

Research Article

Men's Involvement in Wives' Contraceptive Choices: A Comparative Study in Rural and Urban Communities of Akure South Local Government Area

Ebenezer Obi Daniel^{1,3,*} , Oluseyi Oludamilola Olawale² , Ahmed Mamuda Bello³ , Israel Olukayode Popoola⁴ , Olukayode Oladeji Alewi³ , Michael Olabode Tomori³ , Michael Avwerhota⁵ , Adebanke Adetutu Ogun⁶ , Taiwo Aderemi Popoola⁷ , Aisha Oluwakemi Salami³ , Celestine Emeka Ekwuluo⁸ 

¹Department of Public Health, Swansea University, Swansea, United Kingdom

²Department of Public Health, Walden University, Minneapolis, United States of America

³Department of Public Health, Texila American University, Georgetown, Guyana

⁴Department of Epidemiology and Community Health, University of Ilorin, Ilorin, Nigeria

⁵Department of Public Health, Atlantic International University, Hawaii, United States of America

⁶Department of Policy, Governance, Liaison, and Support, International Organization for Migration, Abuja, Nigeria

⁷Department of Research, PhMetrika Limited, Birmingham, United Kingdom

⁸Department of Child Health, United Nations International Children's Emergency Fund, Abuja, Nigeria

Abstract

In rural Nigerian communities, men play a crucial role in family planning decisions, often determining if and how their wives can practice contraception. This study aimed to examine the extent of husbands' influence on their wives' contraceptive choices, comparing rural and urban areas in Akure South local government area. The research included a sample of 360 men, using a researcher-developed questionnaire and interview guide for data collection. Descriptive statistics such as frequencies, percentages, means, and standard deviations were used to analyze the data, and chi-square inferential statistics tested the hypothesis at a 0.05 significance level using SPSS version 17. Findings revealed that only 46% of rural respondents participated in family planning practices. Men's engagement in these activities showed low mean values (2.21, 2.11, 2.25), indicating minimal involvement, primarily due to lack of information (40.5%) and limited contraceptive options (34.8%). Most men used condoms (23.8%), a combination of condoms and withdrawal (27.5%), or vasectomy (13.1%). The study concluded that male participation in family planning was low. To improve this, communities need better access to information, education, and communication. Cultural and religious barriers hindering male involvement in family planning should be addressed, and more male contraceptive options should be made available.

Keywords

Contraceptives, Rural and Urban Communities, Men's Involvement

*Corresponding author: dannypressy@yahoo.com (Ebenezer Obi Daniel)

Received: 1 June 2024; Accepted: 21 June 2024; Published: 26 June 2024



Copyright: © The Author(s), 2024. Published by Science Publishing Group. This is an **Open Access** article, distributed under the terms of the Creative Commons Attribution 4.0 License (<http://creativecommons.org/licenses/by/4.0/>), which permits unrestricted use, distribution and reproduction in any medium, provided the original work is properly cited.

1. Introduction

Globally, 190 million adolescent girls and women of reproductive age have an unmet need for contraception, affecting 10% of the population in need [1]. This unmet need, defined as the gap between women's reproductive intentions and their contraceptive use [2], results in significant setbacks in ensuring positive reproductive health outcomes. Contraception, essential for effective family planning, includes modern and traditional methods such as oral contraceptives, implants, IUDs, and the rhythm method [3]. However, a substantial unmet need persists due to factors like limited access to modern contraceptives, particularly for adolescents and unmarried women, cultural and religious restrictions, fear of side effects, and provider bias [3].

The framing of contraception primarily as a family planning resource for couples often excludes unmarried and adolescent girls seeking to prevent pregnancy or manage menstrual health. This exclusion leads to stigma and higher unmet needs among younger women [4]. Additionally, religious beliefs significantly influence cultural norms about contraception, contributing to the global unmet need. Religions such as Catholicism, Christianity, Judaism, and Islam often discourage premarital sex and contraceptive use, leading to shame and reluctance among women and girls to seek contraception [5, 6]. Healthcare providers' personal beliefs can also affect their willingness to provide contraceptives [7]. Misconceptions and lack of education about contraceptives further exacerbate fears of side effects, despite serious side effects being rare. Accurate reproductive health education, as advocated by Hennegan et al. [8], is crucial to improving contraceptive knowledge and usage.

High unmet contraceptive needs are linked to negative health outcomes, including high maternal mortality rates. Maternal mortality, defined as the death of a woman during pregnancy or within 42 days of termination due to pregnancy-related causes [9], predominantly occurs in low- and middle-income countries (LMICs), particularly in sub-Saharan Africa and South Asia [10]. Over 300,000 women die annually from pregnancy and childbirth complications, with a global maternal mortality ratio (MMR) of 216 deaths per 100,000 live births [11]. Adolescent pregnancies significantly contribute to these statistics, being the leading cause of death among adolescents aged 15-19 and often resulting in unsafe abortions due to restricted access to services [12, 13]. These pregnancies also negatively impact infant mortality rates and disrupt educational and economic prospects for adolescent mothers [14].

In Nigeria, a country with a projected population growth from 183 million to 285 million by 2050, there are about 35 million women of reproductive age, contributing to over 7 million births annually. The country's high fertility rate of 5.5 children per woman, coupled with significant economic challenges, exacerbates health issues. Nigeria's maternal

mortality rate is high, with 145 deaths per 100,000 live births, and infant mortality stands at 78 per 1,000 live births [15]. A woman's risk of dying from pregnancy and childbirth in Nigeria is as high as 1 in 13 [16], partly due to the low contraceptive prevalence rate.

Despite global recognition of the importance of male involvement in family planning, Nigerian programs largely focus on women, neglecting the significant role men can play. Men's participation is crucial, either as users of male contraceptive methods or as supportive partners [17]. This is particularly relevant in rural areas like Akure, where traditional and cultural norms heavily influence family planning decisions. Rural communities often resist change, and men exercise considerable control over reproductive health decisions [18]. Addressing these cultural and educational barriers is essential for improving family planning acceptance and reproductive health outcomes in these communities.

2. Materials and Methods

2.1. Study Design

This study employs a cross-sectional descriptive design to collect both quantitative and qualitative data. Cross-sectional designs are useful in observing and analyzing the current status of variables within a population at a single point in time, facilitating the understanding of prevalent conditions and behaviors. This design is particularly suitable for this study as it aims to assess the influence of male participation in family planning practices among married men in Akure South local government area. The descriptive nature of the design allows for detailed documentation and analysis of the existing attitudes, knowledge, and practices related to family planning.

2.2. Sampling Technique

A simple random sampling technique will be utilized to select the study participants. This method ensures that every member of the target population has an equal chance of being included, thereby minimizing selection bias and enhancing the representativeness of the sample. The target population comprises married men living with their wives and having at least one child within Akure South local government area. The local government area is divided into 15 districts, from which a sample size of 360 respondents will be drawn. This sample size is considered adequate to provide reliable and valid data for the study's objectives.

2.3. Data Collection

Data collection will involve both questionnaires and interviews to gather comprehensive information. Structured ques-

tionnaires will be distributed to the selected sample of married men. The questionnaires will include a series of closed-ended questions designed to elicit specific responses about family planning knowledge, attitudes, and practices. A total of 360 questionnaires will be distributed across the 15 districts within Akure South local government area. To accommodate respondents who may be illiterate, trained interviewers will assist in administering the questionnaires orally, ensuring accurate and complete data collection. In addition to questionnaires, in-depth interviews will be conducted with a subset of respondents. These interviews will focus on exploring subjective experiences and perceptions related to contraceptive use and family planning. The combination of quantitative data from questionnaires and qualitative data from interviews will provide a well-rounded understanding of the factors influencing family planning practices in the study area.

2.4. Ethical Consideration

Ethical considerations are paramount in this study to ensure the rights and well-being of participants are protected. Approval for the study will be sought from the relevant ethical review board. Informed consent will be obtained from all participants prior to data collection. Participants will be fully informed about the purpose of the study, the procedures involved, and their right to withdraw at any time without any penalty. Confidentiality will be strictly maintained, with data anonymized to protect the identities of the respondents. The study will also adhere to ethical principles regarding data handling and reporting. Data will be securely stored, and access will be limited to the research team. Findings will be reported in an aggregated manner to prevent the identification of individual participants. By adhering to these ethical guidelines, the study aims to maintain high standards of integrity and respect for the participants' dignity and autonomy.

3. Results

3.1. Socio Demographic Characteristic of the Respondents

Table 1 revealed that 75 respondents (21.6%), 84 respondents (24.1%), and 189 respondents (54.3%) were between the ages of 30 and 49. Additionally, 54 respondents (15.5%) had no formal education, 42 (12.1%) completed primary education, 93 (26.7%) completed secondary education, and 159 (45.7%) completed tertiary education. The occupations of the men were as follows: 78 (22.4%) farmers, 62 (17.8%) traders, 196 (56.3%) public servants, and 12 (3.4%) artisans. The majority of the men were Christians (87.9%), followed by Muslims (18.2%) and traditionalists (6.9%).

Table 1. Socio demographic characteristic of the respondents.

Gender	Frequency	Percentage
Age range		
20-29	-	-
30-39	84	24.1
40-49	75	21.6
50& above	189	54.3
Mean age = 45.2 yrs		
Level of education		
No formal education	54	15.5
Primary education	42	12.1
Secondary education	93	26.7
Tertiary education	159	45.7
Occupation		
Farming	78	22.4
Trading	62	17.8
Public servant	196	56.3
Artisan (plumber, electricians)	12	3.4
Religion		
Christianity	306	87.9
Moslem	18	5.2
Traditional religion	24	6.9

3.2. Proportion of Men Engage in Family Planning

Table 2 reveals that 188 (54%) of the men do not now use family planning, whereas 160 (46%) of them do. In the communities, less than 50% of the men use family planning.

Table 2. Respondents responses to the percentage of men who get involved in practicing family planning.

Are you currently involved in family planning	Frequency	Percentage
Yes	160	46
No	188	54
Total	348	100

3.3. Men's Engagement in Their Spouse Contraception Decisions

Table 3 shows that 32 respondents (9.2%) strongly disagree that cultural ignorance affects men's involvement in family planning, while 148 (42.5%) strongly agree, 118 (33.9%) agree, and 50 (14.4%) disagree. The low standard deviation of 1.26 and high mean value of 3.10 indicate limited diversity of replies and a majority agreement. Regarding the lack of contraceptive methods, 35 respondents (10.1%) strongly agree, 141 (40.1%) agree, 126 (36.2%) strongly agree, and 46 (13.2%) disagree. The low standard deviation of 1.27 and high mean value of 3.03 again indicate limited response diversity and a majority agreement. For the lack of male-specific family planning facilities, 109 (31.3%) strongly disagree, 103 (29.6%) disagree, 81 (23.3%) agree, and 55 (15.8%) strongly agree. The low mean value of 2.24 and small standard deviation of 1.45 suggest more respondents disagree. On poor IEC as a factor, 74 respondents (21.3%) strongly disagree, 67 (19.3%) disagree, 128 (36.8%) agree, and 79 (22.7%) strongly agree. The mean value of 2.61 and standard deviation of 1.33 indi-

cate more respondents agree. Regarding religious views, 87 respondents (25.0%) strongly agree, 80 (23.0%) strongly disagree, 62 (17.8%) disagree, and 119 (34.2%) agree. The mean value of 2.61 and standard deviation of 1.33 reveal a tendency towards agreement. For cultural impact, 62 respondents (17.8%) strongly disagree, 68 (19.5%) disagree, 106 agree, and 112 strongly agree. The high mean value of 2.77 and standard deviation of 1.52 indicate more agreement. On economic concerns, 81 respondents (23.3%) strongly disagree, 87 (25.0%) disagree, 109 (31.3%) agree, and 71 (20.4%) strongly agree. The mean value of 2.49 and standard deviation of 1.49 suggest more disagreement. Regarding spousal influence, 88 respondents (25.3%) strongly disagree, 39 (11.2%) disagree, 120 (34.5%) agree, and 101 (29.0%) strongly agree. The mean value of 2.67 and standard deviation of 1.45 indicate more agreement. Lastly, on provider availability, 105 respondents (30.2%) strongly disagree, 114 (32.8%) disagree, 73 (21.0%) agree, and 56 (16.1%) strongly agree. The mean value of 2.23 and standard deviation of 1.37 suggest more disagreement. Overall, a high mean value of 2.64 indicates these factors determine their participation.

Table 3. Respondents response to aspects of men's engagement in their spouse's contraception decisions.

SN	Factors	Strongly Agree	Agree	Disagree	Strongly Disagree	Mean				
1	Inadequate knowledge	148	42.5%	118	33.9%	50	14.4%	32	9.2%	3.10 ± 1.26
2	Lack of contraceptive for men	126	36.2%	141	40.1%	46	13.2%	35	10.1%	3.03 ± 1.27
3	Lack of exclusive family planning for men	55	15.8%	81	23.3%	103	29.6%	109	31.3%	2.24 ± 1.45
4	Poor IEC	79	22.7%	128	36.8%	67	19.3%	74	21.1%	2.61 ± 1.33
5	Religious belief	87	25.0%	119	34.2%	62	17.8%	80	23.0%	2.61 ± 1.32
6	culture	112	32.2%	106	30.5%	68	19.5%	62	17.8%	2.77 ± 1.52
7	Economic concern	71	20.4%	109	31.3%	87	25.0%	81	23.0%	2.49 ± 1.49
8	Spouse influence	101	29.0%	120	34.5%	39	11.2%	88	25.3%	2.67 ± 1.45
9	Provider availability	56	16.1%	71	21.0%	114	32.8%	105	30.2%	2.23 ± 1.37
	Overall mean	2.64								

3.4. Role Men Play in Family Planning

According to Table 4, 68 (19.5%) and 54 (15.4%) of the men use contraceptives significantly, while 92 (26.4%) use them moderately, and 134 (38.5%) use them extensively. The high average of 2.83 and low standard deviation of 1.53 indicate extensive contraceptive use with little variation in responses. Additionally, 88 (25.3%) and 126 (36.2%) of respondents provide very low or low support for their spouse's use of family planning, with only 64 (18.4%) supporting it

highly and 70 (20.1%) moderately. The low mean value of 2.21 and standard deviation of 1.55 indicate low support and little response variability. Decision-making about contraceptive use is very low for 50 (14.4%) respondents, low for 54 (15.5%), moderate for 129 (37.1%), and high for 115 (33%), with a high mean value of 2.89 and low standard deviation of 1.38 indicating significant decision-making involvement. Regarding open discussion of family planning, 59 (17.0%) engage highly, 66 (19.0%) moderately, and 110 (31.6%) very lowly, with a low mean value of 2.21 and standard deviation of 1.46 indicating low discussion levels. Accompanying

spouses to family planning facilities is very low for 130 (37.4%) respondents, low for 117 (33.6%), moderate for 33 (9.5%), and high for 68 (19.5%), with a mean value of 2.11 and standard deviation of 1.52 indicating low accompaniment levels. Finally, 104 (29.9%) give money for family planning

to a very low extent, 114 (32.8%) to a low extent, 68 (19.5%) to a moderate extent, and 62 (17.8%) to a high extent, with a mean value of 2.25 and standard deviation of 1.46 indicating low financial support. Overall, the mean value of 2.42 indicates poor involvement generally.

Table 4. Showing the kind of role men plays in family planning.

SN	Items	Highly extent		Moderate extent		Low extent		Very low extent		Mean + SD
1	I use contraceptive method	134	38.5%	92	26.4%	54	15.4%	68	19.5%	2.83 ± 1.53
2	I support my wife to use a family planning method	64	18.4%	70	20.1%	88	25.3%	126	36.2%	2.21 ± 1.55
3	I decide in favour of contraceptive use and continuity within the family	115	33.0%	129	37.1%	54	15.5%	50	14.4%	2.89 ± 1.38
4	I discuss family planning freely with my wife	59	17.0%	66	19.0%	113	32.5%	110	31.6%	2.21 ± 1.46
5	I accompany my wife to the facilities to obtain family planning services	68	19.5%	33	9.5%	117	33.6%	130	37.4%	2.11 ± 1.52
6	I give my wife money for family planning	62	17.8%	68	19.5%	114	32.8%	104	29.9%	2.25 ± 1.46
	Over all mean	2.42								

3.5. Type of Family Planning Male Population in the Communities Under Study Prefer

Table 5 shows that out of 160 men who are currently involved in family planning, 38 (23.8%) use only condom, 21 (13.1%) use only vasectomy, 111 (31.9%) use only withdrawal while 44 (27.5%) use both condom and withdrawal methods of family planning.

Table 5. Respondents responses to the methods of family planning adopted mostly by men in these communities.

Which of the following family planning methods do you use	Frequency	Percentages
Condom only	38	23.8
Vasectomy only	21	13.1
Withdrawal only	57	35.6
Both condom & withdrawal	44	27.5
Total currently using	160	100

4. Discussion

4.1. To Determine the Percentage of Men Involved in Practicing Family Planning in the Communities Studied

The findings showed that 46% of men engage in family

planning, indicating that less than half of the respondents participate in family planning within their communities. This result aligns with Hossain's [19] study in Bangladesh, which reported a low male engagement rate (40%). Conversely, studies in India [20] and Ilorin [21] revealed higher rates of male participation at 65.9% and 58%, respectively.

4.2. To Identify Factors Affecting Men's Involvement in Family Planning in These Communities

The study identified several factors influencing men's engagement in family planning: limited awareness, few male contraceptive options, poor information, education, and communication (IEC), cultural and religious beliefs, financial concerns, and spousal influence. Nustas [22] found spousal impact significant in Jordan, noting that men who discuss contraception with their wives are more likely to use family planning. Akafuah and Sossou [23] similarly linked spousal communication with contraceptive use. Hossain [19] highlighted that urban men have better access to contraceptives. Bunce et al. [24] in Jordan both found financial difficulties to be a significant motivator for using family planning methods. Religious affiliation also influenced participation, as noted by Gueye et al., [25], who observed persistent myths about family planning among Tanzanian men, particularly regarding vasectomy.

4.3. To Identify the Nature of Men's Involvement in family Planning

The findings revealed that 35.3% of men make decisions supporting contraceptive use and family continuity, while 24.7% use contraceptives extensively. However, few men actively encourage their partners to use family planning methods, discuss family planning openly, accompany partners to family planning facilities, or financially support their partners. This suggests limited male involvement in contraception. The results are consistent with Sabir et al., who noted that in Bangladesh, men often decide on family planning. Hossain (19) reported a 62.6% contraceptive use rate among Turkish men, similar to findings from Onuoha (18) in Zimbabwe.

4.4. To Identify Methods Mostly Adopted by Men in the Communities Studied

The findings indicated that withdrawal, condoms, and vasectomy are the most commonly used family planning methods among men. This is consistent with Puri et al. [20] in Chandigarh, India, where 31% of men use condoms. Hossain [19] reported low withdrawal method usage (26.2%) in Turkey, while Olawepo and Okedare [21] found withdrawal and vasectomy to be among the least popular methods in Ilorin.

5. Conclusions

In conclusion, improving family planning programming to better involve men is essential for increasing voluntary uptake among couples, particularly in West Africa, where national goals aim to reach new modern contraceptive users by 2020. Engaging men in family planning not only enhances contraceptive use but also promotes gender equality, as men play a

crucial role in decision-making and can act as agents of change. Current programs often exclude men, neglecting their need for collaborative decision-making. Addressing this gap requires understanding men's concerns, misconceptions, and roles in family planning decisions. Programs that encourage joint counseling by community health workers or trusted couples can build trust and facilitate communication. Future research should focus on the practices, attitudes, and motivations that enable men to engage in family planning, integrating these insights into programs and campaigns. Additionally, introducing new male contraceptive methods, ensuring reliable supplies of male condoms, incorporating family planning into formal education, and encouraging men to discuss family planning with their partners can significantly enhance male participation and overall contraceptive use.

Abbreviations

SPSS	Statistical Package for Social Sciences
LMIC	Low- and Middle-Income Countries
MMR	Maternal Mortality Ratio
LGA	Local Government Area
IEC	Information, Education and Communication

Conflicts of Interest

The authors declare no conflicts of interest.

References

- [1] United Nations. World population prospects, the 2012 revisions: Key findings and advance tables. New York: United Nations; Working Paper No. ESA/P/WP.227.
- [2] Bongaarts, J., Bruce, J. The Causes of Unmet Need for Contraception and the Social Context of Services; 1995.
- [3] Çalikoğlu EO, Bilge Yerli E, Kavuncuoğlu D, Yılmaz S, Koşan Z, Aras A. Use of Family Planning Methods and Influencing Factors Among Women in Erzurum. *Med Sci Monit.* 2018 Jul 19; 24: 5027-5034. <https://doi.org/10.12659/MSM.908388> PMID: 30024863; PMCID: PMC6063134.
- [4] Islam, A. Z., Mostofa, M. G., Islam, M. A. Factors affecting unmet need for contraception among currently married fecund young women in Bangladesh. *The European Journal of Contraception & Reproductive Health Care.* 2016, 21(6), 443-448.
- [5] Adamczyk, A., Hayes, B. E. Religion and Sexual Behaviors: Understanding the Influence of Islamic Cultures and Religious Affiliation for Explaining Sex Outside of Marriage. *American Sociological Review.* 2012, 77(5), 723-746. <https://doi.org/10.1177/0003122412458672>
- [6] Belmonte, E., Gavilanes, M., Del Vayo, M., Ramírez, V. Religion: The Sin of Birth Control. *Medicamentalia.* Retrieved from <https://medicamentalia.org/contraceptives/religion/> [Accessed 1 June 2024].

- [7] Bird, M. Even in 'Progressive' States, Doctors Can Still Shame Women Out of Accessing Birth Control. Rewire. News. Retrieved from <https://rewire.news/article/2018/04/04/even-progressive-states-doctors-can-still-shame-women-accessing-birth-control/> [Accessed 1 Jun. 2024].
- [8] Hennegan, Julie et al. Women's and girls' experiences of menstruation in low- and middle-income countries: A systematic review and qualitative metasynthesis. *PLoS medicine*. 2019, 16(5), e1002803. <https://doi.org/10.1371/journal.pmed.1002803>
- [9] World Health Organization. Health statistics and information systems: Maternal mortality ratio (per 100 000 live births). Retrieved from <https://www.who.int/healthinfo/statistics/indmaternalmortality/en/> [Accessed 1 Jun. 2024]; 2019.
- [10] Streatfield, P. K., Alam, N., Compaoré Y., Rossier, C., Soura, A. B., Bonfoh, B., ... Byass, P. (2014). Pregnancy-related mortality in Africa and Asia: evidence from INDEPTH Health and Demographic Surveillance System sites. *Global Health Action*, 7(1). <https://doi.org/10.3402/gha.v7.25368>
- [11] Zureick-Brown S, Newby H, Chou D, Mizoguchi N, Say L, Suzuki E, Wilmoth J. Understanding global trends in maternal mortality. *Int Perspect Sex Reprod Health*. 2013 Mar; 39(1): 32-41. <https://doi.org/10.1363/3903213> PMID: 23584466; PMCID: PMC3886625.
- [12] Guttmacher Institute. Unintended Pregnancy and Unsafe Abortion in The Philippines: Context and Consequences. In Brief; 2013.
- [13] Olukoya, A. A., Kaya, A., Ferguson, B. J., AbouZahr, C. Unsafe abortion in adolescents. *International Journal of Gynecology & Obstetrics*. 2001, 75(2), 137-147.
- [14] Melgar, J. L., Melgar, A. R., Festin, M. P. R., Hoopes, A. J., Chandra-Mouli, V. Assessment of country policies affecting reproductive health for adolescents in the Philippines. *Reproductive health*. 2018, 15(1), 205.
- [15] UNICEF. Situation of women and children in Nigeria. Available from: <https://www.unicef.org/nigeria/situation-women-and-children-nigeria> [Accessed 1 Jun. 2024].
- [16] Ujah, I. A. O., Aisien, O. A., Muthir, J. T., Vanderjagt, D. J., Glew, R. H., & Uguru, V. E. (2005). Factors Contributing to Maternal Mortality in North-Central Nigeria: A Seventeen-Year Review. *African Journal of Reproductive Health / La Revue Africaine de La Santé Reproductive*, 9(3), 27–40. <https://doi.org/10.2307/3583409>
- [17] Fumilayo, O., Kolawole, K. O. Training Handbook for family planning clinics, services providers, fertility Research unit, college of medicine University of Ibadan; 2000.
- [18] Onuoha, J. From vision to Action: An inquiring in the place of men in reproductive health. *Reproductive health in southeastern Nigeria*, institute for development subsidies University of Nigeria, Enugu Campus; 2000.
- [19] Hossain, Kazi. Male Involvement in Family Planning in Bangladesh: Factors Constraining Low Use and the Potential for Augmenting the CPR; 2003.
- [20] Puri CP, Balaiah D, Iyer KS. Increased male responsibility and participation: a key to improving reproductive health. *ICMR Bull*. 2009, 29(6), 59-70.
- [21] Olawepo, R. A., Okedare, E. A. Men's Attitudes towards Family Planning in a Traditional Urban Centre: An Example from Ilorin, Nigeria. *Journal of Social Sciences*. 2006, 13, 83-90. <https://doi.org/10.1080/09718923.2006.11892535>
- [22] Petro-Nustas, W. Men's Knowledge of and Attitudes Toward Birthspacing and Contraceptive Use in Jordan. *International Perspectives on Sexual and Reproductive Health*. 1999, 25, 181. Available at: <https://www.guttmacher.org/journals/ipsrh/1999/12/mens-knowledge-and-attitudes-toward-birthspacing-and-contraceptive-use-jordan> [Accessed 1 Jun. 2024].
- [23] Akafuah, R. A., Sossou, M.-A. Attitudes toward and use of knowledge about family planning among Ghanaian men. *International Journal of Men's Health*. 2008, 7(2), 109–120. <https://doi.org/10.3149/jmh.0702.109>
- [24] Bunce, A., Guest, G., Searing, H., Frajzyngier, V., Riwa, P., Kanama, J., Achwal, I. Factors Affecting Vasectomy Acceptability in Tanzania. *International Perspectives on Sexual and Reproductive Health*. 2007, 33, 13. Available at: <https://www.guttmacher.org/journals/ipsrh/2007/03/factors-affecting-vasectomy-acceptability-tanzania> [Accessed 1 Jun. 2024].
- [25] Gueye A, Speizer IS, Corroon M, Okigbo CC. Belief in Family Planning Myths at the Individual and Community Levels and Modern Contraceptive Use in Urban Africa. *Int Perspect Sex Reprod Health*. 2015, 41(4), 191-9. <https://doi.org/10.1363/4119115>