive methods for women as well as about those for men. Well-informed men can use a method themselves or support their partners in using a method. Well-informed men can also talk with their wives and cooperate in assessing their needs and choosing a family planning method. Men especially need information about sexually transmitted diseases (STDs) since men play a big role in the spread of STDs including AIDS (Blakeslee, 1994). Except for female prostitutes, men are likely to have more sexual partners than women. They have more control over condom use. They are more likely to control the frequency of sexual relations and the possibility of abstinence within a relationship.

An understanding of males influence and the role they play in reproductive decision making can throw better light on mechanisms through which egalitarianism of husband/wife decision making influences fertility.

5.2 Conjugal relationships and decision making

The expectation is that couples who had ever had discussion on issues such as pregnancy matters, when to have another child, discussing or taking decision on family planning etc would be better able to predict partner's position than would a spouse who did not have such discussion. However there are some prevailing socio-cultural and institutional factors that will play

significant impact on couples reproductive behaviour and contraceptive decision making. For instance a number of cultural factors have been identified (Renne, 1993) to have favoured men in matters related to marriage and family life. Probably as a result of dependence of women on their husbands, socially and economically, men greatly influence their family decisions.

Table 5.1 shows that a significant proportion of the respondents claimed that they eat together, sleep together, have leisure together and do many other things together. The table shows that 58.3 percent of the male respondents usually ate together with their wives, 69.5 percent slept together, 61.9 percent usually had leisure together and 78.6 percent usually shared confidences. It is discernable from the focus group discussion that the topics of very frequent discussion with spouses included financial problems, children welfare and children's schooling. Food was also a topic of frequent discussion. We observed from Table 5.1 that pregnancies were seldom discussed. When asked whether husbands had ever discussed the number of children wanted with their wives, more than half of the male respondents compared with 49 percent of female population, reported that they had never had such discussions. About two-fifths of the men had also never discussed whether to do something to delay pregnancy with their wife. About sixty-two percent of male population compared with 72.1 percent of females reported that their wives had never initiated a discussion about family planning with them. We noticed from the

table that conjugal relationships are moderately close according to reports of both husbands and wives. Problems about children's welfare are frequently discussed, but discussions relating to reproduction are avoided in general.

Relatives influence decisions to some extent. About twenty-eight percent of men and thirty-three percent of women reported that relatives always influence their decisions. In 31.6 percent of cases, the influence was occasional. Asked how relatives influence couples decision making, participants in focus group discussions indicated that such influence was mainly 'through advice'. In a few cases, relatives' influence could be 'through withdrawal of financial' or 'moral support'. When asked what the wife's reaction would be to decisions taken without consulting her, some of the male participants in a focus group discussion said that: "she would not take kindly to it"; some thought "their wives would agree to the decision that has been made" and some believe that "their wives would neither agree nor disagree".

Close conjugal relationships can be a good indicator of joint decision making among couples. There exists clear evidence of close consultations between spouses before the decision to take a new job is made.

Table 5.1: Percentage distribution of respondents by sex and according to conjugal relationship

Conjugal Relationship		Male (N=432)	Female (N=527)	Total (N=959)
A. Do you and your spouse				
Eat together	Yes	58.3	56.6	57.2
Sleep together	Yes	69.5	74.1	71.9
Go out together	Yes	61.9	63.0	62.5
Share confidence and secrets	Yes	78.6	79.6	79.2
Pool resources together	Yes	35.7	50.0	43.8
B. Have you and your spouse ever discussed:				
(a) Number of children to have?	Yes	48.9	51.0	49.9
(b) Doing something to delay or avoid pregnancy?	Yes	55.8	56.3	56.1
(c) Whether to stop having children?	Yes	54.1	57.2	55.7
(d) Has your partner initiated discussion about family planning?	Yes	38.4	27.9	31.6
(C) Relative influence on decision making				
(a) How often do relatives influence decision?	Not at all	39.7	32.5	36.1
	Occasionally	33.5	29.8	31.6
	Very often	8.1	7.4	7.7
	Always	18.7	30.3	24.6

Note:- The data exclude non-responses

5.3 Attitude of men to women status

Responses to sex-role ideology statements posed to the respondents are shown in Table 5.2. When asked whether, in their opinion they agreed or disagreed with the statement that 'the husband should be the breadwinner of the family while the wife looks after the house', about 58.2 percent agreed, 12.8 percent disagreed and 29 percent were neutral. Asked whether 'women should not stop childbearing until she has a son' only 21.8 percent agreed, 31.4 percent disagreed and 46.9 percent were neutral. About 45 percent agreed that a wife should not expect her husband to help with housework, 15.9 percent disagreed.

Findings have shown that since men don't have to depend on the status of their wives for their families to survive, their attitudes to their wives' status can be seen as unbiased and independent, providing useful pointers for fertility-related behaviour. The general support in the home given to wives by Yoruba husbands and the fairly positive attitude to women's economic status seem to negate traditionally held views in sex-role ideology among the Yorubas. The men obviously still want to be breadwinners and maintain authority in the home, but gradually, expression of greater opportunities for women to better their positions and to have a better independent standing (i.e. not dictated by number of children or number of sons) does come out of the responses: a pointer to change of traditional values. Such changes are

welcome, not only because they make for greater possibilities in improving status of women, but because, there are implications for decision making, fertility desires and practice of family planning. Positive attitudes to women's improved status, especially in an atmosphere of fairly close conjugal relationships, are likely to result in less independent, and thus more egalitarian decision making, greater approval and use of family planning and hence, greater reduction in fertility.

The indication from responses to the above traditional sex-role ideology statements is one of a gradual shift from a purely traditional to a more modern outlook by men, although the idea that men must always be breadwinner is still very strongly adhered to. The male dominance ideology statements, were generally agreeable to the men. Hence, two-thirds agreed to the statement that 'The wife should not work if the husband is opposed to it'; more than 44 percent agreed that 'It is better for the family when a woman earns less than her husband'; and about 80 percent agreed that the husband should have final say on important family matters.

There is less inclination on the part of the men to agree with the married women's motherhood role ideology statements. Fifty-five percent of the men still believed that 'A married woman should have as many children as her husband wants' but only 21.8 percent agreed that 'A woman should continue to have children until she has a son', 31.4 percent disagreed. The

high value still placed on children in the Yoruba society is evidenced in the fact that 46.2 percent of the men agreed with the statement that 'A man should marry another wife if his wife has no children'; thirty-one percent agreed that women with many children have more prestige than those who have few children while 42.5 percent were neutral and 26.5 percent disagreed.

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Table 5.2: Percentage distribution of men according to sex-role ideology statement among the Yorubas

Sex-Role Statement	Agree	Disagree	Neutral	Total
Woman should have many children as husband wants	54.8	19.9	25.3	100.0
Woman should not stop childbearing until she has a son	21.8	31.4	46.9	100.0
A man should marry another wife if wife has no children	46.2	29.1	24.8	100.0
Women with many children have greater prestige	31.0	26.5	42.5	100.0
Husband should be the breadwinner	58.2	12.8	29.0	100.0
Wife should not expect husband to help with housework	44.6	15.9	39.5	100.0
Wife should not work if husband is opposed to it	66.6	16.7	16.7	100.0
It is better for a woman to earn less than her husband	44.3	28.7	27.0	100.0
Husband should have final say on important family matters	77.6	11.7	10.7	100.0

5.4 Reproductive Decision Making

Table 5.3 shows that both male and female respondents in the study area agreed with the statements that men should decide family size (47.6 percent), decide when to have sex (34.4 percent), decide what to do to unwanted pregnancy (57.3 percent), and when to take decisive decision on family planning. Thus confirming Isiugbo-Abanihe's (1994) earlier findings on

reproductive decision making among couples in Nigeria that most of the vital decisions on reproductive matters rest with men.

The general impression to be deduced from the male responses to these statements is that while they support the fact that women should be assisted in the home, and that they should not be forced to comply with their husbands' wishes with regard to number and sex of children they are very much in favour of maintaining authority and leadership in the home and at the workplace.

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Table 5.3: Percentage distribution of respondents by sex and according to reproductive decision making

Statement		Male (N=585)	Female (N=702)	Total (N=1287)
Men decide family size	Agree	50.3	44.8	47.6
	Disagree	35.1	33.7	34.4
	Undecided	5.4	9.3	7.3
	Don't know	9.2	12.2	10.7
Men decide when to have sex	Agree	28.6	38.9	34.4
	Disagree	54.6	51.9	53.1
	Undecided	14.3	9.3	11.5
	Don't know	2.4	-	1.0
Men decide duration of abstinence	Agree	46.2	40.7	43.5
	Disagree	37.1	40.7	38.8
	Undecided	16.7	14.8	15.6
	Don't know	-	3.7	2.1
Men decide whether to practice family planning	Agree	50.0	35.2	42.6
	Disagree	26.2	38.9	32.5
	Undecided	19.0	16.7	17.7
	Didn't know	4.8	9.3	7.3
Men decide family planning method to use	Agree	45.2	40.7	42.9
	Disagree	19.0	40.7	29.8
	Undecided	28.6	9.3	17.7
	Don't know	7.1	9.3	8.3
	Total	100.0	100.0	100.0
	Total	100.0	100.0	100.0

Note:- The data exclude non-responses

5.5 Family planning decision making

Responses to questions on whether respondents discuss the use of family planning methods after marriage with their spouses, and from whom such decision emanates were examined in Table 5.4. Here, we are trying to know whether contraceptive decisions are influenced more by their own views, the views of spouse, jointly decided or the decisions were those of others (parents, relatives or friends). For responses, we have four categories: those who take personal decision; those who will follow their spouse's advice; those that will engage in joint decision; and those that will never take family planning decisions which are being referred to as 'others' in our tables. Responses to questions on family planning decisions are presented in Table 5.4. The table shows that respondents generally believe that decision to use family planning after marriage should either be taken jointly or follow the advise given by other people. This is clearly shown on the table where we noticed that majority of the respondents fall into these two categories.

Table 5.4: Percentage distribution of respondents by sex and according to indices of decision making

Who decides the use of family planning?	Male (N=585)	Female (N=702)	Total (N=1287)
Respondent	2.3	5.1	3.9
Husband/wife	2.3	4.5	3.5
Both	9.9	7.6	8.8
Friend/relatives	12.9	12.7	13.0
did not use	71.1	69.5	69.7
Total	100.0	100.0	100.0
Who has final say about having another child?			
Husband	41.0	48.0	45.0
Wife	5.1	9.6	7.7
Joint decision	48.7	36.5	41.8
Others	5.1	5.8	5.5
Total	100.0	100.0	100.0
Who decides first birth interval?			
Respondent	15.4	11.8	13.3
Husband/wife	7.7	9.8	8.9
Both	64.1	66.7	65.6
Friends/Relatives	5.1	2.0	3.3
Don't know	7.7	9.8	8.9
Total	100.0	100.0	100.0
Who proposes using family planning method?			
Respondent	41.2	39.5	40.3
Husband/wife	58.8	60.5	59.7
Someone else	-	-	-
Total	100.0	100.0	100.0

Note:- The data exclude non-responses

Figure 7: Percentage distribution of respondents by sex and who decides the use of family planning

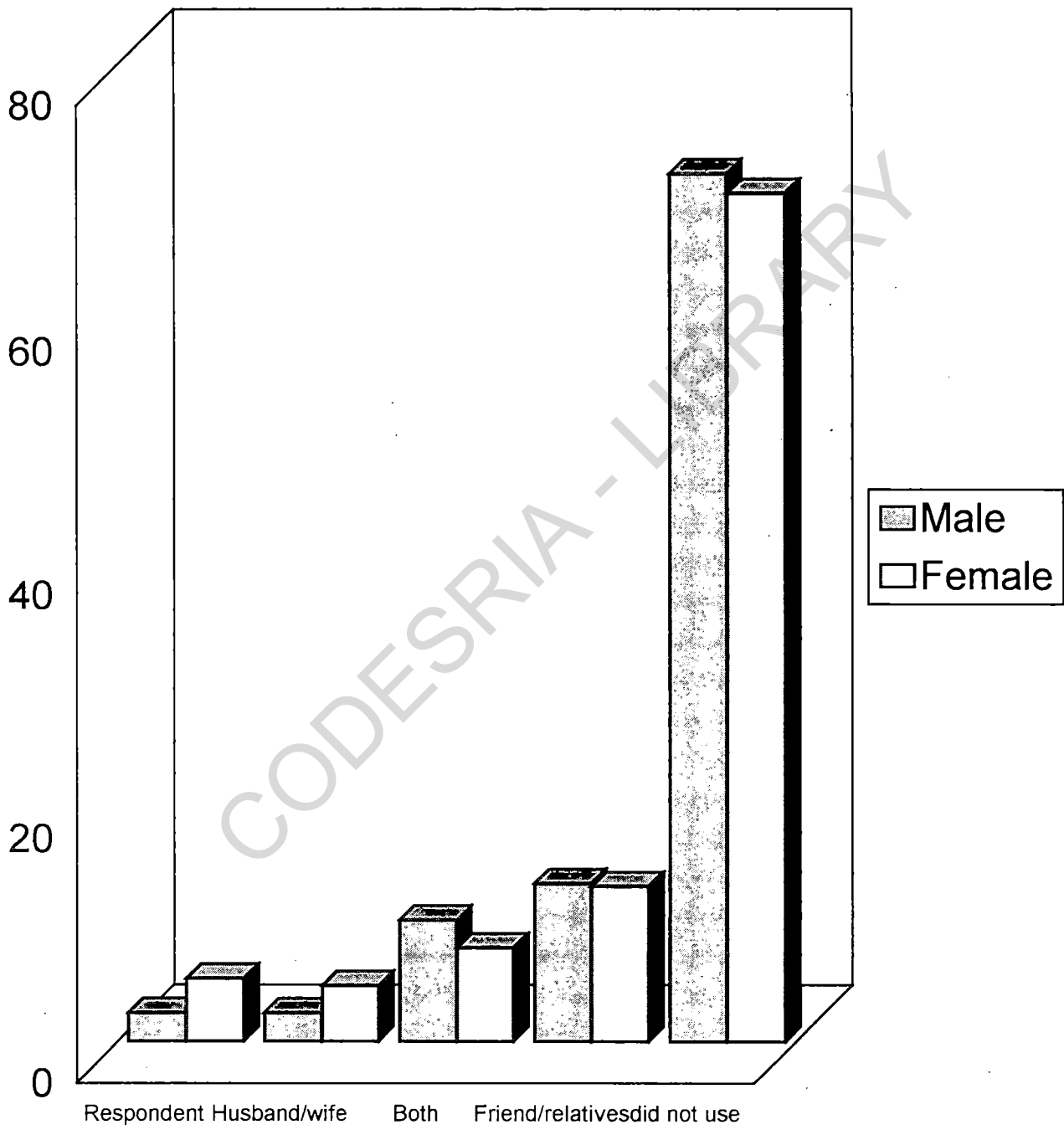
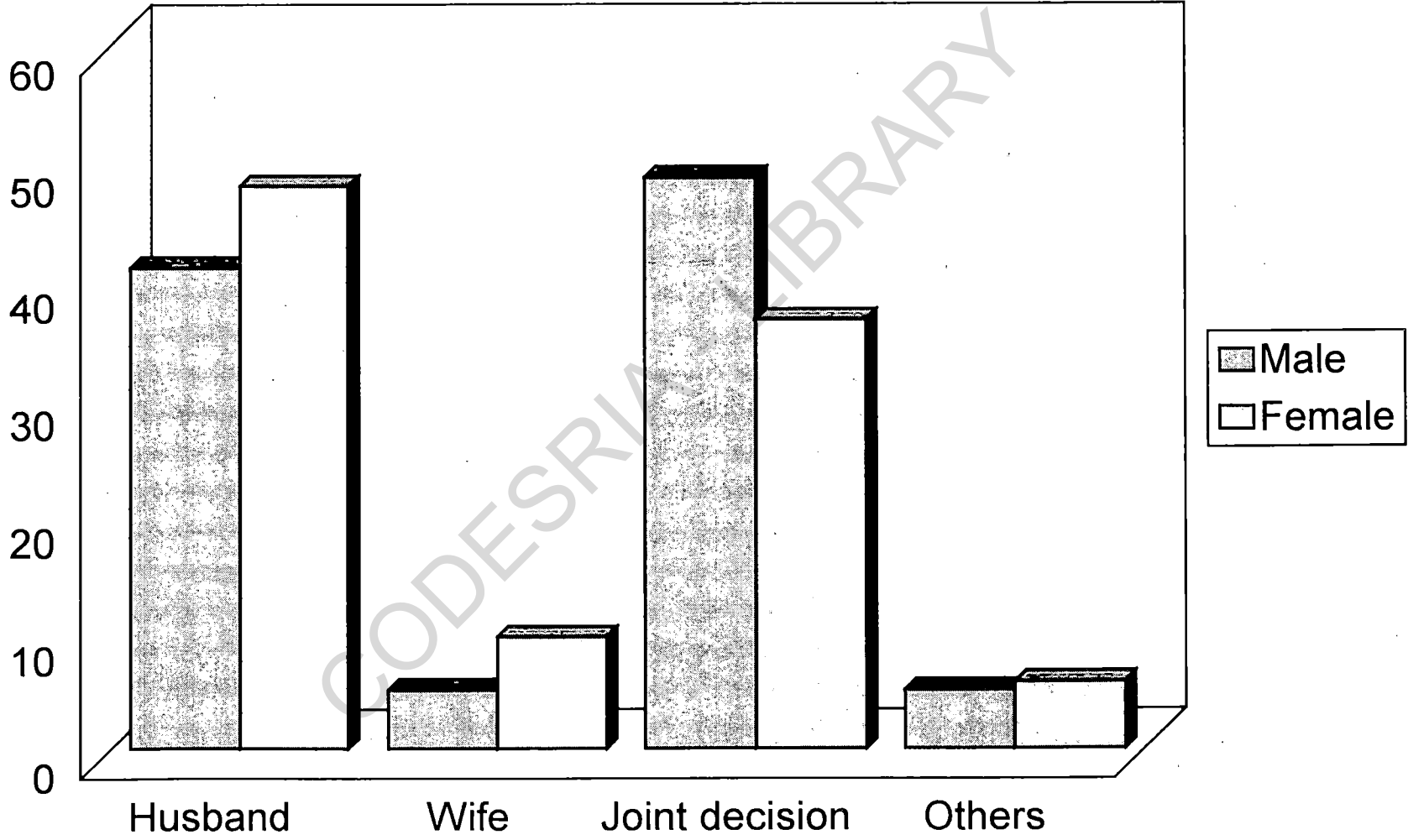


Figure 8: Percentage distribution of respondent by sex who has final say about having another child



5.6 Decision to use family planning by socio-economic and demographic characteristics

Spousal differences in age, education and some other background characteristics of respondents deserve special consideration in the analysis of spousal communication and contraceptive use among the Yorubas. Among this ethnic group, the way people relate to each other is defined by the amount of difference in age. For instance, individuals in younger age grades, irrespective of sex, are expected to show deference to those in older age grades. The deference is observed within marriage where women are not expected to call their husbands by name (Renne, 1993; Feyisetan, 1999). In many homes, it is not unusual to find women calling their husbands "daddy". The larger the age difference between spouses, the more difficult it may be for wives to discuss with their husbands or express views that are contrary to their husbands' even when they feel strongly about those views. Also, spousal differences in education may affect spousal communication. Partners whose levels of education are similar or close to one another, are more likely to discuss issues together than those whose levels of education differ significantly from one another. These background characteristics of respondents will then be related to respondent's family decision-making under this section.

5.6.1 Decision to use family planning by Age

Table 5.5 shows the percentage distribution of respondents by age and decision to use family planning. It indicates that respondents within the age range 15-24 would

not make any definite decision on family planning usage. However, for couples in the age group 25 - 39, decision to use family planning are jointly made. Respondents who are older are more likely to personally take such decision. Majority of respondents in groups 40 - 44 (30.6 percent) and 45 and above (24.1 percent) said they usually take decision on family planning. However, some of them still engage in joint decision. This old respondents believed that they have achieved their desired number of children and consequently want no more children. Moreso many of the old women are already approaching their menopausal ages. These sets of people may have higher rates of contraceptive use for limiting or stopping childbearing.

Table 5.5: Percentage distribution of male respondents according to decision to use family planning and age

Age Group	N	Who Decided the Use of Family Planning				Total
		I Decided	Wife Decided	Both of us Decided	Others	
15 - 24	41	21.9	11.4	11.4	55.6	100.0
25 - 29	58	13.6	10.5	42.1	31.6	100.0
30 - 34	97	8.1	12.2	32.6	47.1	100.0
35 - 39	66	6.3	25.0	43.8	25.1	100.0
40 - 44	71	30.6	5.3	15.0	49.1	100.0
45+	47	24.1	4.8	18.6	52.5	100.0
Total	390	15.8	12.1	29.1	43.0	100.0

Note:- The data set is confined to respondents who are currently using methods of family planning

5.6.2 Decision to use family planning by Educational Attainment

The association between education and decision to use family planning is also presented in Table 5.6. The table shows a positive relationship between education and decision to use family planning. For instance, among those without formal education, 37.5 percent would personally take decision to use family planning, less than 13 percent would engage in joint decision. Most of the respondents who attained higher level of education engaged in joint decision indicating that those with higher levels of education would discuss family issues more than those with none or lower levels of education.

Table 5.6: Percentage distribution of male respondents according to decision to use family planning and educational attainment

Educational Attainment	N	Who Decided the Use of Family Planning				Total
		I Decided	Wife Decided	Both of us Decided	Others	
None	54	37.5	12.5	12.5	37.5	100.0
Primary	56	12.3	48.7	15.1	23.9	100.0
Secondary	172	21.5	12.1	47.1	19.4	100.0
Tertiary	89	6.8	11.4	34.1	43.2	100.0
Others	19	-	-	-	100.0	100.0
Total	390	11.8	15.3	29.4	43.5	100.0

Note:- The data set is confined to respondents who are currently using methods of family planning

5.6.3 Decision to use family planning by Occupation

Occupation is another factor that has been known to affect couples' family

planning decision-making. Generally, the table shows that respondents who would take decision on family planning would either take such decision jointly with their spouse or make it a personal decision. Most of those who would take any decision on family planning usage are the professionals and those in the civil or public service. This is expected since the professionals as well as those in the civil service are more educated; they earn higher income, have greater job security and have access to adequate old age benefit interms of gratuity and pension and consequently can afford not to produce many children for old age support. However, for those who engage in farming and those who are artisan, majority of them would rather follow the decision of their spouse or make it a joint decision.

Table 5.7: Percentage distribution of male respondents according to decision to use family planning and occupation

Occupation	N	Who Decided the Use of Family Planning				Total
		I Decided	Wife Decided	Both of us Decided	Others	
Farming	88	4.0	14.3	18.8	62.9	100.0
Trading	123	21.4	7.1	28.2	43.3	100.0
Public/Civil Service	49	35.9	11.8	42.1	10.2	100.0
Professional	46	28.4	13.1	46.2	12.3	100.0
Artisan	57	8.3	14.1	51.7	31.7	100.0
Others	27	-	-	45.5	54.5	100.0
Total	390	15.4	10.8	29.3	44.6	100.0

Note:- The data set is confined to respondents who are currently using methods of family planning

5.6.4 Decision to use family planning by Religion

Religious beliefs can affect couple's as well as individual's perception, attitudes and practices of family planning. Fertility regulation and contraception vis-a-vis religious moral codes have been a thorny issue that has received world wide attention. Some religious groups like the Catholic, Muslims and Traditionalists are known to be against the use of modern family planning methods and abortion in particular (Adeokun, 1979). So they can hardly be involved in any decision to use or not to use family planning either before or after marriage. This position is supported in Table 5.8 where we noticed that majority of those who would discuss family planning and make a family planning decision are Christians. For instance, 46.7 percent of those who profess Islamic faith would not take decision on family planning as against 32.2 percent of Catholic and 26.4 percent of the Protestants. About fifty percent of these Protestants would take joint decision on family planning as against 26.7 percent in the case of Muslim (Table 5.8). While only 11.6 percent of the Catholic members and 12.7 percent of Muslims would personally take any decision on family planning, 23.1 percent of the Protestants would take a decision to use. The figures observed for the Muslims seem to be higher because the proportion of Muslim who would make a decision to use family planning is small and also most of those Muslims who mentioned that they discuss family planning are referring mainly to traditional methods.

Table 5.8: Percentage distribution of male respondents according to decision to use family planning and Religion

Religion	N	Who Decided the Use of Family Planning				Total
		I Decided	Wife Decided	Both of us Decided	Others	
Catholic	75	7.6	14.3	35.9	42.2	100.0
Protestant	57	23.1	7.7	23.1	46.2	100.0
Other Christian	183	9.8	12.2	34.1	43.9	100.0
Islam	66	20.0	6.7	26.7	46.7	100.0
Others	9	-	51.4	-	49.6	100.0
Total	390	12.7	11.4	31.7	45.2	100.0

Note:- The data set is confined to respondents who are currently using methods of family planning

5.6.5 Decision to use family planning by Residency

Table 5.9 also gives a picture of the distribution of respondents according to 'who make family planning decision' and type of place of residence. The general trend that has been found in most studies is that urban dwellers are more likely to take any decision on family planning for reasons which seem obvious. This has been confirmed in this study. The results in Table 5.9 show that respondents in urban areas are more likely to engage in joint decision making after marriage. However, few of these urban dwellers would take personal decision to use family planning (14 percent of rural dwellers as against 11.6 percent of urban dwellers).

Table 5.9: Percentage distribution of male respondents according to decision to use family planning and Place of residence

Residency	N	Who Decided the Use of Family Planning				Total
		I Decided	Wife Decided	Both of us Decided	Others	
Urban	226	11.6	16.3	30.3	41.9	100.0
Rural	164	14.0	7.0	34.9	44.2	100.0
Total	390	12.8	11.6	32.6	43.0	100.0

Note:- The data set is confined to respondents who are currently using methods of family planning

5.6.6 Decision to use family planning by Media Exposure

Information in Table 5.10 appears to be in conformity with the general belief that exposure to media messages (most especially radio and television), will affect people's habits to listening to radio, watching television and reading newspaper. This will consequently influence contraceptive behaviour of the people. Probably as a result of the exposure, a significant proportion of the respondents would either decide on their own or be advised by their spouse on family planning matters, though a significant proportion of them would still engage in joint decision.

Table 5.10: Percentage distribution of male respondents according to decision to use family planning and media exposure

Media Exposure		N	Who Decided the Use of Family Planning				Total
			I Decided	Wife Decided	Both of us Decided	Others	
Read Newspaper	Yes	172	6.9	13.8	30.6	48.7	100.0
	No	217	25.9	7.4	33.3	33.3	100.0
Listen to Radio	Yes	254	12.5	13.8	31.3	42.5	100.0
	No	136	16.7	33.3	-	50.0	100.0
Watch Television	Yes	204	13.4	10.0	33.3	43.3	100.0
	No	186	16.7	16.7	20.8	45.9	100.0

Note:- The data set is confined to respondents who are currently using methods of family planning

5.6.7 Decision to use family planning by Frequency of Discussion

Frequency of discussion of family planning among couple will influence decision on its usage. Table 5.11 shows that most of those who frequently had discussion on family planning would jointly take decision on whether to use contraceptives or not. On the contrary, a significant proportion of those who seldomly discuss family planning and those who would avoid such discussion would rather personally take such decision. However, the table still shows that the decisions to use contraceptives are in most cases jointly made. The only exception are those who would not at all discuss such issue.

Table 5.11: Percentage distribution of male respondents according to decision to use family planning and Frequency of discussion

Frequency of Discussion	Who Decided the Use of Family Planning					Total
	N	I Decided	Wife Decided	Both of us Decided	Others	
Very Frequently	103	9.1	4.5	45.4	40.9	100.0
Frequently	139	3.3	16.7	40.0	40.0	100.0
Seldom Service	79	21.1	15.8	21.1	36.8	100.0
Not at all	69	26.7	6.7	6.4	60.0	100.0
Total	390	12.8	11.6	29.1	43.0	100.0

Note:- The data set is confined to respondents who are currently using methods of family planning

5.7 Decision on having another child

The effect of some selected background characteristics of the respondents on who should have final say about having another child in the family was examined using cross-tabulation approach. The results are presented in Table 5.12. The table shows that men in the area have the general belief that women have little or no say in the decision to have another baby in any household. This is irrespective of their socioeconomic background. The decision is believed to be either the prerogative duty of the men or it has to be a joint decision.

The age distribution of the respondents shows that for men in almost all ages, the decision to have another baby, is believed to be basically that of men. However, in some cases, there can be joint decision. The educational classification of the

respondents also indicates that couples usually take joint decision on family issues especially when it comes to the question on when to have another baby. This position was supported in the focus group discussion when most of the participants indicated that the decision should be that of the husband and wife. For a substantial proportion of the respondents, and irrespective of the level of education, the view is that husbands should be solely responsible. Table 5.12 also indicates that men who are in the civil service and the professionals believe that husbands should have upper hand in the decision to have another baby - 44.4 percent and 35.7 percent respectively. Among the various religious groups, we equally noticed that decisions are either jointly made or they emanate from the husbands. However, the proportion of Muslims who would abide by their husband's decisions is significantly higher than other religious groups. As expected most of the respondents in the rural area believe that husbands should take such decision while those in the urban area indicated that decision on when to have another baby should be taken jointly by the husband and wife.

Table 5.12: Percentage distribution of respondents decision to have another child according to selected background characteristics

Characteristics	Who has final say about having another child					
	N	Husband	Wife	Joint	Other	Total
Age						
15 - 24	77	50.0	14.3	25.0	-	100.0
25 - 34	460	47.4	-	52.6	-	100.0
35+	603	58.8	5.9	29.4	5.9	100.0
Educational Attainment						
None	152	61.6	6.2	21.1	11.1	100.0
Primary	167	61.5	14.3	30.8	-	100.0
Secondary	616	50.0	5.6	44.4	-	100.0
Tertiary	216	29.8	10.6	51.1	8.5	100.0
Others	36	100.0	-	-	-	100.0
Religion						
Catholic	168	44.3	14.3	48.0	-	100.0
Protestant	212	40.0	6.7	46.7	6.6	100.0
Other Christian	501	33.3	11.9	47.6	7.1	100.0
Islam	201	57.1	-	37.1	5.9	100.0
Others	22	50.0	-	50.0	-	100.0
Occupation						
Farming	245	62.5	-	25.0	12.5	100.0
Trading	447	66.7	-	33.3	-	100.0
Public/Civil servant	192	44.4	11.1	33.3	11.1	100.0
Professional	87	35.7	7.1	57.1	-	100.0
Artisan	121	25.0	16.7	58.3	-	100.0
Others	81	-	-	50.0	50.0	100.0
Residency						
Urban	733	37.0	8.7	45.7	8.7	100.0
Rural	567	53.3	6.7	37.8	2.2	100.0

Note:- The data exclude non-responses

5.8 Men's Influence in Reproductive Issues

Table 5.13 shows that in almost all cases of reproductive issues, husbands and wives reported joint spousal decision making. The marginal frequencies however show that men are less likely than their wives to report joint decision making and are more likely to report that they alone usually take decision. Thus corroborating Isiugo-Abanihe's findings in an earlier study which indicated that 40 percent of men and more than 50 percent of women said their family size was a joint decision (Isiugo-Abanihe, 1994). This response must however, be seen within the context of the Yoruba traditional society where the man is expected to have absolute control of his household and the woman is expected to respect whatever decision the husband takes. The desire to boost his ego and show that he is in control could make a man report that he alone takes decisions (even when the issues are discussed with the wife) and the need to portray that the woman is well cultured through deference to her husband may make her report that only the husband takes decisions on these issues. This situation is more likely among respondents with low level of education and those in the rural areas. Despite these high levels of discordance in partners' responses, a significantly high proportions of couples still reported joint decision making. About thirty-seven percent of the respondents reported joint decision making on 'when to have another child' 40.8 percent on 'whether to stop having children' and 44 percent on 'what to do to stop childbearing'. The sums of the principal diagonal elements which indicate agreement between partners' responses indicate that 53.5 percent, 53.3 percent and 55.7 percent

of partners gave similar responses on who take decisions on when to have another child, whether to stop child bearing and what to do to stop child bearing.

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Table 5.13: Husbands and wife's responses on who takes decision on reproductive issues

Husband	Wife			
	Husband only	Wife only	Husband and Wife	Other
<u>When to have another child</u>				
Husband only	15.1	2.7	19.5	2.1
Wife only	0.6	0.9	1.4	0.2
Husband and Wife	12.8	3.5	37.2	-
Other	1.1	0.2	2.2	0.5
Total	29.6	7.3	60.3	2.8
<u>Whether to stop child bearing</u>				
Husband only	10.7	3.4	16.4	1.8
Wife only	1.1	0.9	0.6	0.1
Husband and Wife	11.8	2.5	40.8	0.6
Other	4.0	0.6	3.7	1.0
Total	27.6	7.4	61.5	3.5
<u>What to do to stop child bearing</u>				
Husband only	7.4	7.7	15.8	1.5
Wife only	0.5	2.1	3.6	0.2
Husband and Wife	4.6	4.4	44.0	0.3
Other	1.7	0.9	0.9	1.5
Total	14.2	15.1	67.2	3.5

Summary

The significant influence which men exact over reproductive issues in less developed societies has been widely recognised. This has been substantiated in this study. Also a number of studies have examined the role of men in family planning as well as their fertility desires using either data on both men and women or data on men alone (Adamchak and Adebayo, 1987; Mason and Taj, 1987; Mbizvo and Adamchak, 1991; Ezeh, 1993; Doodoo, 1993; Isiugo-Abanihe, 1994; Salway, 1994; Bankole and Olaleye, 1995; Meekers and Oladosu, 1996; Ezeh and Mboup, 1997). Many of these studies have noted that in many less developed societies, characterised by patriarchal social structure, little spousal communication exists on reproductive issues. The study indicates that decision on reproductive issues is taken by men. This is irrespective of the background characteristics of the couple. Majority of the women would either rely on the advice of their spouses on such issues as using family planning and having another child or engage in joint decision making. We also found out in the course of the study that reproductive decision making still depends on socio-demographic characteristics of the respondents. Men are, however, less likely to report joint decision making than women.

Prior discussion on reproductive matters will definitely put a spouse in position to be categorical on the attitude of his/her partner. Thus, we noticed that most of the couples in South Western Nigeria eat together, sleep together in the same room, go out together and confide in each other. Probing further on family relationship and decision

making, we noticed that the pattern of doing things together reduces when it comes to question of pooling resources together. One woman participant in a focus group discussion even said " it is not proper for man and woman to pool resources together, though they may do all other things together". Our findings also show that couples in the area jointly take decision on when to become pregnant and when to avoid pregnancy. This is very encouraging.

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CHAPTER SIX**SOME DETERMINANTS OF FERTILITY PREFERENCE
AMONG COUPLES**

Fertility preference is one of the three major attitudinal elements that constitute the immediate decision content of fertility. Others are values of children and the perceptions of and reactions to regulation methods (Asikpata, 1971). Studies have even shown that family size preferences are strong predictors of future fertility levels. For instance, Coombs (1974) found that women with preferences for large families subsequently had more pregnancies and births than those with preferences for smaller families. Family size preferences reflect the values which society or individuals in society attach to children. Such preferences actually indicate the demand for children.

A line of argument from the literature on fertility determinants is that demand for children is expected to decline when societal changes increase the power of women relative to men (Caldwell, 1983). This argument rests on a sound basis; in most or all societies, the costs of rearing children fall more heavily on females than on males, and thus the optimal number of children to bear from the perspective of a female striving to maximize her reproductive success often should be less than for a male.

Many questions have been raised on both theoretical and methodological issues about the use of stated preferences. Some demographers

and social scientists have argued that the concept of fertility preference is meaningless in developing countries since it lacks validity and reliability (Lighbourne and McDonald, 1982). A major shortcoming as identified by Ezeh (1991) is the limitation of enquiry to total family size and not about the respondent's preferences regarding the gender composition of the family. It is further argued that developing societies are non-numeric and fatalistic on their preferences. Ezeh sees non-numeric desire as an inward desire not to have many children but an outward reluctance to do anything about it. Farooq and Adeokun (1976) explain that respondents give non-numeric responses "to avoid direct confrontation with an issue that is beyond their control".

Fertility preference as a subject is conceptualised in a variety of ways. These include ideal family size, desired family size, preferred family size, intended family size, expected family size and sex preference. In practice, surveys have varied widely in the wording of questions used to measure these concepts.

Stated fertility preference, although undoubtedly flawed by theoretical and methodological problems, are the best available indicators of actual and desired family size. Therefore, arising from the nature of the available data, the measures of fertility preference used in this study are the actual and desired family size. The data was collected based on responses to the questions "if you could choose exactly the number of children to have in your lifetime, how

many would that be" and "if you could go back to the time you did not have any children and could choose exactly the number of children to have, how many would that be?". These questions aim at estimating the total number of children these respondents hope to have in future and how many children they already have.

Although fertility preference measures have been controversial, the importance of studying family size preferences derives from the fact that these preferences are potentially very important in shaping the fertility of the society. Information on reproductive attitudes and motivation may be helpful in understanding the factors that affect fertility. This chapter, therefore, discusses the fertility preference of the respondents. The chapter provides insights into the number of children the respondents interviewed consider desirable for themselves. It aims at examining the relationship between fertility preference and some selected background characteristics. Attempts were equally made to examine their fertility history and behaviour and value placed on children.

6.1 FERTILITY HISTORY AND BEHAVIOUR

The analysis as presented in Table 6.1 tells a lot about the demographic pattern among the Yorubas of South Western Nigeria and this tallies with the results obtained elsewhere. The table presents the fertility history, behaviour and preferences of men and women in the region.

Table 6.1 Distribution of Respondents by their reported fertility history and behaviour

Fertility History and Behaviour	Men (N=487)	Women (N=618)
Number of pregnancies ever had		
1	12.4	13.1
2	14.3	13.8
3	12.7	12.1
4+	60.6	61.0
Total	100.0	100.0
Mean number of children dead	1.7	1.9
Number of children had in mind to have		
1	0.0	0.0
2	4.6	1.1
3	32.1	18.6
4+	63.3	80.3
Total	100.0	100.0
% Currently Pregnant	12.7	11.9
Wanted to be pregnant or wife is pregnant	71.8	81.2

Note:- The data set is confined to respondents who respond to questions on fertility history and behaviour

From the above table there is not much difference between the men and women fertility behaviours. More than half of the couples have had 4 children, and also 12 percent reported a current pregnancy. It can also be found from the table that 29.2 percent of men and 18.8 percent of women respectively did

not want the pregnancy when they had it. Most of the respondents reported that when they got married, they had in mind to have an average of 4 children. It is not therefore surprising that the reported average number of children ever born is about 4 children. The respondents' desires were actually translated into action. The minor difference noticeable may be attributed to lack of use of modern fertility regulation methods. This problem is also clearly illustrated by the fact that about one out of every five couples in the sample reported that their last pregnancy was unwanted. This is the problem of unmet need of family planning. The fact that the couples' reported fertility preferences matched with the actual performance may be a result of couples communication on the timing and avoidance of pregnancy.

6.2 FERTILITY PREFERENCE ACCORDING TO RESPONDENTS' DEMOGRAPHIC AND SOCIO-ECONOMIC VARIABLES

6.2.1 Respondent's Age and Fertility Preference

Age has been identified as the single most important source of variation in fertility preference. Some studies on female fertility have even found that as women get older, their stated fertility preference increases (United Nations, 1995).

Table 6.2 shows the mean number of children desired by age of the respondents. We observed from the table that there is positive correlation

between age and the mean number of children desired. These means range from 2.4 children in the youngest group to the highest of 5.6 in the age group 45 years and above. From the table, one can conclude that the earlier findings among women, indicating that fertility preference increases with age is also hold for both men and women respondents in the area. Some reasons may be adduced for pattern observed among women. One of such reasons may be the changing reproductive norms. The preference for higher number of children by older women may be a reflection of traditional reproductive norms which is now given way among younger women. If the desired family size is translated into actual performance, the smaller mean desired number of children by the younger respondents might lead to a decline in future fertility if appropriate fertility regulatory methods are adopted.

Table 6.2: Mean Number of Children Desired by Age of Respondents

Age	Mean Desired Family Size	
	Male	Female
15 - 24	2.1 (7)	2.7 (60)
25 - 34	3.2 (100)	2.9 (296)
35 - 44	4.2 (191)	3.4 (133)
45+	5.6 (175)	4.1 (14)
Total	3.7 (473)	3.6 (502)

Note:- The data set is confined to respondents who respond to questions on desired family size

6.2.2 Level of Education and Fertility Preference

Education has been identified as an important factor influencing taste and ideals. Many studies have shown negative correlation between level of education and family size. For instance, Cochrane (1979) observed that education reduces preference for large family size by changing traditional values attached to 'quantity' of children and raises awareness of the alternative sources of satisfaction. Educated men generally prefer to have smaller families in part because they are more likely to have views and lifestyles that are consistent with low fertility and higher quality of child care, and their perceived cost of child upbringing is higher.

The variation in desired mean family size of different levels of education is presented in Table 6.3 It can be observed from the table that for

both men and women, the desired family size decreases as the level of education increases. For both men and women, respondents with no education have the highest mean number of children desired of 5.7 and 5.5 children respectively. They are followed by respondents with primary education with a mean of 4.2 and 4.7 children for men and women respectively. Respondents with the highest level of education have the lowest mean desired family size. Thus the hypothesis that education is inversely related to fertility preference has been confirmed in the study. That education allows for the adoption of new ideas and values about optimal family size is no longer in doubt. Where couples are educated, they are more likely to communicate about matters concerning fertility and family size goals.

Table 6.3: Mean Number of Children Desired by Educational Attainment

Educational Attainment	Mean Desired Family Size	
	Male	Female
None	5.7 (32)	5.5 (94)
Primary	4.2 (53)	4.7 (84)
Secondary	3.6 (273)	3.3 (230)
Tertiary	2.8 (95)	2.1 (84)
Other	3.5 (20)	3.9 (10)
Total	3.7 (473)	3.6 (502)

Note:- The data set is confined to respondents who respond to questions on desired family size

6.2.3 Types of Place of Residence and Fertility Preference

Fertility preference can be affected by the socio-cultural environment in which the individual lives. The environment helps to modify or reinforce behavioural patterns. People living in rural areas are more likely to stick to traditional African norms which favour large family size, unlike their counterparts in the urban areas who favour smaller family size. Urban environment places emphasis on achieved status rather than ascribed position that affects people's perception about life. Among the reasons proffered for this enforced small family sizes in the urban areas include: the influence of mass media, higher levels of interspousal communication, the degree of

education of urban respondents and their consequent engagement in wage labour and lack of or inadequacy of essential housing accommodation arising from urban congestion etc. as well as some other socio-economic reasons. On the contrary and until very recently, the rural area is associated with the need for more children to assist on the farms and domestic chores and therefore may not see large family size as a burden.

The mean desired number of children by place of residence is presented in Table 6.4. The table indicates that for both men and women, the mean desired family size is higher for rural residents than for urban dwellers. The finding confirms earlier studies on this matter and has serious implication on fertility transition.

Table 6.4: Mean Number of Children Desired by Respondent's Place of Residence

Residency	Mean Desired Family Size	
	Male	Female
Urban	2.1 (284)	2.8 (265)
Rural	4.8 (189)	4.3 (237)
Total	3.7 (473)	3.6 (502)

Note:- The data set is confined to respondents who respond to questions on desired family size

6.2.4 Religion and Fertility Preference

Religion is known to influence the type of marriage, age at first marriage, marital stability and fertility behaviour. For instance, while some religious doctrines (e.g. Islam) encourage polygyny and large families, others (e.g. Christian doctrine) discourage it. In view of the fact that these socio-cultural traits are closely related to fertility, it would be expected that religion will be an explanatory variable for fertility preference. Caldwell (1968) and Ohadike (1968) affirmed that once socio-economic characteristics had been controlled, the religious differential in fertility disappears or reduces. Dow and Benjamin's study in Sierra-Leone shows that the Muslims are more pronatalist than the Christians.

Table 6.5 shows the distribution of the mean number of children desired by religion. In this study, the mean desired number of children by both the Protestant and Catholic members stood at 2.9 children while that of Muslims is 4.8 children. The table reveals that Christians comprising Catholics, Protestants and Pentecostal desire significantly smaller family size than Muslims and other religious groups. This finding is in consonance with other studies. For instance, Campbell (1989) observed among men in Western area of Sierra Leone where Muslims were found to desire larger number of children than their Christian counterparts. This is also in consonance with expected societal norms. For instance, Islamic religion encourages polygyny

and large family size. Also, traditional religion adherents are like to hold on to traditional norms on fertility which is basically pronatalist oriented, thus desiring more children.

Table 6.5: Mean Number of Children Desired by Respondent's Religion

Religion	Mean Desired Family Size	
	Male	Female
Catholic	3.2 (84)	2.5 (65)
Protestant	2.7 (85)	3.1 (93)
Other Christian	3.1 (189)	3.6 (251)
Islam	5.4 (105)	4.2 (84)
Other	4.2 (10)	3.8 (10)
Total	3.7 (473)	3.6 (502)

Note:- The data set is confined to respondents who respond to questions on desired family size

6.2.5 Occupation and Fertility Preference

Table 6.6 shows the mean number of children desired by respondents' occupational categories. It has been hypothesized that women whose occupation requires them to move away from home usually desire smaller families than those whose work is closely tied to the home. It is observed in females that certain jobs and careers such as found in the formal sector are incompatible with childbearing and therefore women in these jobs and careers

tend to have fewer number of children. Again some occupations require larger periods of training. This may consequently contribute to a desire for smaller family size. A trend similar to that of women have been found among men in the study area.

Table 6.6 shows that the professionals and those in civil service have lower mean desired family size with the lowest mean of 2.9 children among civil servants and 3.1 children among the professionals. On the other hand, respondents in agriculture and trade desire relatively larger family size. This finding, thus, corroborates the view that occupations in the informal sector such as sales, conveniently accommodate childbearing. On the other hand, the high mean desired children for respondents in farming may be attributed to an effort to raise enough labour force to work in the household and on the farm (Caldwell, 1976).

Table 6.6: Mean Number of Children Desired by Respondents' Occupation

Occupation	Mean Desired Family Size	
	Male	Female
Farming	5.7 (88)	5.2 (117)
Trading	4.2 (163)	3.9 (209)
Public/Civil Servant	3.1 (101)	2.6 (58)
Professional	2.8 (45)	2.5 (27)
Artisan	3.7 (56)	3.8 (43)
Other	3.5 (20)	3.4 (48)
Total	3.7 (473)	3.6 (502)

Note:- The data set is confined to respondents who respond to questions on desired family size

6.2.6 Type of Marriage and Fertility Preference

Findings on the influence of polygyny on marital fertility remains inconclusive. Whereas some studies have found a positive correlation between polygyny and actual family size (Isiugo-Abanihe, 1994), others have found a negative correlation (Ukaegbu, 1978).

Table 6.7 shows the mean desired family size by type of marriage. From the table, it is observed that there is a higher preference for large family size among respondents who are polygynous. The indices of mean desired number of children for polygynous men and women are 4.8 children and 4.4 children compared with 3.2 children and 3.6 children for monogamous men

and women respectively. The difference might be as a result of competition for number of children among co-wives. Also, it may be that men who desire large family size would achieve their aim by marrying more than one wife. Again, marital disruption is higher in polygynous than in monogamous marriages. Therefore, women in polygynous marriages may consider large family size as ideal to ensure security against possible marital dissolution.

Table 6.7: Mean Number of Children Desired by Type of Marriage

Type of Marriage	Mean Desired Family Size	
	Male	Female
Monogamy	3.2 (366)	3.6 (337)
Polygyny	4.8 (107)	4.4 (165)
Total	3.7 (473)	3.6 (502)

Note:- The data set is confined to respondents who respond to questions on desired family size

6.2.7 Number of Living Children and Fertility Preference

The number of living children is claimed to be an important factor influencing fertility preference. Table 6.8 shows the mean desired number of children by number of surviving children. The table shows that the mean number of children desired increases with increasing number of living children. It is observed from the table that respondents with fewer

children desire smaller families than those with many children. This could be due to some reasons. Respondents with fewer surviving children are more likely to be younger and more educated. They may hold relatively new views about reproductive norms, more probably a shift towards smaller family sizes as against those with more surviving children who may be exhibiting the traditional norms of reproduction. Older men and women may be adjusting their fertility preference upwards to be in consonance with their growing family size. In other words, they may tend to rationalise their family size to avoid implying that some of their children are unwanted.

Table 6.8: Mean Number of Children Desired by Number of Living Children

Number of Living Children	Mean Desired Family Size	
	Male	Female
0	2.6 (6)	2.8 (10)
1	3.7 (43)	3.4 (62)
2	4.3 (69)	4.2 (49)
3	4.9 (99)	4.5 (106)
4	4.6 (197)	4.6 (177)
5+	4.9 (59)	4.8 (98)
Total	3.7 (473)	3.6 (502)

Note:- The data set is confined to respondents who respond to questions on desired family size

6.3 PREFERENCE FOR SONS AND DAUGHTERS

The desire to have or not to have children depends not only on the age and actual family size but also on the sex composition of the children a person has already produced.

There is preference for sons both for economic and cultural reasons. For instance, in many developing countries, sons are their parents' only source of security in old age. Particularly where women have little economic independence or cannot inherit property, sons are insurance for a mother against the loss of her husband's support due to death or desertion (Cain, 1984; Ram, 1992). Where women have few opportunities to earn income, investing household resources in female children, who will marry and leave the family, is likely to have little pay-off, and so poor families tend to invest what little they have on sons (Kishor, 1991; Lloyd and Gage-Brandon, 1993). Male children are expected to make financial contributions towards keeping their parent's farm or business going, towards building new houses, paying younger siblings' school fees, taxes, levies etc. Male children perpetuate the family name by marrying and raising children. They inherit the family's property after the death of their parents (Orubuloye, 1983, 1987). Also in many countries, kinship systems, traditional, and religion value males over females.

We can conclude from the results of our study (see Table 3.18) that there is still much higher desire for male child than female in Nigeria. The

preference is partly borne out of the fact that culturally, Nigerians would prefer to pass on their inheritance and the family names or titles to their sons rather than to their daughters. Traditionally, male child gives more prestige to parents. As can be deduced from the focus group discussion, it is generally held that if the first child of the newly married wife is a boy, she always has a special place in husband's heart. Male children are needed particularly to carry on family name, they are a source of prestige and equally as security against old age.

SUMMARY

It should be appreciated that fertility preference proves an important motivation for acceptance of family planning and contraceptive use as well as influencing couples decision making on other reproductive issues.

Among the variables considered in this chapter, educational attainment of respondents was found to be the most important variable affecting fertility preference. This is because differentials in respondent's level of education were the most consistent variable to emerge in the analysis. There was a marked difference between fertility preferences of respondents with no education relative to those with higher levels of education. While respondents with no education desired the largest size of 5.6 children, their counterparts with secondary education and post-secondary education reported mean desired

family size of 3.5 and 2.5 children respectively.

Fertility preference was also found to be closely related to some other selected demographic and socioeconomic variables. For instance, fertility preference tends to be closely related to respondent's occupational status. The professionals and civil servants have preference for smaller family size compared with their counterparts in farming and trading. This may be due to the labour requirements of their jobs.

Another variable found to have effect on fertility preference is the number of living children a couple has. In this study, we observed that the mean number of children desired increases with increase in the number of living children.

Fertility preference was found to differ considerably by place of residence. The desired family size among rural dwellers exceeded those of urban residents. Respondents in urban areas desired 2.5 children while those in the rural areas have a mean desired family size of 4.6 children. Distribution of respondents by religion indicates that Christians desired relatively smaller family size compared to that of Muslims and other religions. Generally, the study is a pointer to the fact that respondents with high socio-economic status have preference for smaller family size unlike those with low status.

The study showed that respondents in South Western part of Nigeria still have preference for high number of male children. So also, their opinion

about number of children they wish to get varies according to demographic and socio-economic background of the respondents. Respondents with high socio-economic status expressed opinion on number of children they hope to get unlike those with low socio-economic status who were not prepared to divulge such information. Also, we observed that irrespective of socio-demographic background of the respondents, males generally desire higher family size than their female counterparts.

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CHAPTER SEVEN.**FERTILITY PREFERENCE AND FAMILY PLANNING****7.1 Ideal Family Size**

As shown in Table 7.1, close to three out of every ten respondents considered 3 or 4 children as ideal compared to 54.7 percent and 72.7 percent of the husbands and wives respectively who considered 3 or 4 children as ideal in Olusanya's study (Olusanya, 1967). In another study, Olusanya (1969) found that 11.9 percent women in Ife and 11.7 percent women in Oyo thought that 3 or 4 children were ideal. Ohadike's study of married women of some sections in Lagos (1968) showed that only a small percentage (10 percent) would go for 3 or 4 children as their ideal family size. Okediji (1969) found that 56.47 percent of the wives with University education and professional status would want a mean ideal children of 3.6. Caldwell (1968) also found among the Ghana new urban elites that 31 percent of the male and 30 percent of the female respondents preferred four children as ideal while only two percent of the males preferred two children as ideal. One can cautiously draw a conclusion from this few comparative data that the respondents in the study area could therefore be said to represent a generation in transition because of their preference for a smaller family size than the respondents in most of other studies.

However, there are few methodological problems that we must bear in

mind when making comparison between this study and other studies. For instance, some of the earlier studies were to a certain extent limited to women population, usually married and mothers of children whereas the major thrust of this study are men of reproductive age and their wives.

A significant proportion of the various socio-economic groups indicate an ideal family size of four or less which in the light of the actual fertility levels in the society must be seen as a marked departure from the norm. As observed earlier, more than seventy percent of the respondents have a minimum of secondary education. It is, therefore, relevant to note in Table 7.2 that more than fifty percent of the men with either secondary or higher education idealize three or four children. It may, consequently, be summarised that with education, respondents bring other consideration into determining ideal family size apart from the culturally determined response to many children as an asset and that many children give assurance of continuity of the family name (Olusanya, 1969). It may be that educated men and to a lesser degree, urban residents, leaving the subsistence economy are from experience feeling their way to a cost-benefit look at the value of children. It is apparent from Tables 7.1 and 7.2 that the ideal family size for respondents in the area was substantially smaller compared with other studies made in Nigeria and some African countries. It is particularly encouraging to note that a high proportion of all the respondents would go for the small family size of between

1 and 4 children. This is a significant mechanism for the control of future Nigerian population.

Table 7.1: Percentage distribution of respondents by sex and according to ideal family size

Ideal Family Size	Male (N=473)	Female (N=502)	Total (N=975)
1 - 2	4.6	1.1	2.9
3 - 4	32.1	28.3	30.2
5+	29.7	35.7	32.7
Don't know	33.6	34.9	34.3
Total	100.0	100.0	100.0

Note: The variation from the expected sample size is due to the exclusion of non-response for questions to this variable- Ideal Family Size

Table 7.2: Percentage distribution of men according to ideal family size educational attainment

Ideal Family size	Educational Attainment				
	None (N=47)	Primary (N=59)	Secondary (N=283)	Tertiary (N=82)	Total (N=473)
1 - 2	0.6	0.9	2.5	10.3	4.6
3 - 4	35.4	38.3	44.2	37.5	36.8
5+	28.7	19.6	16.4	13.7	20.7
Don't know	36.3	41.2	36.9	38.5	37.9
Total	100.0	100.0	100.0	100.0	100.0

Note: The variation from the expected sample size is due to the exclusion of non-response for questions to this variable

7.2 Desired Family Size

It could be observed from Table 7.2 that more than three out of five respondents desired to have between three and four children. The mean desired family size is 3.7. Only 8.2 percent of the sampled population desired 1-2 children, while 24.5 percent would prefer a minimum of five children. More males (26.1 percent) than females (23.1 percent) preferred 5 or more children indicating that men want larger family size than the women in the area. Various studies (Oppong, 1985, Olusanya, 1969) have shown that African men value and cherish children for economic and social reasons. Children are assets to their parents because they would be helping them on the farm and because of the absence of social security scheme in the continent, men tend to have preference for larger number of children so that when they are old, the children would be fending for them.

However, the concentration of respondents preferring less than four children in the area may be due to the prevailing poor economic situation of the country in which people now consider their financial capability before they start bearing children or having an additional one. Since ideal desired family size is measured in terms of the children ever born and the number of children still desire, the preference for four children or less does not mean that most of the respondents may have four children because some of them are still in the process of childbearing.

Table 7.3: Percentage distribution of respondents by sex and according to number of children wanted at first marriage

Desired Family Size	Male (N=473)	Female (N=502)	Total (N=975)
1-2	4.3	11.5	8.2
3-4	69.6	65.4	67.3
5+	26.1	23.1	24.5
Total	100.0	100.0	100.0

Note: The variation from the expected sample size is due to the exclusion of non-response for questions to this variable- Desired Family Size

7.3 Children Ever Born

Children ever born is an important demographic factor that can influence the use of contraceptives and the level of discussion between spouses. The expectation is that couples with greater number of children are more likely to use contraceptives and are likely to take decisive decision on family size and contraceptive use.

Table 7.4 shows that males generally prefer higher number of children than females. The proportion having 3 or 4 children were respectively 37.5 percent and 32.1 percent among male and female respondents respectively; while those having 5 or more children were 36.3 percent and 30.6 percent among male and female respondents respectively. It can therefore be deduced from the table that fertility is higher among male respondents than among

females. This may be because men tend to report the number of children from all their wives while a woman would only report the number of children she has.

Table 7.4: Percentage distribution of respondents according to children ever born and sex

Children Ever born	Male (N=473)	Female (N=502)	Total (N=975)
1 - 2	31.2	36.3	34.7
3 - 4	37.5	32.1	35.7
5+	36.3	30.6	29.6
Total	100.0	100.0	100.0

Note: The variation from the expected sample size is due to the exclusion of non-response for questions to this variable- Children Ever Born

7.4 Want More Children

Yoruba culture puts a premium on having many children, for both financial and economic reasons. From the financial point of view, parents expect to receive, on the balance, more benefits from children compared with the costs of children raising. Child-raising costs to parents are usually minimised because of assistance from the extended family, the practice of child-fostering, and strong social obligations to relatives (World Bank, 1986). Two other factors, namely the large population in the child-bearing ages along with the practice of early and almost universal marriage patterns, have

contributed to high fertility among the Yorubas.

Table 7.5 shows the percentage distribution of respondents according to whether they want more children or not. About fifty-three percent of the men and forty-one percent of women answered affirmatively. This position was confirmed in the focus group discussion where most respondents indicated that men naturally want more children, since they can marry as many women as they want. Some men also posited that having more children boosts a man's ego more than a woman's.

Table 7.5: Percentage distribution of respondents by family size decision and sex

Want more children	Male (N=488)	Female (N=579)	Total (N=1067)
Yes	52.6	40.8	44.8
No	47.4	59.2	52.9
Total	100.0	100.0	100.0

Note: The variation from the expected sample size is due to the exclusion of non-response for questions to this variable- Children Ever Born

7.5 Additional Children Desired

With respect to additional children wanted by the respondents, over half of the men were not sure, leaving the decision 'up to God'. This is a frequent occurrence in developing country situations (Caldwell, 1982) where external

locus of control (Simons, 1990) may be prominent in explaining the outcome of family size, especially among the uneducated. Table 7.6 shows that the few who gave actual figures, however, expressed a desire for small family sizes of between 1-4, a departure from the previous pattern of high ideal family sizes reported by males in 1971 (Adeokun, 1979) and which may be attributed to a combination of current economic realities and general improvement in educational levels of the populace and other modernization factors.

Table 7.6: Percentage distribution of respondents by sex and additional children desire

Additional Children desire	Male (N=257)	Female (N=236)	Total (N=493)
1-2	45.7	48.6	47.1
3-4	24.1	32.5	28.3
5+	30.0	18.9	24.6
Total	100.0	100.0	100.0

Note: *The data in Table 3.15 are confined to respondents who desire additional children*

7.6 Reason for wanting more children

There remains a variety of both economic and non-economic reasons why couples still want children even if in limited numbers. Among the most important reasons is the persistence of expectations of help from children, especially in the form of providing comfort and support during the parents' old

ages. However, focus group discussions show that many participants viewed a reduction in the amount of support they received as the inevitable price for avoiding the hardship of raising many children. Others, however, believed that a simple association between number of children and economic support later in life no longer holds. Some even felt that there was more to be gained from having a few better educated children than from many less educated ones.

Table 7.7 shows the percentage distribution of respondents by the reasons for wanting more children. Majority of the respondents (66.1 percent) claimed that 'they don't have enough children yet' and that accounted for their desire to have more children. A significant proportion of males (14.3 percent) and of females (15.7 percent) were still looking for a son or daughter; hence their desire for more children. Helping family income was reported by 9.5 percent of males and 5.2 percent of females; while just 0.7 percent of males adduced the reason for more children to husband recommendation; more than 2 percent of female respondents said their desire for more children was their husband decision.

Responses of the respondents with regard to benefits of having more children, included expectations in terms of financial (68.4 percent and 59.3 for male and female respondents respectively) and moral support (20.8 percent and 23.1 percent for male and female respondents respectively), especially from working children and to some extent from children 18 years and above.

On the basis of responses obtained on the perceived advantages of having many or few children, two broad categories of motives were identified. These are positive motives otherwise referred to as benefits and negative motives which refer to the costs of rearing children. These countervailing motivations reflect the multiplicity of meanings attached to childbearing by the respondents. Most of the motives are definitely parent-oriented and border on calculated self-interest. Other motives are normatively regulated.

The actual reproductive pattern which in this case favours having a family size of between 1 and 4 children tends to suggest that, to a large extent, children are today visualised as a burden. Unlike before, when the extended family system "reduces the housewife's burden and household's cost of rearing children" (Ketkar, 1979), the situation has changed. Much of the burden which is absorbed through the process of family symbiosis whereby adult siblings and other relations share in the upbringing of the younger children in the family, is now the responsibilities of individual parents.

Table 7.7: Percentage distribution of respondents by sex and according to reason for desiring more children

Reason for more children	Male (N=339)	Female (N=468)	Total (N=807)
Don't have enough	64.9	67.3	66.1
Have no son/daughter	14.3	15.7	15.0
Custom/Religion	3.7	4.1	3.5
Husband recommended	0.7	2.1	1.4
Help family income	9.5	5.2	7.4
Others	6.9	5.6	6.3
Total	100.0	100.0	100.0
Obligation of working children to parents			
Financial Support	68.4	69.3	63.8
Moral Support	20.8	28.1	26.9
Other	10.8	2.6	9.3
Total	100.0	100.0	100.0

Note: The data set is confined to respondents who express desire for more children and reasons for more children

7.7 Reason for preferring son or daughter

A section of the questionnaire was devoted to asking questions on the subject of value of children. Table 7.7 shows that 52 percent of men and 54.7 percent of the women respondents want to have more children.

It is imperative to consider respondents' preference for sons or

daughters so that we can understand how this preference for a particular sex influences respondents' decisions. Table 7.8 shows a comparison between preference for sons and daughters. About twenty-three percent and twenty-seven percent of males and females respectively have preference for daughters so as to have somebody to look after them later in life. Many of the respondents believed that sons are the pillars of the family hence the preference for son by 36.8 percent males and 39.6 percent females. Whereas both males and females respondents have preference for son for continuity of the family name/lineage, we observed that more males (18.4 percent) than females (15.5 percent) express their preference for this reason. A significantly higher proportion of females (14.2 percent) still believe that sons would take better care of them when they are old than daughters. Among other reasons posited for preference for either son or daughter was security at old age. A significant proportion of both males (28.9 percent) and females (27.1 percent) have preference for daughters to assist in business while sons are still regarded by a number of respondents as source of security.

Table 7.8: Percentage distribution of respondents by sex and according to reason for preferring son

Reason for preferring son or daughter	Preference for son		Preference for daughter	
	Male (N=337)	Female (N=422)	Male (N=411)	Female (N=520)
Continuity of the family name/linage	18.4	15.5	13.2	10.4
To look after the parent	2.6	14.2	23.2	27.5
They are the pillars of the family	36.8	39.6	7.9	12.5
For security	15.8	18.8	15.5	10.4
To assist on the farm	21.1	7.8	6.1	7.9
To assist in business	5.3	2.1	28.9	27.1
Others	-	2.1	5.3	4.2
Total	100.0	100.0	100.0	100.0

Note: The data are confined to respondents who express preference for either a son or a daughter

7.8 Value placed on children: men's response

There is currently a growing body of data from different parts of the world to indicate that fertility declines do not simply follow changes in such indexes of modernization as literacy, women's work or female autonomy, but that macro-level socio-economic changes affect different sectors of the population of a given community in different ways and fertility declines occur according to changes in the value of children within the context of class specific family economies and costs (Oppong, 1985; Greenhalgh, 1990,

Mhloyi, 1991). Reproductive behaviour is largely a response to the underlying preferences of parents for children.

A section of the questionnaire was devoted to asking questions on the subject of value of children. Table 7.9 shows that in spite of the reduced desire for large family sizes, there is still clear evidence of a high value placed on children by the men. Asked what a husband should do if the wife has no child, 48.5 percent thought he should remarry, 13 percent thought he should send the woman away. The desire for children is still so deep rooted that in the opinion of the men, childlessness would be negatively viewed by the community; a childless woman, in their opinion, could incur social neglect (24.3 percent), be despised (32.8 percent), or have no respect in the community (17.7 percent). Responses of the men concerning the good things about having children were security at old age, perpetuation of family name and other cultural values. Son preference was still slightly evident. The most popular reasons for having a son was to be able to carry on the family name followed by enhanced social status. The popular reason among the men for having a daughter, on the other hand, was to be able to help in the household chores (59.3 percent). Men's attitude to women without a child include despise (32.8) and social neglect (24.3). Many of them believed that a woman without children would command no respect in the society. This position was also reflected in focus group discussions by both with men and women.

Table 7.9: Percentage distribution of men by value placed on children

Value Placed on Children	Male (N=585)
What husband should do if wife has no children	
Remarry	48.5
Send the woman away	13.1
Keep on looking for one	23.5
Other	14.9
Attitude of community to a woman without a child	
Social Neglect	24.3
Despised	32.8
No respect	17.7
Other	25.1
Total	100.0

Note: *Excluding non-responses*

7.9 Attitude to family planning

Many men appear ready to change their reproductive behaviour and are willing to participate more in reproductive health activities. However, some, for certain reasons may oppose such participation.

Respondents were asked if they 'approve' or 'disapprove' the statement that many couples do something to delay or prevent a pregnancy so that they can have just the number of children that they want and have them when they want them. About 63 percent of men compared to just 35.7 percent of women

would give consent to the use of family planning. This is in spite of the claim by most of the respondents that they discuss family planning issues. At least 50 percent of women and 38.1 percent of men indicated that they had discussed family planning matters with their spouses on three or more occasions. About 36 percent of the respondents gave an indication that their spouse would not stop them from using family planning methods (37.3 percent male as against 35.5 females). Table 7.10 further shows that more than 30 percent of the respondents had ever discussed family planning matters with other persons aside from their spouses.

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Table 7.10: Percentage distribution of respondents by sex and attitude to family planning

Attitude	Male (N=521)	Female (N=647)	Total (N=1168)
(a) Approval of family planning			
Approved	62.7	35.7	50.5
Disapprove	7.8	26.2	16.1
Don't know	29.5	38.1	33.3
Total	100.0	100.0	100.0
(b) How often do you talk about family planning?			
Once	17.3	33.3	24.5
Twice	32.7	28.6	30.9
Three/More	38.1	50.0	44.7
Total	100.0	100.0	100.0
(c) Does your partner agreed with you using family planning?			
Yes	37.3	35.5	36.3
No	62.7	64.5	62.6
Total	100.0	100.0	100.0
(d) Ever discussed with any other person aside from spouse			
Yes	31.3	34.2	32.6
No	68.7	65.8	67.4
Total	100.0	100.0	100.0

7.10 Reason for approval of family planning

Table 7.10 shows the percentage distribution of respondents according to reasons for using family planning methods. The most frequently mentioned reason for approval of family planning is that it is good for the health of both the mother and child. Nearly half of the respondents who gave reasons for approval of family planning methods included the mother's health factor. The second most frequent reason, given for approval, is that family planning is good for childbearing stoppage (32.1 percent). About 18 percent said family planning is a useful tool for spacing birth.

Table 7.11: Percentage distribution of respondents by reason for using a method

Reason	Male (N=169)	Female (N=221)	Total N=390)
Space births	35.7	27.6	32.1
Stop children	16.7	19.7	18.2
Health mother and child	42.8	47.4	44.8
Others	4.8	5.3	5.0
Total	100.0	100.0	100.0

Note: The data set is confined to respondents who give reason for approval of family planning methods

7.11 Reason for not using family planning method

Table 7.12 shows the distribution of respondents according to reasons for disapproval of family planning. The extent of disapproval of family planning mirrors that of approval of family planning. Among the most common reasons given for disapproval are "wants of children (29.2 percent)", "side effect (26.0 percent)", Health concerns (11.5 percent)" etc.

Table 7.12: Percentage distribution of respondents by sex and according to reason for not using method and sex

Reason for not using method	Male (N=341)	Female (N=437)	Total (N=776)
Wants children	31.0	27.8	29.2
Lack of knowledge	2.4	5.6	4.2
Cost too much	2.4	9.3	6.3
Side effect	23.8	27.8	26.0
Health concerns	19.0	5.6	11.5
Hard to get methods	2.4	3.7	3.1
Religion	19.0	11.1	14.6
Partner opposed to family planning	7.1	9.3	8.3
Others	4.0	-	2.1
Total	100.0	100.0	100.0

Note: The data are confined to respondents who disapprove family planning

7.12 Family Planning Information, Education and Counseling

Information on counselling was obtained by asking each respondent to state if he/she had ever been counselled on family planning. The question was informed, among others, by our knowledge of the activities of community based distributors of family planning methods and other groups with respect to the provision of family planning information, education and counseling services in the study area. Table 7.13 shows that with respect to family planning information, education and counseling, the husbands have lower exposure rate. The significant impact of counselling on contraceptive use is worth noting, especially the implications for the participation of men in family planning (Feyisetan and Bamiwuye, 1998). Men are more likely to take part in family planning once the needs for family planning are made clear to them.

Table 7.13: Percentage distribution of respondents by family planning information, education and counselling

Variable	Male	Female	Total
<u>Ever Counseled on Family Planning?</u>			
Yes	38.6	71.2	53.7
No	61.4	28.8	47.3
<u>Counselling Status of Partners:</u>			
Both husband and wife counseled	-	-	31.5
Only one partner counseled	-	-	37.2
No partner counseled	-	-	21.3
Total	100.0	100.0	100.0

Considering desired family size, majority of the respondents have preference for between 3 and 4 children probably owing to economic reasons. For instance, the impact of Structural Adjustment Programme (SAP) has affected the purchasing powers of a large proportion of Nigerians. However, some of the respondents already have higher number of children than they would have preferred. This is evident in the study where we noticed that 29.6 percent of the respondents already have 5 or higher number of children as against 24.5 percent who expressed preference for this family size.

CHAPTER EIGHT**MULTIVARIATE ANALYSIS**

In this chapter, multivariate analyses are employed to examine the interrelationships between male reproductive behaviour, spousal communication and family size. However, before we bring to focus the interrelationships, we first of all showed the relationships between some selected background variables of men and some reproductive issues on the one hand; on the other hand, we also showed the relationships between these background variables and spousal communication. This will enable us to first of all see the relationships between each of these background variables and the two principal independent variables (male reproductive behaviour and spousal communication) before looking at the interrelationships between the independent variables and dependent variable which is family size.

Logistic regression analysis is employed to assess the association between background variables like place of residence, age, partners' education, religion etc. and measures of spousal communication (determined through couples joint decision making) and reproductive behaviour (determined by the use of contraception). Logistic regression models are used to determine the net impact of some selected background variables on the probability that a couple would report joint decision-making and current use of modern methods by man.

The technique of causal modelling is later used to examine both direct and indirect relationships as well as the degree of spuriousness between the two principal independent variables and family size. Three models are presented to examine the net impact and the nature of relationships between these variables.

The first model, referred to as family size model, serves as a basic model to the other two models. This model assumes that actual family size of household is affected and influenced by educational attainment (socioeconomic variable), knowledge of source of contraception (motivational variable), joint decision making (spousal communication) and contraceptive use (reproductive behaviour). The second model referred to as spousal communication model, is specifically designed to see the impact of joint decision making on actual family size. In this model, the effects of age of a man, his educational attainment, knowledge of source of contraception and joint decision making on family size are examined. The third model, being referred to as respondents attribute, tries to see the net impact of some selected socio-demographic variables on family size. This model which serves as supplement to the other models looks at the impact of age, education, age at marriage and occupation on family size.

The recursive path analytic technique examines the causal connections among the variables in the models developed to explain the effects of male

reproductive behaviour and spousal communication on actual family size of a couple.

8.1 Effect of Socio-Demographic Variables on Spousal communication

Spousal communication is strictly defined in terms of joint spousal decision making which is the expected outcome of any meaningful discussion between marital partners. The use of joint decision making is informed by the difficulty in justifying or establishing the existence of husband-wife communication on an issue when only one or none of them claims to have been involved in decision making. Therefore, the definition of joint decision making is adopted in order to avoid ambiguity in the perceptions of what constitutes real husband-wife communication.

To determine the net impact of some selected background variables on the probability that a couple would report joint decision making, we make use of logistic regression model. Joint decision making takes a value of one if both partners reported to be involved in decision making. The estimates are presented as relative odds in Table 8.1. With a value of one for the reference category, a value less than one implies that individuals in that category have a lower probability of reporting joint decision-making than individuals in the reference category. The reverse is the case with a value greater than one.

Table 8.1 shows that at higher levels of education and with little difference in educational attainment, partners appear to feel more relaxed discussing reproductive issues which are traditionally thought to be under the control of men. The table shows that joint education of partners is the only factor that has significant impact on the likelihood that partners would discuss and take joint decisions on most of the reproductive issues. The significance is more pronounced when none of the partners has below secondary education and at least one of them has a post-secondary education. Urban residence is significantly associated with joint decision making on reproductive issues. Findings in the study tend to confirm the traditional practice of according women more recognition and greater participation in decision making process as they grow older. Age of the woman is also significantly associated with participation in decision making. Women in age group 25-34 years are significantly less likely than their older counterparts to take part in decision making on reproductive matters. They partake in decision making only when the issue relates to having another child. Table 8.1 shows that Christians are more likely than Moslems to report joint decision making. This difference between Christians and Moslems tends to reflect the differences in the perceptions of women between the two religious groups; Christianity accords women greater recognition and rights than Islam.

Table 8.1: Logistic Regression of Effects of Joint Decision Making on Reproductive Issues

Background Characteristics	Reproductive Issues		
	When to have a (another) child	Number of children to have	When to stop child bearing
<u>Place of Residence</u>			
Urban	1.522*	1.357*	2.083
Rural (RC)	1.000	1.000	1.000
<u>Age of wife</u>			
15 - 24	0.732	0.427	0.834
25 - 34	0.563	0.755*	0.584
35 & above (RC)	1.000	1.000	1.000
<u>Partners joint education</u>			
Both have primary or no education (RC)	1.000	1.000	1.000
One partner with primary or none, the other with secondary or higher	1.724	1.265	1.057
Both have secondary education	3.722*	2.539*	2.357*
One partner with post-secondary, the other secondary	3.642*	3.712**	4.113**
<u>Husband Religion</u>			
Protestant	3.424	1.773	1.672
Catholic	3.175*	1.825	2.154
Other Christian	3.341*	3.542	2.081
Muslim (RC)	1.000	1.000	1.000
-2 log likelihood	452.335	447.362	481.346
Model Chi-square	65.379	72.105	54.295

**Significant at $p \leq 0.01$; *Significant at $p \leq 0.05$; RC = Reference category

8.2 Effect of Selected Background Variables on Male Contraceptive use

It is recognised that contraceptive use will be more effective in households where both partners reported a common understanding that they are using a method of contraception. However, the emphasis in this study is on male's current use of contraceptives since the primary focus is on male reproductive behaviour.

Contraceptive use takes a value of one if a male partner reported use and zero if otherwise. The result of the logistic regression models are presented as relative odds in Table 8.2. The reference category of each dichotomously measured independent variable has a value of one and the values for other categories are compared to that of the reference category. A value less than one implies that individuals in that category have a lower probability of reporting current use of contraceptives than individuals in the reference category. For continuously measured independent variable, a value less than one implies a decline and a value greater than one, an increase in the likelihood of reporting current use of contraceptives as value of that variable increases.

Education, age, when to stop childbearing and the number of surviving children were found to have significant impact on contraceptive use. The impact of education is particularly pronounced when none of the partners had

below secondary school education. Men with female partners below 25 years of age are also significantly more likely to use or report use of a modern contraceptive. The significant net impact of communication on contraceptive use is worth noting, especially the implications for the participation of men in family planning. The result draws attention to the possibility that men can actually use or support their partners' use of contraceptive if they are given adequate information, education and communication (IEC) on the need and ways to regulate fertility. Thus confirming an earlier study by Feyisetan and Bamiwuye (1998) which recognised the importance of counseling in contraceptive use. Whether partners take joint decision on when to stop childbearing and the number of surviving children have significant positive association with the probability that a man would report current use of a modern method after controlling for other factors.

Table 8.2: Logistic Regression Result of Effect of Current Use of Modern Methods

Background Characteristics	Odds Ratio
<u>Residence</u>	
Urban	1.472
Rural (RC)	1.000
<u>Age</u>	
15 - 24	4.235*
25 - 34	2.562
35 and above (RC)	1.000
<u>Joint education of partners</u>	
Both had primary or below (RC)	1.000
One had primary or below, the other secondary or above	1.265
Both had secondary	3.477*
At least one had post-secondary, the other secondary	4.512**
<u>Desired family size</u>	
Both partners want no more (RC)	1.000
Husband more, wife no more	0.492
Husband no more, wife more	1.564
Both want more	0.519
<u>Religion</u>	
Protestant	0.673
Catholic	0.097*
Other Christian	0.469
Islam	1.000
<u>Joint decision on contraception</u>	
Yes	1.115
No	1.000
<u>Joint decision on number of children</u>	
Yes	3.217
No	1.000
-2 log likelihood	352.172
Model Chi-square	126.616

**Significant at $p \leq 0.01$; *Significant at $p \leq 0.05$;
RC = Reference category

RECURSIVE MODEL

The main aim of this study is to examine the interrelationship between male reproductive behaviour, spousal communication and family size. Such interrelationship can best be described using path analytic procedure. The technique is useful in providing a more satisfactory evaluation in determining the importance of a particular independent variable on a given dependent variable. Unlike the simple regression analysis which only shows the direct effects, the path analytic procedure offers an opportunity to investigate other sources of relationship between the independent variables and the dependent variable. The approach helps in determining whether a proposed set of interpretations is consistent throughout.

The recursive path analytic procedure is, therefore, used to investigate the causal connections among the variables in the models developed to explain the effects of independent variables on dependent variables. As noted earlier in chapter two, path analysis is a procedure for estimating the magnitude of the linkages between variables and using these estimates to provide information about the underlying causal processes. Apart from this, path analysis also provides (i) a means of evaluating the relative importance of an independent variable for explaining a given phenomenon and (ii) a more adequate interpretation of an independent variable's impact since it enables a decomposition of the correlation between any two variables into a sum of

simple and compound paths with some of these paths being substantively meaningful indirect effects and others possibly not. The use of the total effect (direct and indirect effect) in determining the relative importance of the variables is an improvement over beta (β) coefficients (the direct effect) of the regression analysis and the correlation coefficient of the correlation analysis. The effect of male reproductive behaviour on each of spousal communication and family size would be under-estimated if the beta (β) coefficients of the regression analysis should be used only. There is need to examine the indirect effect of variables like education, age etc. which have been missed from the logistic regression analysis. The regression analysis explained above might have even over-estimate the importance of spousal communication as a determinant of family size because of the magnitude of spuriousness. The dependent variable, family size, is assumed to be affected by spousal communication, male reproductive behaviour and some other variables.

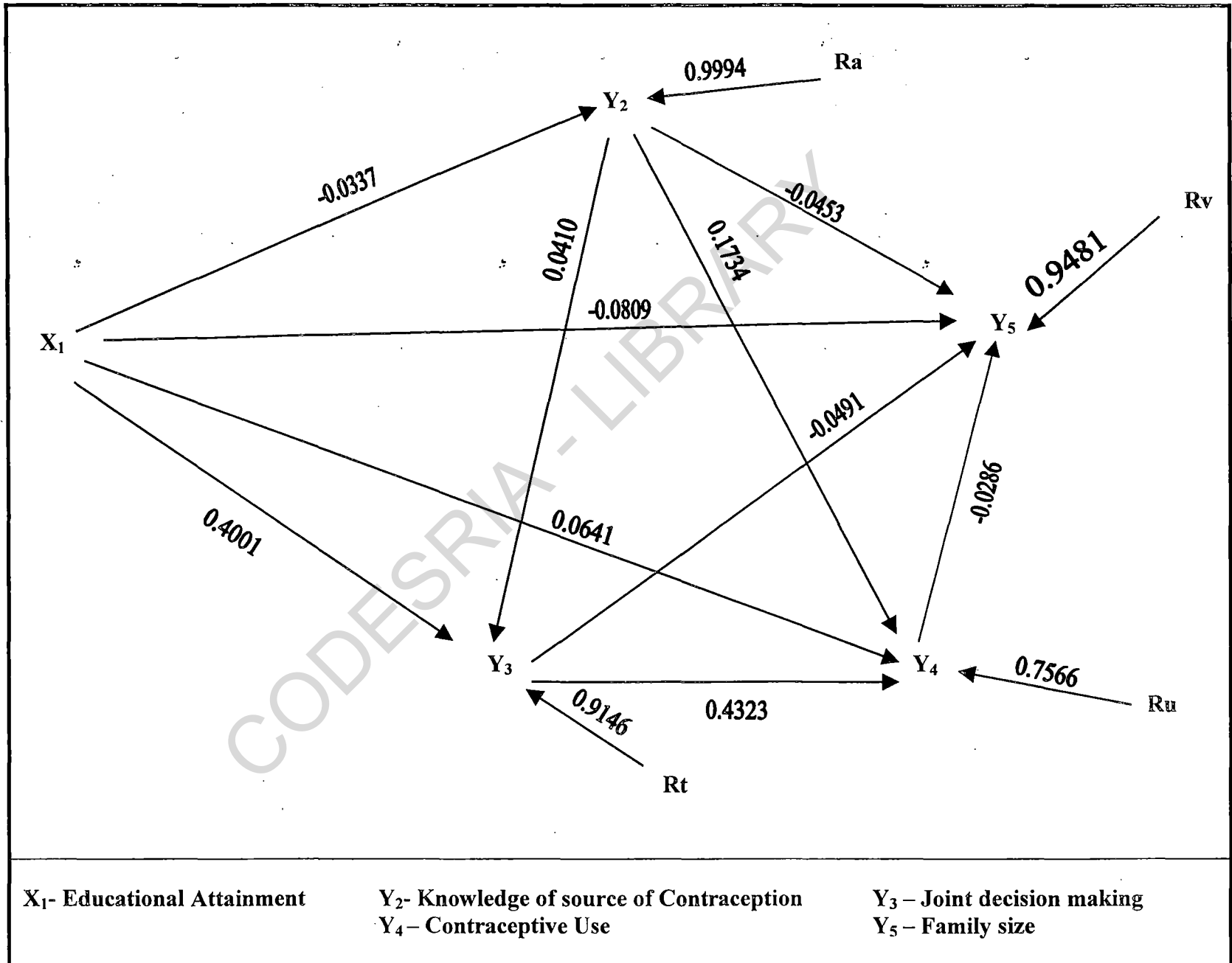


Figure12: Path Diagram Showing Varied Effects of the Independent Variables on the family size

8.3 Model A: Determinants of Family size

In the family size model, the variables - socioeconomic variable (educational attainment), motivational variable (knowledge of source of family planning), spousal communication (joint decision making), and male reproductive behaviour (contraceptive use) denoted as X_1 , Y_2 , Y_3 , and Y_4 respectively are known to influence the choice of ultimate family size (Y_5) by a man (figure 12). The model assumes that desired family size is affected and influenced by some variables. For instance, educational attainments of a man can influence and thus determine the level of knowledge of source of contraception and also influence the level of discussion of family size and family planning among couples. Education is also assumed to have direct influence on contraceptive use and determines the choice of family size of a man. Contraceptive use also have a direct influence on the desired choice of family size of the man etc.

The path diagram in figure 12 shows the system of relationships among the four independent variables and family size. The independent variables are educational attainment of men (X_1), knowledge of source of contraception (Y_2), joint decision making (Y_3), contraceptive use (Y_4), and the dependent variable is family size (Y_5).

As an illustration, family size is assumed to be affected by some variables each of which is affected by some socioeconomic and demographic

variables as shown above. Male reproductive behaviour, represented by contraceptive use is believed to affect family size both directly and indirectly. Also spousal communication is hereby assumed to precede family size since it is believed that discussion about family size, family planning or exchange of information between spouses which are the main reproductive issues in couples joint decision making may lead to changed behaviour as regards family size.

In the model, Y_2 , Y_3 , Y_4 , and Y_5 are all endogenous variables and represent the variables to be explained, whereas, X_1 is already pre-determined outside the model. It stands for variables that are not explained by the model and, more specifically are assumed to be uncorrelated with the error terms in the model. Since the endogenous variables will not be completely determined by variables in the system, there will, therefore be errors in estimating them. Thus, these error terms or otherwise referred to as residuals represent the effect of variables not included in the model. This is denoted as R_i 's in the model. Residual path is merely a convenient representation of the extent to which measured cause in the system fails to account for the variation in the effect variables.

Based on notions of precedence, the relationships between male reproductive behaviour and other variables in the model and family size are expressed mathematically by a system of linear equations. In the model, the

Y's are endogenous (i.e. are determined within the model), representing the variables to be explained. While the exogenous X's (predetermined outside the model) stand for variables that are not explained by the model and more especially are assumed to be uncorrelated with the error terms in the model. It therefore assumed that the endogenous variables will not be completely determined by the variables in the system and so there will be errors in estimating them. Thus, these residual or error terms (denoted by R's) represent the effects of variables not included in the model. Therefore, since only Y variables are to be explained, we have the following set of equations:

$$Y_2 = P_{21}X_1 + P_{2t}R_t$$

$$Y_3 = P_{31}X_1 + P_{32}Y_2 + P_{3u}R_u$$

$$Y_4 = P_{41}X_1 + P_{42}Y_2 + P_{43}Y_3 + P_{4v}R_v$$

$$Y_5 = P_{51}X_1 + P_{52}Y_2 + P_{53}Y_3 + P_{54}Y_4 + P_{5w}R_w$$

where the P's known as path coefficients, are the structural β coefficients for the variables involved. They measure the importance of the direct effects of the independent variables on the dependent variables. The R's are the errors, that is, effects of the variables not included in the model.

Each equation in the system expresses the dependent variable as the linear additive effects of all the preceding variables together with a residual term which may be thought of as the effect of variables not included in the model. Resulting from the assumption that each variable is measured about its

mean, there is no constant term in the equation (Blalock, 1969). The P's, known as path coefficients, are the standardized regression coefficients (beta weights). They measure the importance of the direct effect of the independent variables on the dependent variable. The correlation between the two exogenous variables is given by the simple correlation coefficient.

The above model is mathematically complete as the number of the recursive equations coincides with the number of endogenous variables. Also, each of the equations in the model is exactly identifiable (i.e. solvable) in the sense that numbers of exogenous variables not included is exactly equal to the number of endogenous variables included.

The model is held to be recursive, hence it is subject to the special requirements of a triangular matrix of coefficient (β) and a diagonal matrix of the correlations of the error terms (Σ) (Christ, 1966; Johnson, 1972). In order to determine the conformity of this model to these conditions, revised systems of structural equations in which the residual terms are isolated on one side of the expression are obtained. For instance, the set of equations which defined the family size model are represented in match form, in which the residual terms are isolated on one side of the set of structural equations (Wonnacott and Wonnacott, 1970).

$$X_1 = P_{1a}R_a$$

$$P_{21}X_1 + Y_2 = P_{2t}R_t$$

$$P_{31}X_1 + P_{32}Y_2 + Y_3 = P_{3u}R_u$$

$$P_{41}X_1 + P_{42}Y_2 + P_{43}Y_3 + Y_4 = P_{4v}R_v$$

$$P_{51}X_1 + P_{52}Y_2 + P_{53}Y_3 + P_{54}Y_4 + Y_5 = P_{4w}R_w$$

Thus the matrix of coefficient (β) for these equations consists of the endogenous variables coefficients and is triangular for the equation of this model

$$\begin{array}{ccccc} 1 & 0 & 0 & 0 & 0 \\ P_{21} & 1 & 0 & 0 & 0 \\ P_{31} & P_{32} & 1 & 0 & 0 \\ P_{41} & P_{42} & P_{43} & 1 & 0 \\ P_{51} & P_{52} & P_{53} & P_{54} & 1 \end{array}$$

Also the matrix of the correlations of the error term (Σ) is:

$$\begin{array}{ccccc} \delta_{11} & 0 & 0 & 0 & 0 \\ 0 & \delta_{22} & 0 & 0 & 0 \\ 0 & 0 & \delta_{33} & 0 & 0 \\ 0 & 0 & 0 & \delta_{44} & 0 \\ 0 & 0 & 0 & 0 & \delta_{55} \end{array}$$

Thus, the satisfaction of these conditions by the model implies that every endogenous Y variable is uncorrelated with the error terms in the equations in which it appears as an explanatory variable. As such the use of ordinary least square (OLS) in estimating the parameter of each equation is appropriate since the error term will always be independent of the explanatory endogenous variables.

Decomposition of the relationship between variables in family size model

The relationship existing between the ultimate dependent variable (Y_5) and other independent variables can be decomposed into direct and indirect effects. Duncan (1966) showed how in a recursive model, the easiest and systematic way of sorting out the multiple influences is through the decomposition of the bivariate correlation between the variables. That is by using the instrumental variables technique, rewriting the structural equations for the current dependent variable in a type of reduced form by expressing each of its independent variables in terms of the truly exogenous variables in the system. The total correlations between each independent variable and the dependent variable is, however composed of direct, indirect effects and spuriousness.

Thus

$$r = \text{Direct Effect (DE)} + \text{Indirect Effect (IE)} + \text{Spuriousness (S)}.$$

The relative importance of each factor is determined by the size of its total effect on the dependent variable. Hence, the relationship of the component effects to the correlation coefficient can be stated explicitly in general terms. Since the endogenous variables are not completely determined by the variables in the system, the errors in estimating them are represented by the R_i 's.

As an exposition of how the instrumental variable technique works, an

example of the correlation between the contraceptive use and family size is presented (see Appendix I).

Table 8.3: Decomposition of the Relationship Between the Independent Variables and Family size

Variable	NATURE OF RELATIONSHIP BETWEEN CONTRACEPTIVE USE AND FAMILY SIZE				
	Direct	Indirect	Spurious	Total Effect	Total Correlation
Educational Attainment (X_1)	-0.0809	0.023	-0.0115	-0.0579	-0.0694
Knowledge of source of contraception (Y_2)	-0.0453	-0.0012	-0.0088	-0.0441	-0.0529
Joint decision making (Y_3)	-0.0491	0.0204	-0.0322	-0.0287	-0.0609
Contraceptive use (Y_4)	-0.0286		-0.037	-0.0286	-0.0656

Table 8.3 shows the decomposition of the total correlation coefficients and the total effects of the exogenous variable and endogenous variables Y_2 , Y_3 , and Y_4 on the dependent variable (Y_5) into direct, indirect effects and spurious relationship. The relationship between education and reproductive behaviour as well as spousal communication as observed under the logistic is still upheld. An examination of the total effects shows that education of a man, as the head of the household has significant impact on couples family size. Infact it is the most important factor determining actual family size of a couple. A closer look at the direct and indirect effects reveals that the indirect

effects is higher. Thus indicating that education has significant effect on other variables that determine family size among the Yorubas and which are contained in the model. For instance, we noticed from figure 1 that higher educational attainments affect the desired family size by indirectly affecting decision-making in the household. Education increases the probability of making use of contraceptives which also have depressant effect on actual family size of a couple. It enhances the rate and levels of discussion among couples. Also noticed in the table is a significant spurious effect which gives an indication that education has significant impact on family size decision-making among couples. Figure 12 further shows that education is positively associated with discussion about family planning and contraceptive use which have negative correlation with family size.

The direct impact of reproductive decision making, being negative, indicates that couple's discussion of reproductive issues will have a depressant effect on family size. The result indicates that husbands who engage in joint decision-making tend to have preference for smaller family size than their counterparts who do not. The size of the direct effect compared with the indirect effect and spuriousness gives an indication that the correlation between spousal communication and family size is almost neither dependent upon intervening variables nor a result of the correlation of each of the variables with other variables in the family size model. However, it is shown that joint

decision making about reproductive issues tends to favour the choice of family size and the effect is through decision to use contraceptives.

Knowledge of source of contraception has a depressant effect on the actual family size. Worth mentioning is the strong positive association between knowledge of source of contraception and contraceptive use. This is expected since a knowledge of where to obtain contraceptives coupled with availability of contraceptive devices will surely encourage its use. This will eventually have a depressant effect on the actual family size. An examination of the total effects of knowledge of source of contraception on family size shows a direct path size of -0.0453 and indirect path size of -0.0012 (Table 8.3). The negative association observed suggests that all things being equal, higher level of exposure to source of contraceptive depresses the desired and actual family size of a couple. In addition, examination of the indirect path reveals that knowledge of source of contraceptives depresses family size through couples joint decision making.

It is evident from figure 12 that contraceptive use plays a major role in the determination of couples choice of family size, most especially among educated husbands. Contraceptive use has a depressant effect on the choice of family size of a man. The total correlation between contraceptive use and family size is negative. This is also true for the direct association between the two variables. This finding supports the negative association earlier observed

and the incompatibility between contraceptive use and larger family size. The relative size of the spurious effects of contraceptive use on family size signifies the importance of the interaction of other independent variables vis-a-vis their direct and indirect effects on family size. In addition, all the antecedent variables have positive direct association with contraceptive use. Also, the relative size of the spurious association suggests that the correlation between contraceptive use and family size is highly dependent on these antecedent variables which are education, knowledge of source of contraception and joint decision making.

Finally, examination of the total effects shows that men's contraceptive use is determined by joint decision making, followed by knowledge of source of contraception and then educational attainments of respondents. Thus confirming the earlier studies (Lasce and Becker, 1997; Omondi-Odhiambo, 1997; Salway, 1994; Nyblade and Menken, 1993; Hardee-Cleaveland, 1992; Oni and McCarthy, 1991) which indicate a positive association between spousal communication and contraceptive use. Once the level of contraceptive use is high, the assumption is that it will ultimately have a depressant effect on family size; this has also been confirmed in the study.

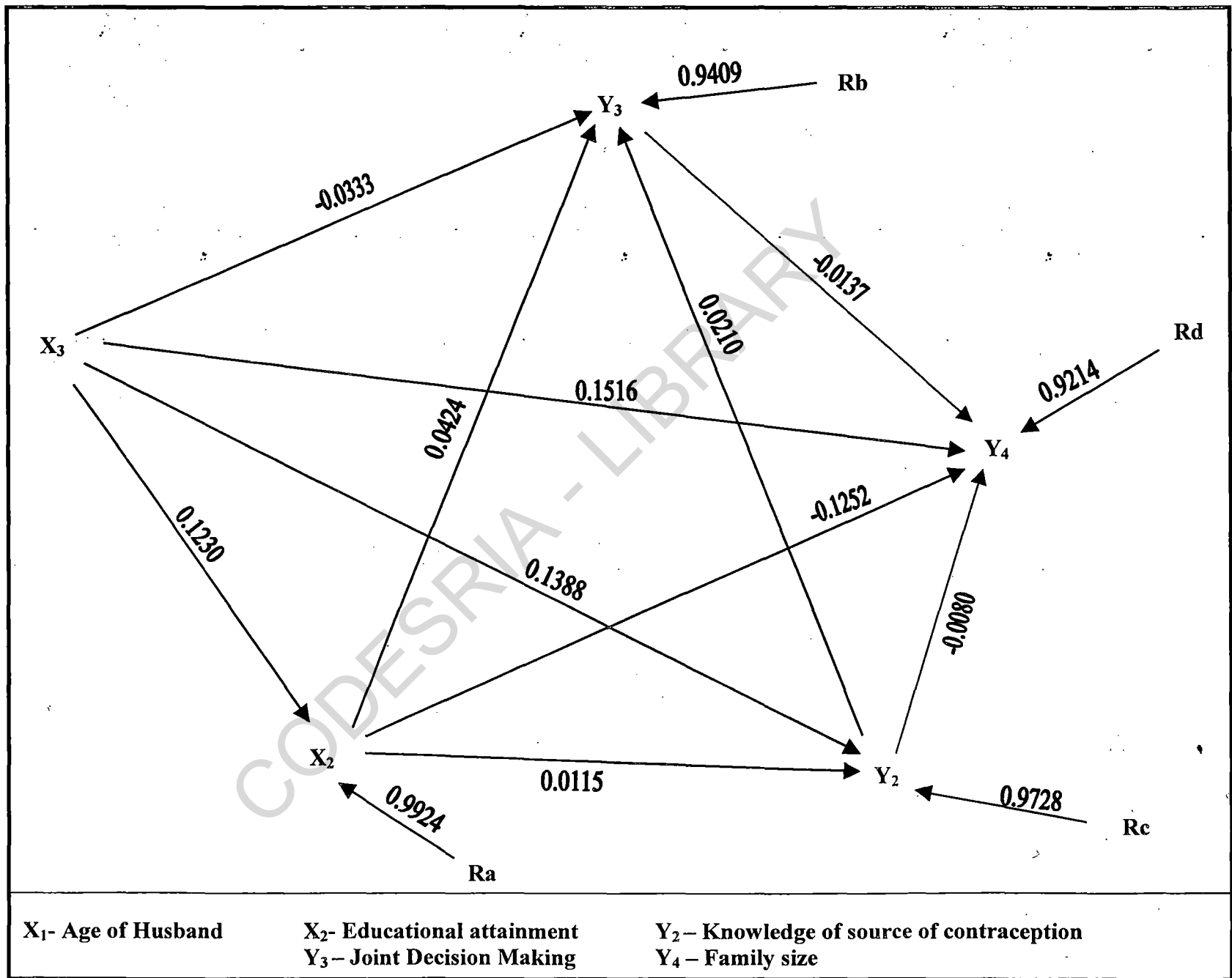


Figure 13: Path Diagram Showing Varied Effects of Spousal Communication on the family size

8.4 Model B: Determinants of Spousal Communication

Just like the model on family size which is explained above, spousal communication model is held to be recursive and thus satisfies the conditions of triangular matrix of coefficients and a diagonal matrix of the correlation of error terms. The breakdown of the various effects of the independent variables X_1 , X_2 , and Y_2 on joint decision making on the one hand, is shown in Table 8.4. On the other hand, the various effects on the choice of family size are presented in Table 8.5.

Figure 13 demonstrates the various effects of age of husbands, their educational attainments and joint decision making on family size and the effects of the discussion about family size on desired and actual family size. The results are presented in Tables 8.4 and 8.5.

Table 8.5 shows that age of a husband has a positively high correlation with family size. The relative size of the direct effect reveals that older men are more likely to have preference for large family size and to actually have large family size when compared with their younger counterparts. However, the size of the indirect effect indicated the significant contribution due to the interaction between age and other variables contained in the model on family size. Discussion about family size is both negatively correlated and associated with actual and desired family size (Table 8.5). The size of the total effect indicates the extent to which actual and desired family size is affected by

couples joint decision making on reproductive issues. The negative impact may imply that the desired and actual family size of the individual is favoured by spousal communication; that is joint decision making.

Surprisingly an unexpected negative correlation between education and joint decision making on family size is observed in the model (Table 8.4). The size of the direct association however, seems to explain the extent to which education influences discussion about family size. But the impact being negative suggests that either education plays a least influential role in encouraging such discussion or rather, suffices it to suggest that majority of the respondents have relatively higher level of education (secondary and above). The size of the spurious effect is relatively large to indicate the significant effects of other variables. Upon all these, education is still seen to have a depressant effect on actual family size (Table 8.5).

Table 8.4: Decomposition of the Relationship Between the Independent Variables (with specific reference to Knowledge of Source of Contraception) and Family size

Variable	NATURE OF RELATIONSHIP WITH FAMILY SIZE				
	Direct	Indirect	Spurious	Total Effect	Total Correlation
Age of man (X_1)	-0.0333	-0.0037	-	-0.037	-0.037
Educational Attainment (X_2)	-0.0424	-0.0012	0.0041	-0.0436	-0.0395
Knowledge of source of contraception (Y_2)	0.0120		0.0053	0.0120	0.0173

Table 8.5: Decomposition of the Relationship Between the Independent Variables (with specific reference to Joint Decision Making) and Family size

Variable	NATURE OF RELATIONSHIP WITH FAMILY SIZE				
	Direct	Indirect	Spurious	Total Effect	Total Correlation
Age of man (X_1)	0.1516	-0.0148	-	0.1368	0.1368
Educational Attainment (X_2)	-0.1252	-0.0007	0.0187	-0.1259	-0.1072
Knowledge of source of contraception (Y_2)	-0.0080	0.0002	0.0201	-0.0078	0.0123
Joint decision making (Y_3)	-0.0137	-	0.0003	-0.0137	-0.0134

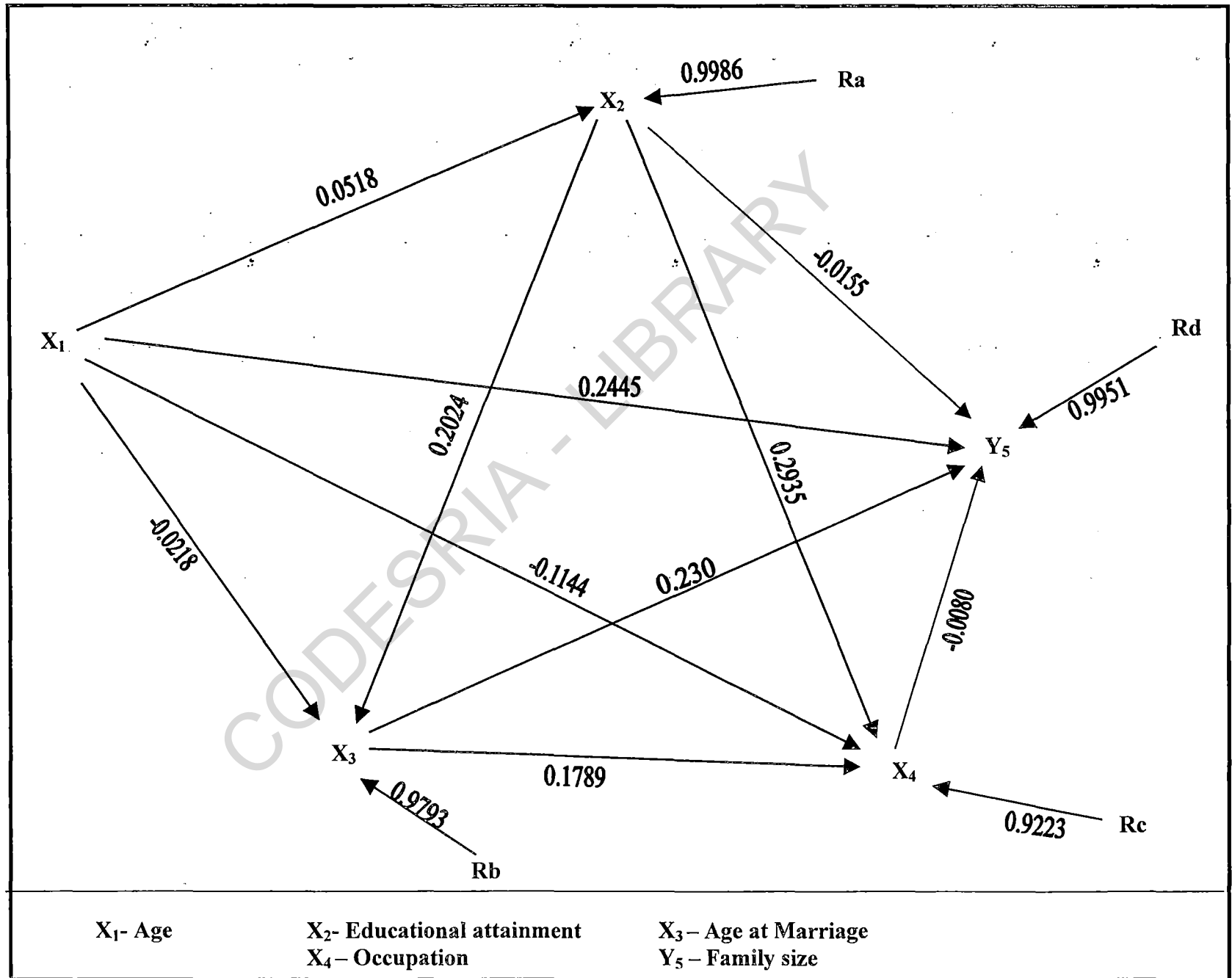


Figure 14: Path Diagram Showing Maximal Effects of Reproductible Attributes on the family size

8.5 Model C: Respondents' Attributes

Figure 14 shows the system of relationships among the respondents' attributes and family size which is the dependent variable. The model examines the effects of socioeconomic and demographic variables on family size desired by husbands. Age of husband (X_1), educational attainment (X_2), age at marriage (X_3), and occupation (X_4) of husband are known to influence the choice of family size of a couple. It is assumed in the model that couples family size is influenced by male background characteristics. For instance, the educational attainment of man depends on his age; age and level of education can also determine the age at marriage. Age at marriage which determines the duration of marital union of the couple and the childbearing period influences the choice of family size of couple. Education is also assumed to have a direct influence on the choice of family size and determines the occupation of the man. Finally, occupation is assumed to have a direct influence on the desired family size of a couple.

In the model (X_2), (X_3), (X_4) and Y_5 are endogenous variables, while X_1 is the exogenous variable, that is, already pre-determined outside the model. The connections among the variables and family size can be represented by a system of structural equations:

$$X_2 = P_{21}X_1 + P_{2t}R_t$$

$$X_3 = P_{31}X_1 + P_{32}X_2 + P_{3d}R_d$$

$$X_4 = P_{41}X_1 + P_{42}X_2 + P_{43}X_3 + P_{4u}R_u$$

$$Y_5 = P_{51}X_1 + P_{52}X_2 + P_{53}X_3 + P_{54}X_4 + P_{4u}R_u$$

The model is held to be recursive, and thus satisfies the conditions of a triangular β matrix of coefficients and a diagonal matrix of the correlations of the error terms. The path diagram dissects the various effects of the independent variables on family size into direct, indirect and spurious effects, and these are shown in Table 8.6 below.

Table 8.6: Decomposition of the Relationship Between the Independent Variables and Family size

Variable	NATURE OF RELATIONSHIP WITH FAMILY SIZE				
	Direct	Indirect	Spurious	Total Effect	Total Correlation
Age (X_1)	0.2411	0.0155	-	0.2566	0.2566
Education (X_2)	-0.0155	-0.0566	0.0121	-0.0721	-0.060
Age at marriage (X_3)	-0.0230	-0.0282	-0.0223	-0.0512	-0.0735
Occupation (X_4)	-0.1574	-	-0.0366	-0.1574	-0.1940

8.6 Summary

It has been established from the findings in this study that while education has a positive correlation with contraceptive use and joint decision making, it has a negative correlation with family size. The size of the direct

effect relative to those of the indirect effect and spuriousness still shows that education has a depressant effect on fertility but positively associated with spousal communication. Thus confirming the hypothesis postulated in chapter one that "the educated males will show greater willingness to discuss reproductive issues with their partners than thier non-educated counterparts and more likely to have smaller family size".

Three of our findings are extremely noteworthy. The first relates to the relationship between contraceptive use and family size. It is observed that the size of direct effect of contraceptive use on family size relative to that of spuriousness indicates that the correlation between the two variables is totally dependent upon the result of the correlation of each of the variables with other variables. This implies that the size of the spurious effects is greater than that of the direct effect and it suggests that the influence which contraceptive use has on the desired and actual family size of a couple should be attributed to the interraction among the antecedent variables which all have positive impact on contraceptive use. Furthermore, the effects of some other variables not included in the model cannot be ruled out as its magnitude is even comparable to that of the direct effect. This finding is suggesting that there are other factors that should be taken into consideration, especially some important socio-demograhic and motivational variables. For instance, age difference and educational difference among couples may be determining factors in the extent

of spousal communication among couples and this may ultimately influence the desired and actual family size.

Another notable finding is the nature of association between male partner's education and family size. The estimate of the direct association obtained after controlling for the effects of other variables shows the depressant effect that education has on family size. The magnitude of the spurious association further indicates the influences of education through intervening variables on family size. This finding suggests that education influences other variables that have profound impact on family size. The finding is indicating that an increase in the average level of education of the male population is likely to bring about a decline in family size (desired or actual) not only directly but also indirectly. The positive correlation between education and each of the intervening variables implies that an increase in each of motivational factors measured, spousal communication and contraceptive use (which is a measure of male reproductive attitude) is expected as educational attainment increases. Indeed, the negative correlation between each of the three intervening variables and family size suggests that a reduction in family size could be expected as each of the three variables experiences an education-induced increase.

The third finding relates spousal communication, determined through joint discussion about reproductive issues, to male family size desired. As

seen in figure 13, there is a positive association between education and spousal communication and negative relationship with family size.

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CHAPTER NINE

SUMMARY, CONCLUSION AND RECOMMENDATION

9.1 Summary and Conclusion

The main objective of this study was to examine the interrelationships between male reproductive behaviour, spousal communication and family size among the Yorubas of South Western Nigeria. Specifically, the study aimed at providing insight into male fertility aspirations and the intricacies in reproductive decision making process which may affect their actual and desired family size.

A breakdown of the background characteristics of the male respondents shows that only 6.7 percent have no formal education compared with 18.8 percent of women population. Men were found to have attained higher levels of education compared with women. The analysis reveals that most of the male respondents were in the age range 30 years to 49 years, while the majority of female respondents were in the age range 25-39 years. Males were found to be older than females. Forty percent of the male population were residing in the rural areas compared with 47.3 percent of the women population. The distribution of the study population by occupation indicates that majority of both male and female respondents were traders. The professionals and civil servants constitute only 7.4 percent and 16.4 percent respectively. Christians

were found to dominate the sample with a proportion of 79.8 percent while the Muslims represent only 18.2 percent. Marriage is an accepted norm among the Yorubas. Seventy-two percent of the women are in monogamous union.

The effects of a number of factors on current use of contraceptives were highlighted in the study. Communication variables such as decision about family size and family planning as well as spouse's perception of partner's approval of family planning, all have significant impact on current use of contraceptives. The study revealed that marital partners who discuss and take joint decisions on what to do to delay or stop child bearing are more likely to use contraceptive than their counterparts who have not discussed the issue. However, the significance of the impact decreases while controlling for other factors. That couples who discuss about reproductive issues use contraceptives and take decisions on family size is a very important justification for this study. The finding that joint decision making was an important explanatory variable in current contraceptive use shows that men have a role in the adoption of contraception. We equally noticed that there is a highly significant impact of family planning counselling on contraceptive use, especially its implication for participation of men in family planning. Findings in the study tend to show that men are more likely to take part in family planning once the needs for family planning are made clear to them. Hence, the need for men mobilisation and education about reproductive issues.

Relating contraceptive usage with respondents' background characteristics, the study revealed that respondents between ages 25 and 39 years are more likely to use contraceptives than those in other age groups. Level of education was found to have a positive correlation with current contraceptive use. The professionals, civil servants and traders were observed to be making use of contraceptives more than other categories. Christians were more likely to use contraceptives than Muslims and respondents in other religions. Contraceptives usage also increased with the number of living children.

It emerged from the study that 64.8 percent of men compared with 53.9 percent of women know of at least one source of contraception; condom being the most popular among all the methods. Twenty-nine percent of men and 26.4 percent of the female population indicated that they are currently using condom. The results further show that no respondent has ever undergone sterilization. Current contraceptive prevalence rate of men stand at 32.3 percent which is higher than that of women (27.6 percent). However, the expectation is that contraceptive prevalence rates for male and female respondents could be very close. The discrepancy might have arisen because the females may be reporting only their contraceptive use and not that of their partners or with their co-wives (for those in polygynous type of marriage). The difference may also be attributed to male's usage of contraceptives outside the

matrimonial union.

On human sexuality, a significant proportion of respondents had indicated that it was not possible for human beings to stay away from sex citing biological necessity as the main reason. This view was further reinforced by participants in focus group discussions who held the view that normal human being can never stay away from sex. This might have been one of the reasons why some of the male respondents engaged in polygynous type of marriage.

The respondents showed a high knowledge and awareness of sexually transmitted infections (STIs) and the mode of transmission. Almost 90 percent of male and 93 percent of their partners promptly mentioned sexual contact as the main mode of transmission of STIs including AIDS. However, virtually all of them qualified such sexual contact to be one with a prostitute; thus introducing some level of misconception into their knowledge. Another sign of misconception was shown in their belief that STIs\AIDS could be caused by witches, supernatural power and through kissing.

Furthermore the study has examined the level of spousal communication on reproductive issues and its impact on couple's contraceptive use among the Yorubas of South Western Nigeria. The situation which formerly prevailed among the Yorubas on the issues of procreation is rapidly changing probably due to the impact of education, in which case more women are now attaining

higher levels of education. In the traditional Yoruba society, issues related to procreation were hardly discussed by marital partners, even when each partner had a reproductive goal. The husband's kinsmen exert more influence on reproductive issues than the wife, and as the role of kinsmen diminishes over time, the usually large age difference between the husband and his partner has often made it difficult for the woman to adequately negotiate her reproductive goals. Hence, the fairly high levels of joint decision making on reproductive issues reported by both men and women in the sample may be reflecting the fairly high levels of education attained by women. However, apart from the relative impact of education, the down turn in Nigeria's economy, associated with increased retrenchment of workers and a rise in the cost of essential goods, has adversely affected the male purchasing power to take care of all household needs. Men traditional responsibility for providing their families economic support is clearly a motivating factor for fertility regulation among male respondents. Therefore, in addition to exposure to family life information, education and counseling programmes, the relative decline in men's resources appears to have facilitated the emergence of a new perception of the roles and rights of their partners. As a result of their increased contribution to family resources in the recent times, women participation in decision making could have risen.

The effect of fertility decision making on desired family size is clearly

shown in the study. We observed from the study that respondents who took decision on particular family size are more likely to have preference for a smaller family size. Also, those who took some decisions to use family planning are more likely to desire smaller family size. Other factors that may have profound effect on desired family size include age and age difference between spouses, education (especially the difference between educational attainment of husband and wife), spousal approval of family planning etc. Thus the claim in some studies (Coombs and Fernandez, 1978; De Silva, 1994; Meekers and Oladosu, 1996) that the closer a man and a woman are in their levels of education, and the more education they have, the more likely they are to discuss and use family planning has been substantiated in this study. The study also lay credence to the claim in some studies (Balk, 1997; De Silva, 1994; Gage, 1995) that a woman's power to make decisions sometimes increases with her level of education and with her husband's level of education. This may also depend on age difference between partners. Younger woman who marries much older man has less power than woman who marries someone closer in age.

Strongly held traditional beliefs about the responsibilities and roles of husbands and wives have influenced the range and control of reproductive decision making. For instance, within the family, women and men of all ages and educational levels believed that husbands should provide guidance to their

wives. Therefore, almost all participants in focus group discussions agreed that husbands must be more educated, older and presumably as a result, wiser than their wives. These attitudes are consistent with traditional cultural tenets in which age is accorded respect. Moreover, the man is expected to be the primary income earner. These widely held beliefs reinforce hierarchical features within the society. A woman's marriage to an older man reinforces male dominance both in terms of gender and age. Because she occupies a subordinate position, the wife is subject to her husband's tutelage. That educated women embrace this traditional belief raised questions about respondents' views on the meaning and importance of female education (Mihira, Stark and Wolf, 1997).

The extent of conjugal relationship was brought to focus in the study. This was also shared in the focus group discussion sessions. It is revealed in the study that spouses in the area eat together, sleep in the same room, go out together and confide in each other. However, there was a reduction in this pattern when it comes to question of pooling resources together as only 35.7 percent of the male population and half of the female population indicated that they pool resources together.

The study revealed that though couples in the area engaged in joint decision making, however, there were still some instances when either of the spouses would personally take such decision. We found in the study that when

either wife or the husband takes reproductive decisions, men were noticed to have more power than women. Differences in power between men and women are however not absolute or universal. Caution must therefore be taken to avoid over-generalisation since the amount of control men have over their wives varies from place to place. For instance, among younger men and women in some cultures, gender roles are changing toward more equality. Also among the Yorubas of South Western Nigeria, women have always enjoyed some level of economic autonomy which avails them the opportunity to take independent decisions on certain issues or participate in decision making. This has been confirmed in this study. Women participation have risen probably as a result of their increased contribution to family resources in the recent times.

The relationships between fertility preference and some selected background variables were investigated in the study. The study revealed that desired family size increases with age advancement of the respondents. Level of education was found to have a negative correlation with desired family size. Men and women with no formal education have preference for larger family size. This is consistent with an earlier study among Nigerian males by Isiugo-Abanihe (1994). Respondents in rural communities have desire for more children than their urban counterparts. Also respondents who engaged in farming or trading have preference for larger family size relative to that of the

professionals and civil servants. The results further indicate that men in monogamous marriages desire relatively smaller family size compared with those in polygynous union. Christians also desire smaller family size compared with Muslims and respondents in other religions.

It has been established from our findings in the multivariate analysis that education has a negative correlation with family size. The size of the direct effect relative to those of the indirect effect and spuriousness still shows that education has a depressant effect on family size but positively associated with spousal communication. Thus the hypothesis that "the educated males will show greater willingness to discuss reproductive issues with their partners than their non-educated counterparts and are more likely to have smaller family size" has been confirmed in this study.

9.2 Recommendation

Evidence from current study as well as other studies (Ekanem and Ebigbola, 1975) suggest that a higher fertility level is the major determinant of the high growth rate which the country is witnessing. The need for a corresponding control of fertility as recognised in the 1988 Population Policy, is therefore a matter of necessity. Evidence of a decline in desired family size should become apparent before any widespread fertility change can take place. Along with the economic and social changes, there are attempts to make

modifications in the demographic sphere. The attempts so far do not appear to be strong enough to alter the demographic parameters substantially. The degree of adoption of birth control methods and the consequent change in male reproductive behaviour would depend on the tempo of communication among couples and improvements in women's status in the rapidly changing socio-economic reality.

For the adoption of family planning and the concretization of pre-determined family size, education emerges as a major determinant. The educated as well as high status group are more likely to engage in interspousal communication, and offer a visible leadership. At a time when governments at various levels are embarking on free education, education is unlikely to remain a scarce commodity and its effect can be expected to become widespread. Therefore, based on the assumptions of demographic transition, increasing education and attendant increase in interspousal communication will contribute to reduction in desired and actual family size of couples.

The finding that husband's approval is an important factor in male reproductive behaviour has important programme implications because most of the available family planning programmes in Nigeria today are designed to serve primarily women. Husband's approval has been shown to improve the utilization of family planning services and the success of family planning programme (Cook and Maine, 1987). Thus, while men's actual influence on

birth control decisions may be less than would appear from their statements during the survey, there seems to be no good basis for excluding them altogether from family planning activities. The results of this study have shown that success in achieving a smaller family size will depend on how responsive husband's fertility preferences are to the changes in their spouses' preferences and on the influence of husbands' preferences on couples' reproductive behaviour. The study recognises that men play an important role in decisions pertaining to family size and family planning. The results of the multivariate analysis further indicate that the husband's fertility preference exerts a stronger influence on the couples' contraceptive behaviour among the Yorubas of South Western Nigeria. Therefore apart from focusing on women alone in reproductive matters, efforts should be made to increase men's knowledge. This is in line with the recommendation of Lasee and Becker in a study conducted in Kenya in 1997. Also, as recommended at the 1994 International Conference on Population and Development (United Nations, 1995), male involvement could encourage greater communication between spouses, leading to joint contraceptive decision making. Focusing men in reproductive matters could ease the alienation men often feel toward family planning programmes by gaining their interest, cooperation and involvement in such programmes.

Findings from the study suggest that the importance of an individual's motivation to reduce fertility cannot be over-estimated. Motivation campaigns,

therefore become particularly important for increasing contraceptive acceptance; they must focus on issues of concern to men as well as women in ways that are acceptable to them if they are being asked to practise contraception.

9.3 Policy Implications

It has generally been emphasised that education is one of the most important factors that may likely bring about fertility reduction through contraceptive use. Government and other agencies interested in controlling population growth may through their activities ensure universal education at least at the secondary school level for all males and females in the country. A good example is the Universal Basic Education (UBE) programmed embarked upon by the present government in Nigeria.

Secondly, because of men's influence over their wives, women may rather be targeted with their husbands in family planning programmes.

Increased emphasis should be placed on encouraging men to take an active role in all aspects of family life. In this respect, men should be recognised as having a stake in reproductive health through their multiple roles as sexual partners, husbands, fathers, community leaders, and gatekeepers to health information and services.

Finally, to improve male involvement in fertility regulation, effort must

be made to improve the understanding of male needs through research, increase spousal communication, increase access to services and encourage open discussion among men. Research on alternative contraceptive methods for males need to be given further momentum. This will accelerate the successful implementation of fertility regulation programmes in developing countries in general and Nigeria in particular, thereby ensuring sustainable socio-economic development and improved living standard of the people.

9.4 Areas for further research

More research work needs to be done on the interrelationships between male reproductive behaviour, spousal communication and family size in Nigeria. This will further throw more light on the observed relationships.

Further study should be carried out on the relationship between contraceptive use and desired family size. This will bring to focus the real causal connection between the two variables. As at present, most of the studies on the relationship between contraceptive use and desired family size have highlighted the impact of contraceptive use on desired family size. But what we have observed in this study is that desired family size of a couple will actually determine whether or not they will use contraceptives. This should be thoroughly investigated in future studies.

There is need for large-scale comparative studies among different ethnic

groups in the country in order to be able to determine the extent to which some other important factors (for instance, cultural background) will affect couples' spousal communication. Also the analysis of this research is based on the cross-sectional information from a single survey whose predictive power may not equal that of information from longitudinal study. Longitudinal studies is therefore suggested since attitudinal/behavioural studies require a great length of time as to be able to measure satisfactorily the variables of interest. Moreover it is impossible to make causal inferences from cross-sectional data. Thus as noted by Lasee and Becker (1997), rather than predicting contraceptive use, discussion between spouses about family planning may actually have occurred after contraceptive acceptance, given that the question on discussion referred to the 12-month period before the survey. Also, the approach is poor at providing insight into the actual decision-making process surrounding the initiation of contraceptive use. As noted by Hill *et al.* (1959), the power relations within the couples are important to understand in this regard.

Furthermore, the present analysis is still amenable to improvements. There are other variables that are important and should be included in the model as to further expose the relative contributions and effects of the intervening variables. For instance, the impact of media exposure on couple's decision making (as well as other variables that have not been made use of in

this study) require our consideration. But since the use of path analytic techniques has its own limitations, it becomes more difficult to accurately decompose the relationships between the independent and dependent variables, if we incorporate so many variables into the model.

Finally, it is recognised that there are some variables which are very important in determining the relative impact of spousal communication on male reproductive behaviour and family size. Such variables include, for instance, age and educational differences between spouses. The impact of these variables on spousal communication and family size should be examined in subsequent studies.

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APPENDIX I

DECOMPOSITION OF INDEPENDENT VARIABLE

The equation for Y_5 is

$$Y_5 = P_{51}X_1 + P_{52}Y_2 + P_{53}Y_3 + P_{54}Y_4 + P_{4w}R_w$$

Substituting for the endogenous variables Y_3 and Y_4 in order to put it in reduced form:

$$\begin{aligned} Y_5 &= P_{51}X_1 + P_{52}Y_2 + P_{53}Y_3 + P_{54}(P_{41}X_1 + P_{42}Y_2 + P_{43}Y_3 + P_{4v}R_v) \\ &\quad + P_{4w}R_w \\ &= P_{51}X_1 + P_{52}Y_2 + P_{53}Y_3 + P_{54}P_{41}X_1 + P_{54}P_{42}Y_2 + P_{54}P_{43}Y_3 + \\ &\quad P_{54}P_{4v}R_v + P_{4w}R_w \\ &= P_{51}X_1 + P_{52}Y_2 + P_{53}(P_{31}X_1 + P_{32}Y_2 + P_{3u}R_u) + P_{54}P_{41}X_1 + \\ &\quad P_{54}P_{42}Y_2 + P_{54}P_{43}(P_{31}X_1 + P_{32}Y_2 + P_{3u}R_u) + P_{54}P_{4v}R_v + P_{4w}R_w \\ &= P_{51}X_1 + P_{52}Y_2 + P_{53}P_{31}X_1 + P_{53}P_{32}Y_2 + P_{53}P_{3u}R_u + P_{54}P_{41}X_1 \\ &\quad + P_{54}P_{42}Y_2 + P_{54}P_{43}P_{31}X_1 + P_{54}P_{43}P_{32}Y_2 + P_{54}P_{43}P_{3u}R_u + \\ &\quad P_{54}P_{4v}R_v + P_{4w}R_w \\ &= P_{51}X_1 + P_{52}(P_{21}X_1 + P_{2t}R_t) + P_{53}P_{31}X_1 + P_{53}P_{32}(P_{21}X_1 + P_{2t}R_t) \\ &\quad + P_{53}P_{3u}R_u + P_{54}P_{41}X_1 + P_{54}P_{42}(P_{21}X_1 + P_{2t}R_t) + P_{54}P_{43}P_{31}X_1 \\ &\quad + P_{54}P_{43}P_{32}(P_{21}X_1 + P_{2t}R_t) + P_{54}P_{43}P_{3u}R_u + P_{54}P_{4v}R_v + P_{4w}R_w \\ &= P_{51}X_1 + P_{52}P_{21}X_1 + P_{52}P_{2t}R_t + P_{53}P_{31}X_1 + P_{53}P_{32}P_{21}X_1 + \\ &\quad P_{53}P_{32}P_{2t}R_t + P_{53}P_{3u}R_u + P_{54}P_{41}X_1 + P_{54}P_{42}P_{21}X_1 + P_{54}P_{42}P_{2t}R_t \\ &\quad + P_{54}P_{43}P_{31}X_1 + P_{54}P_{43}P_{32}P_{21}X_1 + P_{54}P_{43}P_{32}P_{2t}R_t + P_{54}P_{43}P_{3u}R_u \end{aligned}$$

$$\begin{aligned}
& + P_{54}P_{4v}R_v + P_{4w}R_w \\
= & P_{51}X_1 + P_{52}P_{21}X_1 + P_{53}P_{31}X_1 + P_{53}P_{32}P_{21}X_1 + P_{54}P_{41}X_1 + \\
& P_{54}P_{42}P_{21}X_1 + P_{54}P_{43}P_{31}X_1 + P_{54}P_{43}P_{32}P_{21}X_1 + P_{52}P_{2t}R_t + \\
& P_{53}P_{3u}R_u + P_{53}P_{32}P_{2t}R_t + P_{54}P_{42}P_{2t}R_t + P_{54}P_{43}P_{32}P_{2t}R_t + \\
& P_{54}P_{43}P_{3u}R_u + P_{54}P_{4v}R_v + P_{4w}R_w
\end{aligned}$$

Multiplying the equation through by X_2

$$\begin{aligned}
X_2Y_5 = & P_{51}X_1X_2 + P_{52}P_{21}X_1X_2 + P_{53}P_{31}X_1X_2 + P_{53}P_{32}P_{21}X_1X_2 + \\
& P_{54}P_{41}X_1X_2 + P_{54}P_{42}P_{21}X_1X_2 + P_{54}P_{43}P_{31}X_1X_2 + \\
& P_{54}P_{43}P_{32}P_{21}X_1X_2 + P_{52}P_{2t}R_tX_2 + P_{53}P_{3u}R_uX_2 + P_{53}P_{32}P_{2t}R_tX_2 + \\
& P_{54}P_{42}P_{2t}R_tX_2 + P_{54}P_{43}P_{32}P_{2t}R_tX_2 + P_{54}P_{43}P_{3u}R_uX_2 + P_{54}P_{4v}R_vX_2 \\
& + P_{4w}R_wX_2
\end{aligned}$$

Taking expectations and considering the variable to be in standard form:

$$\begin{aligned}
E(X_2Y_5) = & P_{51}E(X_1X_2) + P_{52}P_{21}E(X_1X_2) + P_{53}P_{31}E(X_1X_2) + \\
& P_{53}P_{32}P_{21}E(X_1X_2) + P_{54}P_{41}E(X_1X_2) + P_{54}P_{42}P_{21}E(X_1X_2) + \\
& P_{54}P_{43}P_{31}E(X_1X_2) + P_{54}P_{43}P_{32}P_{21}E(X_1X_2) + P_{52}P_{2t}E(R_tX_2) + \\
& P_{53}P_{3u}E(R_uX_2) + P_{53}P_{32}P_{2t}E(R_tX_2) + P_{54}P_{42}P_{2t}E(R_tX_2) + \\
& P_{54}P_{43}P_{32}P_{2t}E(R_tX_2) + P_{54}P_{43}P_{3u}E(R_uX_2) + P_{54}P_{4v}E(R_vX_2) + \\
& P_{4w}E(R_wX_2)
\end{aligned}$$

Since the exogenous X 's, as noted above, are assumed to be uncorrelated with the error terms, then

$$E(R_uX_2) = E(R_tX_2) = E(R_uX_2) = E(R_vX_2) = E(R_wX_2) = 0$$

where

$$E(X_2 Y_5) = r_{25} \cdot E(X_1 X_2) + r_{12} \cdot E(X_2^2) = 1$$

Hence as an exposition of how the various effects were derived, the effects of knowledge of source of contraception variable are presented as follows:

$$\begin{aligned} r_{25} &= P_{52} + P_{52}r_{12} + P_{53}r_{13} + P_{54}r_{14} \\ &= P_{52} + P_{52}r_{12} + P_{53}r_{13} + P_{54}(P_{41} + P_{42}r_{12} + P_{43}r_{13}) \\ &= P_{52} + P_{52}r_{12} + P_{53}r_{13} + P_{54}P_{41} + P_{54}P_{42}r_{12} + P_{54}P_{43}r_{13} \\ &= P_{52} + P_{52}r_{12} + P_{53}(P_{31} + P_{32}r_{12}) + P_{54}P_{41} + P_{54}P_{42}r_{12} \\ &\quad + P_{54}P_{43}(P_{31} + P_{32}r_{12}) \\ &= P_{52} + P_{52}r_{12} + P_{53}P_{31} + P_{53}P_{32}r_{12} + P_{54}P_{41} + P_{54}P_{42}r_{12} \\ &\quad + P_{54}P_{43}P_{31} + P_{54}P_{43}P_{32}r_{12} \end{aligned}$$

The equation thus becomes

$$\begin{aligned} r_{25} &= P_{52} \text{ (Direct Effect)} \\ &\quad + P_{53}P_{31} + P_{54}P_{41} + P_{54}P_{43}P_{31} \text{ (Indirect Effect)} \\ &\quad + P_{51}r_{12} + P_{53}P_{32}r_{12} + P_{54}P_{42}r_{12} + P_{54}P_{43}P_{31}r_{12} \text{ (Spuriousness)}. \end{aligned}$$

$$r_{25} = -0.0453 + 0.0012 + (-0.0088) = 0.0529$$

The total effect of education on family size is:

$$TE_{25} = DE_{25} + IE_{25} = -0.0453 + 0.0012 = -0.0441 \text{ as shown on}$$

Table 7.3

Similarly, if we decompose the relationship between contraceptive use (Y_4), which is an earlier endogenous variable, and family size (Y_5), we have:

$$r_{45} = P_{51}r_{14} + P_{52}r_{24} + P_{53}r_{34} + P_{54} \dots\dots(a)$$

This is obtained after multiplying

$$Y_5 = P_{51}X_1 + P_{52}Y_2 + P_{53}Y_3 + P_{54}Y_4 + P_{4w}R_w \text{ by } Y_4$$

When we substitute for r_{14} , r_{24} and r_{34} in equation (a), it then becomes:

$$r_{45} = P_{51}(P_{41} + P_{42}r_{12} + P_{43}r_{13}) + P_{52}(P_{41}r_{12} + P_{42} + P_{42}r_{23}) + P_{53}(P_{41}r_{13} + P_{42}r_{23} + P_{43}) + P_{54}$$

Further substitution of $r_{13} = (P_{31} + P_{32}r_{12})$ and $r_{23} = (P_{32} + P_{31}r_{12})$.

Re-arranging the terms, the equation simplifies to:

$$\begin{aligned} r_{45} = & P_{54} \text{ (direct effect)} \\ & + P_{51}P_{41} + P_{51}P_{43}P_{31} + P_{52}P_{42} + P_{52}P_{43}P_{32} + P_{53}P_{41}P_{31} + \\ & P_{53}P_{42}P_{32} + P_{53}P_{43} \text{ (Indirect effect)} \\ & + P_{51}P_{42}r_{12} + P_{51}P_{43}P_{32}r_{12} + P_{52}P_{41}r_{12} + P_{52}P_{43}P_{31}r_{12} + \\ & P_{53}P_{41}P_{32}r_{12} + P_{53}P_{42}P_{31}r_{12} \text{ (Spuriousness)}. \end{aligned}$$

Therefore, $r_{45} = -0.0286 + (-0.037) = -0.0656$

The total effect is given as:

$$TE_{45} + DE_{45} = -0.0286.$$

The summary of the classification of various effects into direct, indirect and spuriousness is presented in Table 7.1.

To calculate the residual paths, we employ the following formula:

$$r_{ij} = \sum P_{ij}r_{ja}$$

and setting $i = j$, we have:

$$1 = \sum P_{iq} + 2 \sum P_{iq} r_{qk} P_{ik}$$

When the range of q and k ($k > q$) includes all variables. For example, an exposition of how the residual path P_{5w} was obtained is shown below:

$$1 - r_{55} = \sum P_{5q}^2 + 2 \sum P_{5q} r_{qk} P_{5k}$$

where $q = 1, 2, 3, 4, w$

and $k = 2, 3, 4; k > q$

$$\begin{aligned} &= P_{51}^2 + 2 \sum P_{51} r_{1k} P_{5k} + P_{52}^2 + 2 \sum P_{52} r_{2k} P_{5k} + P_{53}^2 + 2 \sum P_{53} r_{3k} P_{5k} + P_{54}^2 \\ &+ 2 \sum P_{54} r_{4k} P_{5k} + P_{5w}^2 + 2 \sum P_{5w} r_{wk} P_{5k} \\ &= P_{51}^2 + 2(P_{51} r_{12} P_{52} + P_{51} r_{13} P_{53} + P_{51} r_{14} P_{54}) + P_{52}^2 + 2(P_{52} r_{23} P_{53} + \\ &P_{52} r_{24} P_{54}) + P_{53}^2 + 2(P_{53} r_{34} P_{54}) + P_{54}^2 + P_{5w}^2 \\ &= (-0.0809)^2 + 2(0.0014 + 0.0217 + 0.0032) + (0.0453)^2 + \\ &2(0.0011 + 0.0024) + (0.0491)^2 + 2(0.0149) + (0.0286)^2 + P_{5w}^2 \\ &= (0.0065) + (0.0526) + (0.0021) + (0.007) + (0.0024) + (0.0298) \\ &+ (0.0008) + P_{5w}^2 \\ &= 0.1012 + P_{5w}^2 \end{aligned}$$

$$P^{5w} = \sqrt{1 - 0.1012} = 0.9481$$

APPENDIX II
QUESTIONNAIRE FORMAT

DEPARTMENT OF DEMOGRAPHY AND SOCIAL STATISTICS
OBAFEMI AWOLOWO UNIVERSITY, ILE-IFE

MALE REPRODUCTIVE BEHAVIOUR, SPOUSAL COMMUNICATION
AND FAMILY SIZE

IDENTIFICATION				
Identification Number				
Place of Interview				
Household Number				
Respondent's Number				
Name of Respondent				
Sex of Respondent				
Address of Respondent				
Interviewer's Name				
Interviewer's Visit	1	2	3	4
Date				
Outcome of Interview				
RESULT CODES				
Completed				
Not at Home				
Refused				
Other (specify)				

SECTION A: RESPONDENTS' BACKGROUND

101. For most part of the time until you were 15 years old, did you live in a city, in a town or in a rural village? City1 Town.....2 Village...3
102. How long have you been living continuously in (current place)?.....
103. How old were you at your last birthday?.....
104. Are you now married, divorced or widowed? Married.....1 Divorced.....2 Widowed.....3
105. Age at marriage.....
106. Have you ever attended school? Yes....1 No....2
107. What is the highest level of school you attended?
 None..... 1
 Primary 3
 Secondary 5
 Tertiary..... 7
 Others (specify)..... 8
108. Do you usually listen to a radio at least once a week? Yes.....1 No.....2
109. Do you usually watch television at least once a week? Yes.....1 No.....2
110. Do you usually read a newspaper or magazine at least once a week? Yes...1 No.....2
111. Does your house have any of the following?
- | | Yes | No |
|----------------|-----|----|
| Electricity | 1 | 2 |
| A Radio | 1 | 2 |
| A Television | 1 | 2 |
| A Refrigerator | 1 | 2 |

112. Does any member of your household own:
- | | | |
|---------------|---|---|
| A Clock/Watch | 1 | 2 |
| A Canoe | 1 | 2 |
| A Bicycle | 1 | 2 |
| A Motorcycle | 1 | 2 |
| A Car | 1 | 2 |
113. What is your religion? Catholic.....1
 Protestant.....2 Other Christian.....3 Islam.....4
 Other (specify).....5
114. Are you presently working? Yes.....1 No.....2 (skip to 117)
115. What is your occupation?
- | | |
|----------------------|---|
| Farming..... | 1 |
| Trading..... | 2 |
| Public/Civil Servant | 3 |
| Professional..... | 4 |
| Business man/woman | 5 |
| Artisan..... | 6 |
| Unemployed..... | 7 |
117. What is your income from all sources per month or per annum? Per Month..... Per Annum.....

SECTION B: REPRODUCTIVE HISTORY

201. Have you or your wife ever been pregnant?
 Yes.....1 No.....2(skip to 301)
202. How many times have you/your wife been delivered of a baby (live births)?.....
203. How many of your children live with you?
 Sons..... Daughters..... Total.....
204. Do you have sons or daughters to whom you have given birth, who are alive but do not live with you now?
 Sons..... Daughters..... None.....99

205. How many of these children are dead?
Sons..... Daughters..... Total..... None.....99
206. Are you or is your wife pregnant now?
Yes.....1
No.....2 --- > skip to 209
Unsure.....3
207. What is the duration of the pregnancy?Months
208. At the time you/she became pregnant, did you/she want to become pregnant then, did you/she want to wait until later, or did you/she not want to become pregnant?
Wanted to be pregnant..... 1
Would like to be pregnant later..... 2
Did not want to be pregnant..... 3
209. Have you/your wife ever had a pregnancy that miscarried, was aborted or ended in stillbirth? Yes.....1 No.....2
210. Just to make sure that I get you right: You have had in Total (AS IN 202) live births during your life? IS THAT CORRECT?
Yes.....1 No.....2

SECTION C: SEXUAL BEHAVIOUR AND KNOWLEDGE OF STIs/AIDS

301. How many partners have you had sex with in the last three months, in the last year and in your whole lifetime?
Last three months..... 1
Last Year..... 2
Lifetime..... 3
302. How often do you meet your sexual partner?
Regularly..... 1
Occasionally..... 2
Depends on my mood..... 3
Other (specify)..... 4

303. What are your reasons for having sexual relations?
- | | | |
|----------------------|---|---|
| For pleasure..... | 1 | 2 |
| Want a child..... | 1 | 2 |
| No reason..... | 1 | 2 |
| Other (specify)..... | 1 | 2 |
304. Do you take any precautions against pregnancy/disease? Yes.....1
No.....2
305. If Yes, what do you do?
306. Have you heard of venereal diseases (STIs) before?
Yes....1 No....2
307. How are STIs and AIDS transmitted (state true or false to the following statements):
- | | | |
|---|---|---|
| Through sexual contact..... | 1 | 2 |
| Through having sex with prostitute..... | 1 | 2 |
| Act of God/supernatural | 1 | 2 |
| Witches/Wizards..... | 1 | 2 |
| Through blood transfusion..... | 1 | 2 |
| Through kissing people..... | 1 | 2 |
308. Have you ever used a condom during sexual intercourse? Yes.....1
No.....2
309. If your partner wanted a condom to be used during intercourse, how would you feel?
- | | |
|---------------------------------------|---|
| I may use it with hesitation..... | 1 |
| I will oblige..... | 2 |
| It may upset me..... | 3 |
| I will use it if partner persist..... | 4 |
| Other (specify)..... | 5 |
310. Has your sexual behaviour been modified since learning of AIDS?
Yes.....1 No.....2

SECTION D: KNOWLEDGE AND PRACTICE OF FAMILY PLANNING

401. There are various ways or methods that a couple can use to delay or avoid pregnancy or birth which of these ways or methods have you ever heard of? (Circle as many as applicable)

Pill.....	1	2
IUD.....	1	2
Diaphragm/Jelly/Foam.....	1	2
Condom.....	1	2
Norplant/Implant.....	1	2
Female Sterilization.....	1	2
Male Sterilization.....	1	2
Injection.....	1	2
Other traditional methods....	1	2
Safe period.....	1	2
Post-partum Abstinence.....	1	2
Withdrawal.....	1	2

402. Have you ever used anything or tried in any way to delay or avoid getting pregnant? Yes....1 No.....2(skip to 406)

403. Are you currently doing something or using any method to avoid getting pregnant? Yes....1 No.....2(skip to 406)

404. Which method(s) are you using?.....

405. Where did you obtain the method used?

Hospital.....	1
Health centre.....	2
Maternity centre.....	3
Family Planning clinic.....	4
Private clinic.....	5
Pharmacy.....	6
Patient Medicine Shop.....	7
Friend/Relative.....	8
Other (specify).....	9

406. What is the main reason why you are not using a method of family

planning?

Space births.....	1
Stop childbearing.....	2
Health-child and me.....	3
Other (specify).....	4

407. What is the main reason why you do not intend to use method?

Wants children.....	1
Lack of knowledge.....	2
Cost too much.....	3
Side effects.....	4
Health concerns.....	5
Hard to get methods.....	6
Religion.....	7
Partner opposed to fp...	8
Other (specify).....	9

408. Do you think that breastfeeding can be used to delay or avoid pregnancy? Yes.....1 No.....2

409. In general do you approve or disapprove of couples using a method to avoid pregnancy? Approve.....1 Disapprove.....2

SECTION E: SPOUSAL COMMUNICATION AND REPRODUCTIVE DECISION-MAKING

501. Could you please tell me whether you and your spouse/partner usually undertake the following activities together:

	Yes	No
(a) Eat together	1	2
(b) Sleep in the same room	1	2
(c) Do you go out together	1	2
(d) Do you and your spouse confide in each other	1	2
(e) Do you and your spouse pool resources together or maintain a common purse	1	2

502. How frequently do you discuss the following issues? (Indicate whether

(1) very frequently, (2) frequently, (3) seldom or (4) not at all

- (a) When to become pregnant 1 2 3 4
- (b) When to avoid pregnancy 1 2 3 4
- (c) Children's welfare 1 2 3 4
- (d) Children's schooling 1 2 3 4
- (e) Food 1 2 3 4
- (f) Financial Matters 1 2 3 4
- (g) Use of Contraceptives 1 2 3 4
- (h) Other family problems (specify).....

503. Before you got married, did you know or have an idea of how many children you would want to have? Yes.....1
No.....2(skip to 505)

504. How many children did you have in mind?.....

505. When you got married, did you and your spouse talk about the number of children you would like to have? Yes.....1 No.....2(skip to 509)

506. Did you agree with your spouse's choice?
Agreed.....1 Disagree.....2

507. Please give reasons?
Agree.....
Disagree.....

508. How many children did you agree to have?
Boys..... Girls..... Total.....

509. After your marriage and /or before you had your first child, did you or your spouse decide to use a family planning method?
I decided to use family planning 1
My husband/wife decided to use..... 2
Both of us decided to use..... 3
Others decided for us..... 4
Did not use at all..... 5(skip to 512)
Don't know/No response..... 9

510. Which method did you use?.....

511. Who decided that you should have your first child
- | | |
|-----------------------|---|
| I decided..... | 1 |
| My husband/wife..... | 2 |
| Both of us..... | 3 |
| Others relations..... | 4 |
| Don't know..... | 9 |
512. What was your first birth interval (that is between your date of marriage and the first birth)? (record in Months).....
513. Who decided on the first birth interval?
- | | |
|----------------------|---|
| I decided..... | 1 |
| My husband/wife..... | 2 |
| Both of us..... | 3 |
| Other relations..... | 4 |
| Don't know..... | 9 |
514. Who should have the final say about having another baby in the family?
- | | |
|-----------------------------------|---|
| Husband..... | 1 |
| Wife..... | 2 |
| A joint decision..... | 3 |
| Other extended family members.... | 4 |
| Don't know..... | 9 |
515. What is your opinion on the following issues? (indicate whether (1) Agree, (2) Disagree, (3) Undecided or (4) Don't know)
- | | | | | |
|---|---|---|---|---|
| (a) Men should decide the family size | 1 | 2 | 3 | 4 |
| (b) Men should decide when to have sexual intercourse | 1 | 2 | 3 | 4 |
| (c) Men should decide the duration of sexual abstinence | 1 | 2 | 3 | 4 |
| (d) Men should decide whether family planning should be | 1 | 2 | 3 | 4 |
| (e) Men should decide on which family planning method to use | 1 | 2 | 3 | 4 |
| (f) Men should decide what to do when unwanted pregnancy occurs | 1 | 2 | 3 | 4 |

516. Do you think your spouse approves or disapproves of couples using a method to avoid pregnancy? Approves.....1 Disapproves.....2 Don't know.....3
517. How often have you talked to your spouse/partner about this subject in the past year?
Never.....1 Once/Twice.....2 Three/More.....3
518. Have you ever discussed whether to stop having children with your spouse? Yes.....1 No.....2
519. If Yes, how many children had you given birth to when you first discussed it?
Number..... Don't remember.....98
520. Aside from your spouse, have you ever talked to anyone else about stopping having children? Yes.....1 No.....2
521. If Yes, Who.....
522. If you are using a method, does your partner/spouse know that you are using a method now? Yes.....1 No.....2
523. If No, what do you think would happen if he/she discovers that you are doing something to delay or avoid pregnancy?.....
524. Does your spouse agree with you using a method now? Yes.....1 No.....2
525. Have you and your spouse ever discussed doing something to delay or avoid pregnancy? Yes.....1 No.....2
526. Who proposed using a family planning method?
Respondent..... 1
Spouse..... 2
Someone else (specify)..... 3

527. Please tell me if you (1) agree, (2) disagree or (3) have no opinion about the following statements:
- (a) If my partner doesn't want to use family planning (e.g. condom), there is nothing I can do to change his/her mind (1) (2) (3)
- (b) A couple can choose the exact number of children they will have and stop after that (1) (2) (3)
- (c) If I decide that I want no more children, I will be able to have my way. (1) (2) (3)
- (d) If I decide that I want to delay the next birth, I will be able to have my way (1) (2) (3)
- (e) Even if my spouse doesn't agree at first, I could convince my spouse to use family planning if I feel we should (1) (2) (3).

SECTION F: FERTILITY PREFERENCES

601. Do you think your spouse/partner wants the same number of children that you want or does he want more or fewer than you want? Same number.....1 More children.....2
Fewer children.....3 Don't know.....4
602. **IF NO LIVING CHILDREN:** If you could choose exactly the number of children to have in your whole life, how many would that be? Boys..... Girls..... Total.....
603. **HAS CHILDREN LIVING:** If you could go back to the time you did not have any child and could choose exactly the number of children to have in your whole life, how many would that be? Boys..... Girls..... Total.....
604. Just before your last pregnancy, did you really want another child? Yes.....1 No.....2 Indifferent.....3

SECTION G: VALUE OF CHILDREN

701. Do you want to have more children than you have now? Yes.....1 No.....2(skip to 703)

702. What is the main reason why you want more children?
- | | |
|---------------------------|---|
| Don't have enough | 1 |
| Have no son/daughter..... | 2 |
| Custom/Religion..... | 3 |
| Husband recommended..... | 4 |
| Help family income..... | 5 |
| Others..... | 6 |
| Don't know..... | 9 |
703. What is the main reason why you don't want any more children?
- | | |
|-----------------------------|---|
| Have enough children..... | 1 |
| Too old/tired | 2 |
| Health..... | 3 |
| Unable to support them..... | 4 |
| Government Policy..... | 5 |
| Too busy..... | 6 |
| Others..... | 7 |
| Don't know/No response..... | 9 |
704. What do you think is the ideal or generally desirable number of children for a woman in this area to have under the present economic situation?
- | | |
|---------------------|--|
| Desired number..... | |
| Don't know..... | |
705. What in your opinion, are the reasons for having children?
.....
706. What in your opinion, are the reasons for having sons?
.....
707. What in your opinion, are the reasons for having daughters?
.....

Appendix III

Focus Group Discussion Guide

1. Who decides the timing of marriage and choice of partner?
2. Who decides the extent to which status of parents, their religion and ethnic affiliations influence the choice of partners?
3. Are there differences between these choices in relation to the sexes?
4. Before marriage, did you think of number of children you needed to have? Did you discuss of number of children before marriage?.

Discuss the following:

- (i) the importance of children
 - (ii) the point at which couples decide the number of children they desire to have
 - (iii) person(s) they discuss with
 - (iv) the number of children participants decided to have
 - (v) the circumstances or factors that influence those decisions (Probe the role of significant others such as parents, grand parents, friends, economic situations, etc.).
- Discuss whether there is agreement or disagreement between you and your partner on choice of family size.
 - Where there is no agreement whose views prevail? (probe why).
 - Discuss whether participants are aware of the national population policy? Probe for specific issues relevant to the study such as family size of four children per woman etc.

5. What do you perceive as the men's role in their wives health?

6. Identify the roles that men in this community play with respect to their wives's health.
7. In this community, to what extent do you think that the men perform these roles?
8. What role do men play in this community in reproductive decision making?
9. How can we promote joint decision making between couples on reproductive choice in this community?
10. To what extent do you think a woman has control over her health and sexuality in this community? (Probe further- knowledge about family planning techniques). If you do not want to be pregnant (or your wife), do you know how to avoid pregnancy? How?
11. To what extent can you say that what men in this community know about family planning is adequate or inadequate?
12. What do you think the men know about family planning?
13. In terms of contraceptive use, who do you think always initiate action among the husband and wife?
14. What are the cultural factors contraining or enhancing male participation in the promotion of family planning?
15. What do you think could be done to enhance knowledge of family planning techniques among men in the reproductive age?
 - Discuss possible ways of preventing pregnancy (probe for both traditional and modern such as breastfeeding, abstinence, use of rings, pill, IUD, condom, other traditional and modern methods)
 - Type use by participants and why?
 - Who decides the choice of contraceptives?
16. What specific support do men give their wives when such wives start to attend family planning clinic?

17. Discuss whether you have ever had cause to disagree with your partner on the issue of using family planning methods? If you ever disagreed, why?
18. In your opinion, what do you consider to be the most effective way of sensitizing the community - male and female on the issue of family planning?
19. Discuss way by which men can be reached on the effectively on what they need to know about family planning techniques and why they need to complement the efforts of their wives.

