
**FACTORS DETERMINING THE ADOPTION OF FAMILY PLANNING METHODS IN
KADUNA NORTH LOCAL GOVERNMENT AREA, NIGERIA**

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ABSTRACT

This research focused on the factors determining the adoption of family planning in Kaduna north Local Government Area. Ancestral customs gives men rights over women's procreative power. In such situations, the husband's approval is often a precondition for a woman to use family planning (FP). The views of gender have not received proper attention, thus leading to a backdrop of knowledge on the role of gender and responsibility in reproductive health decision and this research tend to address part of this challenge. Data for the research was acquired through questionnaire, in-depth interview with key informants and focus group discussions (FGDs). Krejcie and Morgan, (1970) formula was used to determine the sample size of 400 out of the total population of 497,783. A multi-stage sampling technique was used in which purposive, systematic and random sampling techniques were used at different stages. Both graphical and inferential statistical techniques were employed in the analysis of data collected. The results indicated that age, educational attainment, religion, and income level of the respondents were among the factors determining family planning adoption method in Kaduna north Local Government Area with significant values of ($p= 0.03, 0.00, 0.00, \text{ and } 0.035$) respectively. However, for better adoption of FP programmes, the study recommended that greater political will from the local government officials, which includes more commitment in supporting family planning programmes, is needed and not just population policies on paper. There should be spousal communication on FP matters, where both gender can come up with reasonable mutual decision on reproductive health issues. This will help facilitate transition to lower fertility.

KEYWORDS: Adoption, Family planning, Method, Kaduna north

INTRODUCTION

Family planning is now seen as a human right basic to human dignity. People and governments around the world understand this. For several decades, demographers working in Africa have focused their attention largely on women's attitudes and behaviour in matters concerning reproduction forgetting men. Although men and women are biological partners in the reproductive processes, greater emphasis has been placed on the role of women, who bear the physical and emotional strains of pregnancy and childbirth. This preoccupation with women has tended to minimize the reproductive motivation of African men, thereby ignoring the social significance of people who are dominant not only within the family, but also at community and governmental levels. On account of the patriarchal system in Nigeria, fertility attitudes of women are mostly dictated by masculine values (Isiugo-Abanihe, 2003).

Pronatalist pressures are reinforced by males over females which preclude women from controlling their own fertility. Most rapid increase in Nigeria's population growth is accentuated by pronatalist attitudes of men. In addition, men's perception of their fecundity and their actual paternity status can have a dramatic impact on their definition of sex and their subsequent behaviour, especially if the culture associates reproductive prowess with masculinity, as is common among many ethnic groups in Nigeria (Adamchak and Adebayo, 1985). Danforth (2009), indicated that overwhelming reliance on female FP methods has led to the assumption on the part of many women and men that contraception is only for women. This also resulted in women being the most family planning users, not men due to the perception or belief that men want large families to prove their virility. In spite of all these realizations, there is paucity of demographic data on male knowledge, attitude and practice of contraception in Nigeria. In other words, there is need to know the reproductive intentions and expectations of Nigerian men more than ever before. Ignoring men in fertility research and programmes undermines effort both to change their attitudes on population matters and to motivate them, and through them, their wives, toward FP.

Men are dominant in the society and family, they play many powerful roles as husbands, fathers, uncles, religious leaders, policy makers, local and national leaders, doctors and much more (Varga, 2001). The values and practices that subjugate women are also deeply rooted in religious belief. Christianity, Islam, and indigenous Nigerian religions, share a rare agreement with respect to the position of the woman in the home. These religions prescribe that women should obey their husbands, should be submissive to them and feed the family members. In Nigeria, patriarchy promotes high fertility by providing incentives among women for a large family size; for instance, "Ewu-Ukwu" is a ceremony held for mothers of ten or more children in the Igbo culture. Women who attain this position of distinction enjoy some privileges with high esteem. Much more, socioeconomic realities confer on men the status of providers of the family, and women, generally depend on men for their sustenance and wellbeing. Some men as a result, disapprove of their wives working outside the home or acquiring property, in a bid to ensure women's dependence on men; thereby maintaining women's compliance to the whims and caprices of men (Isiugo-Abanihe, 2003). These traditional values continue to shape conjugal relations, notwithstanding the forces of modernization.

The roles men and women can play in FP are at the most basic level, the product of human biology. Women have more of a stake in FP, because it is they not men, who get pregnant, bear the physical and emotional strain of carrying pregnancy for nine months; if they live and may also face the substantial risk of dying in childbirth. Men in contrast, share none of the burdens or health problems of pregnancy and childbirth. The narrow perspective of the role men can play in FP and in the family in general is largely a product of male stereotype. In this traditional view, the typical man wants a large family to prove his masculinity (Stokes, 1980).

Given the overwhelming dominance of men in family life, there is the urgent need to change their orientation and behaviour as a prelude to a positive change in family relationships and behaviour, which have deep cultural roots. For FP to succeed, it is important that men lend it their utmost support.

STATEMENT OF THE PROBLEM

In spite of the introduction of FP services as a means of curbing fertility rate, the population of Nigeria still rises because of the attitudes of the people involved. This is noticed especially in men and the role they play in reproduction. More so, in a country where culture and religion are deeply rooted in people's lives, achieving the four children per couple is almost unrealistic. It is particularly urgent, however, for men on account of their dominant role in the society as heads, community, religious and political leaders to assume an active role in planning the family (Isiugo-Abanihe, 2003).

Most communities in Kaduna State still have male dominated cultures. Ancestral customs give men rights over women's procreative power. In such situations, the husband's approval is often a precondition for a woman to use FP. Even in developed societies, studies have shown important effects of the husband's desires on a couple's fertility. Many men feel they are losing their role as the head of the family, because FP gives women greater economic empowerment. So they dig their heels and refuse to cooperate in FP matters, even though they may acknowledge that taking responsibility for FP would be in their own and family's best interest (Stokes, 1980).

Kaduna North LGA, a Hausa society located in northern Nigeria is patrilineal with a strong male influence on many household decisions including those involving reproduction. This makes the attitudes of male toward Health decision making and contraceptive use a significant factor influencing the overall fertility level in the Local Government Area. It is against this background that this research focus on the factors determining the adoption of family planning method in Kaduna north LGA.

STUDY AREA AND METHODOLOGY

Study Area

Kaduna North is a local government in Kaduna State. It is located between latitudes 10°29'0"N to 10°38'59"N and longitudes 7°26'E to 7°31'E. It has its secretariat at Magajin Gari area of Doka District. Kaduna North LGA is bordered by Chikun Local Government Area in the South and South-eastern part, while at Northern part by Igabi Local Government Area, and to the West by Kaduna South Local Government Area. Kaduna North Local Government Areas is made up of 12 wards as:

Badarawa/Malali, Hayin banki/Ugwan Kanawa, Kabala ward, Kabala Costain, Maiburuji, Kawo/Rafin guza, Shaba Ward, Ungwan Liman, Ungwan Rimi, Ungwan Shanu/Abakwa, Ungwan sarki,, and Ungwan Gaji

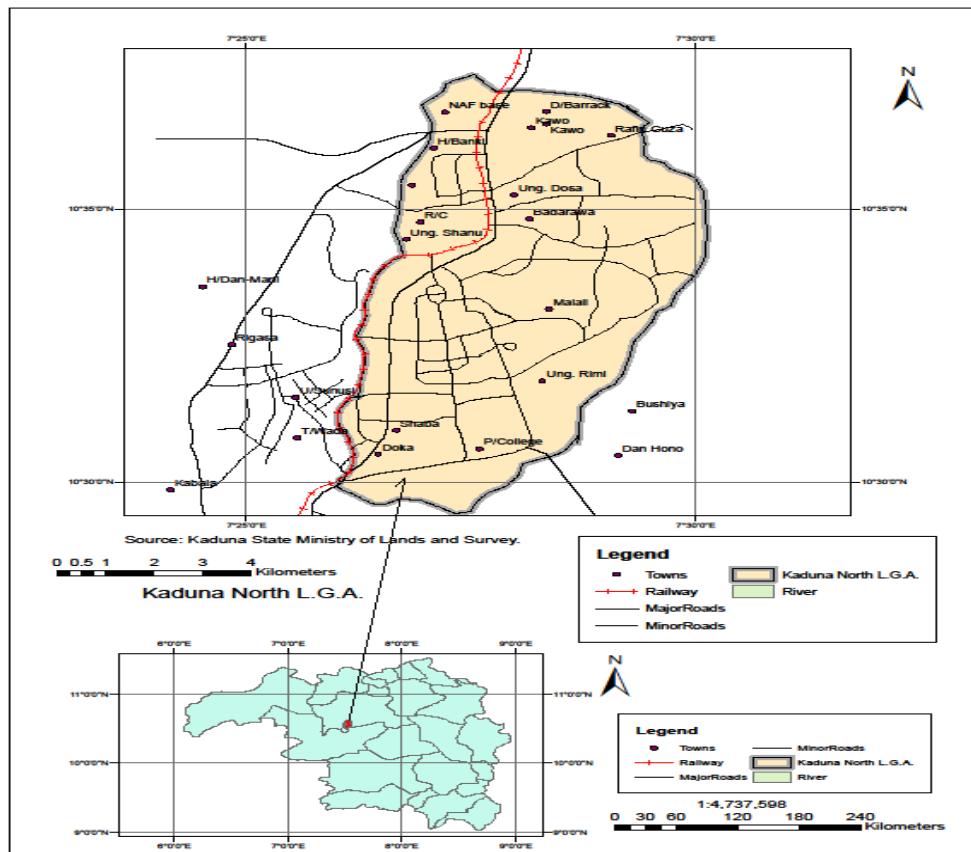


Fig. 1: Kaduna Metropolis Showing Kaduna North
Source: Adapted From Google Earth, 2018.

The Geology of Kaduna North is that of the Precambrian Basement Complex rock. The topographical relief is relatively flat, having an elevation of between 600–650 meters in large areas of the local government. It is over 650 meters above mean sea level in some places, and below 500 meters in places that slope downward towards the river Mamman (1992).

The climate is part of the tropical wet and dry climate of Nigeria. The wet season begins in April and ends in October, though there is fluctuation in the beginning and the ending of the wet season from year to year Mamman (1992). The annual rainfall received ranges between 900mm-1100mm with a raining period of 150-160 days. The peak of the rainy season occurred during the month of August.

From October to April, the area is subjected to cool dry north-easterly winds which have no rain. During this time, farming can only take place by means of irrigation (Blair et al., 1977).

The mean maximum monthly temperature occurs in March to May which ranges between 33.40c and 34.90c while the mean minimum temperature was in December and January with records of 19.10c to 21.80c (Mamman, 1992). During the rainy season, especially in the month of August, humidity of more than 80% are recorded with low mean monthly records of less than 20% in January (Mamman, 1992).

The soils of Kaduna North are typical red-brown to red-yellow tropical ferruginous soils. The soil is developed from the crystalline rocks of the basement complex, mainly sandstone sedimentary rocks which serves as parent material. (Mamman, 1992). The vegetation falls within the Northern sub-zone of the Guinea Savannah that is characterized by savannah type of vegetation which has been greatly altered and modified. The dominant species of trees include *Isobertina* (doka), *Isobertinatomentosa*, *Monotes Kerstingii* and *Uapacatogensis*. The savannah woodland has been severely exploited for grazing, cultivation, fuel wood, building materials, and construction purposes Mamman (1992).

The Tribes found in the study area are Gwari, Hausas and Fulani, Yoruba, Idoma, Calabar, Igbo and Igala etc. It has an area of 72 km² and a population of 357,694 at the 2006 census, with the population projection of 497,783 in 2017. The area has a mixed of population, but the major dominants ethnic groups are the Hausas. Kaduna North Local Government Area consists of several health care facilities both public and private. The public health care facilities in the area are Barau Dikko Teaching Hospital, General Hospital Kawo, Primary Health Care Badarawa, Primary Health Care U/Shanu and Zakari Isa Hospital; all these render Health Care services with free family planning services. The private health care centers are many; to mentioned few of them are Giwa Hospital, Garkuwa Specialist, Brains Specialist Hospital Limited, Albarka Hospital and Maternity, Alba Clinic and Medical Center Limited, Chasel Hospital, Jodeb Hospital and Marternity, Jowako Specialist Hospital, National Board for Technical Education (NBTE) Medical Center.

METHODOLOGY

Data Required

The types of data required for the research are information on sex, age, level of education attained, place of residence, occupation, religion, income, family planning status, and knowledge about family planning, method of family planning on each household. List of public health care centers in the study area. Registered number of men and women in the health care centers that are taking part in family planning, different methods of family planning adopted.

Sources of Data

The data needed for this study was obtained through the administration of questionnaire, in-depth interview with key informants. Focus group discussions (FGDs) were also used to provide

information on what people perceive on the role of gender in reproductive decision making. Data were also collected from the following: Kaduna State Ministry of Health, Public Health Care Centers, National Population Commission Office.

Sampling Design

Purposive, systematic and random sampling techniques were used at different stages. Kaduna north Local Government Area has a projected population of 497,783 people in 2017, and 12 wards. The wards were used as the basis for selecting respondent for the study. Five residential study areas were selected, they include Kawo, Ungwan Rimi, Kabala, Badarawa/Malali and Ungwan Shanu. These wards consist of virtually all ethnic occupational, educational, income and religious groups found in Kaduna north Local Government Area of Kaduna State. To select the actual households for sampling, systematic sampling technique was employed. Where more than one eligible respondent is found, a random selection process is embarked upon to pick the eligible respondent in the household. Both men and women were interviewed and that do not have to be a couple.

The researcher made use of Krejcie and Morgan, (1970) formula to determine the sample size as:

$SS = \frac{N}{1+N(e)^2}$. Where SS = sample size, N = Number of population under study, e = Degree of precision (0.05). $SS = 492,100/1+492,100(0.05)^2$. SS = 400

DATA ANALYSIS

Both graphical and inferential statistical techniques were employed in the analysis of data collected. Graphical method was used to describe the characteristics of respondents using frequency distributions, percentages, table and charts. With respect to inferential statistics, chi-square analysis was used to ascertain the relationship between socio-economic variables (marital status, educational attainment, occupation, income, religion, ethnicity) and knowledge, current use of FP as Reproductive Health Decision Making, who makes family planning and FP methods used.

RESULT AND DISCUSSIONS

Factors Determining the Adoption of Any Family Planning Method

Table 1, shows the distribution of respondents by factors determining the adoption of any FP method. 30.6% and 24.0% of the respondents indicated spousal approval and effectiveness as the main reasons determining the adoption of any method of FP accordingly (Table 1).

During the IDI, some respondents reiterated the significance of spousal approval in FP saying: “In my own understanding no woman will practice FP without her husband’s permission, so it is very important to mobilize men especially Islamic scholars”. (29 year old Hajiya Hadiza, Malali)
“FP is very important, men should practice it based on the approval of their wives”. (29 year old Salisu, Angwan rimi)

Table 1: Distribution by Determinants for Adopting any FP Method

Reasons		Frequency	Percentage
Spousal approval		37	30.6
Effectiveness		29	24.0
Availability		20	16.5
Convenience		19	15.7
Cost		7	5.8
Others		9	7.4
Total		121	100.0

According to Mamman (2002), the determinants for using any FP method is convenience and approval by husband with 75.3% and 10.0% respectively. Ekpo (2011) also revealed that 27% and 26% said it is spousal approval and convenience.

Distribution on who Obtains Family Planning Services/Methods

Information on who obtains family planning services/methods is very important because it reveals who is in support of practicing FP. Figure 2, shows 40.6% of husbands and 30.2% of wives paid the bills for FP services/methods. The high percentage of husbands paying for FP methods/services is not surprising in the study area since men are economically more

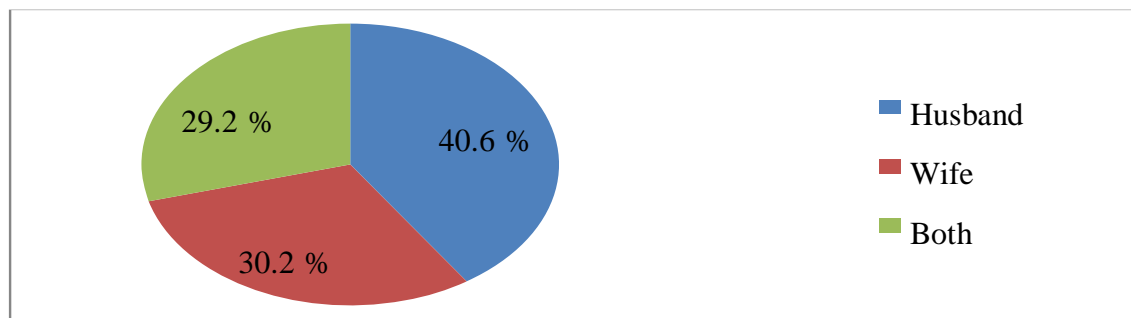


Figure 2: Percentage Distribution of Respondents by Who Obtains FP de

Advantaged than women; especially in a society where religion and culture have made men to be the major providers and some women are not even allowed to work to earn salary except with their husbands’ approval. This reaffirms the findings by Ekpo (2011) in Kaduna, where 43.0% of husbands paid the bills for FP services/methods and 30.4% said payment was made jointly.

Future Use of Family Planning

Intention to use FP methods in the future is an important indicator of the changing demand for FP because it reveals the extent to which non-users plan to use FP methods in the future. Respondents who were not using any FP method at the time of the survey were asked about their intentions to use

FP in the future. Figure 3, reveals that 26.8% of the respondents said they would want to use FP methods in the future. This corresponds with the NDHS (2008) report, where 21.0% of nonusers intended to use a FP method in the future.

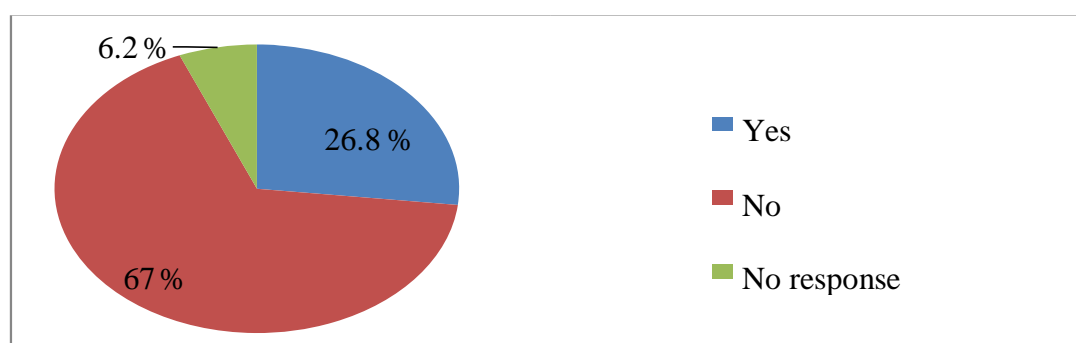


Figure 3: Percentage Distribution of Respondents by Future Use of FP

Reasons for Future Use of Family Planning Methods

From the 26.8% respondents who intend to use FP in the future, only 7.2% of each respondents said they would practice FP in the future if child bearing poses health risk to spouse or if they reach the desired number of children (Table 2).

Table 2: Distribution of Respondents by Desire to use FP in the Future

Reasons for Future Use	Frequency	Percentage
No response	13	6.2
Don't intend future use of FP	140	67.0
Child bearing poses health risks to spouse	15	7.2
Reached the desired number of children	15	7.2
Economic hardship	13	7.2
Due to old age	5	6.2
Others	8	2.4
		3.8
Total	209	100.0

Decision Making on Desired Number of Children.

Figure 4, indicates that 53.1% of the respondents made joint decision on the number of children they desired and 29.7% said it is made by husband. This corroborates the NDHS (2008) report where 47.3% of the respondents thought that decision on the number of children to have

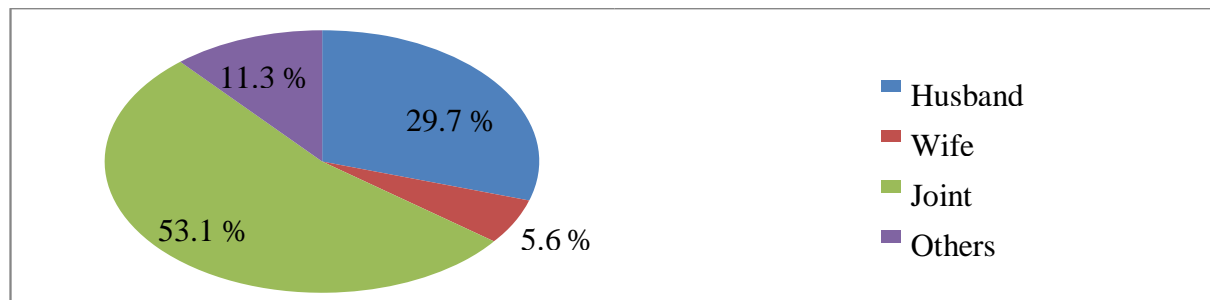


Figure 4: Percentage Distribution of Respondents by Decision Making on Desired Number of Children

should be made jointly and 43% by husband. Decision making about fertility is often controlled by the husbands, women in many African societies are yet to gain autonomy that would enable them make decisions on the number of children they want (Morgan and Niraula, 2005).

Child Spacing

With regards to decision making on child spacing, Table 3, reveals that 67.8% of the respondents made the decision jointly by both. Nevertheless, men still dominate decision making on family matters. This is typical of the Hausa/Fulani culture where men control the sexualities of their wives and also determine how long their wives should breastfeed their children. Some 58.7% of the respondents give a gap of 1-2 years, only 4.5% give less than 1 year between childbirths. This result does not correspond with Ekpo’s finding in Kaduna where 14.2%, 11% and 24.2% had child spacing of 1 year, 18 months and 2 years accordingly. This is because her study focused on women who know the actual gap between their children.

Table 3: Distribution on Child Spacing and Duration of Child Spacing

Decision makers on the duration of child spacing	Frequency	Percentage
Husband	47	19.4
Wife	31	12.8
Both	164	67.8
Total	242	100.0
Duration of child spacing		
< 1year	11	4.5
1-2 years	142	58.7
> 2 years	89	36.8
Total	242	100.0

Availability of Family Planning Facilities

Figure 5 shows availability of FP facilities. It indicates that 82.2% of the respondents have FP facilities near their residence. This is due to the fact that there are many health care facilities scattered throughout Kaduna North. Thus, family planning facilities are easily accessible to people who want to use it. Information on the availability of family planning facilities in any society is an indication that family planning programmes are making huge efforts to provide the population with family planning services and methods.

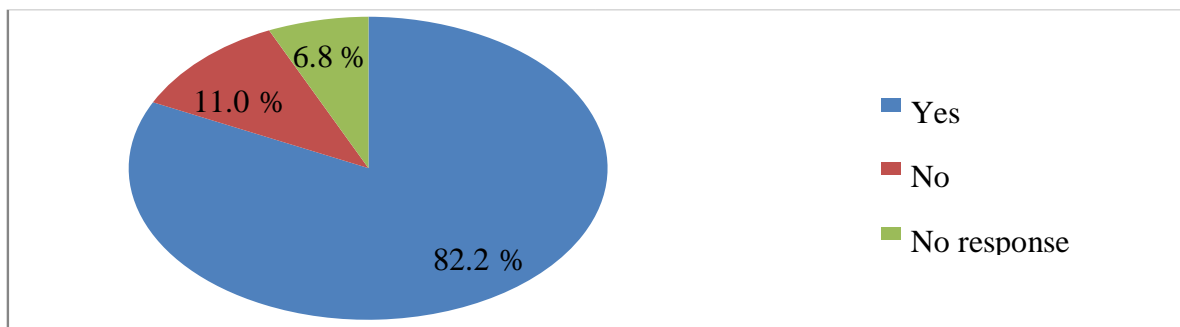


Figure 5: Percentage Distribution by Availability of Family Planning Facilities

Sources of Family Planning Facilities

Information on where respondents obtain their contraceptive methods is useful for family planning programme, managers and implementers for logistic planning (NDHS, 2013). Figure 6, shows that for 73.5% of current users of modern contraceptive methods, hospitals (private and public medical sectors) were the major sources of FP services and methods and 16.8% said clinics such as the maternal and child health or family planning clinics. Other sources were used by only 1.0% of the respondents.

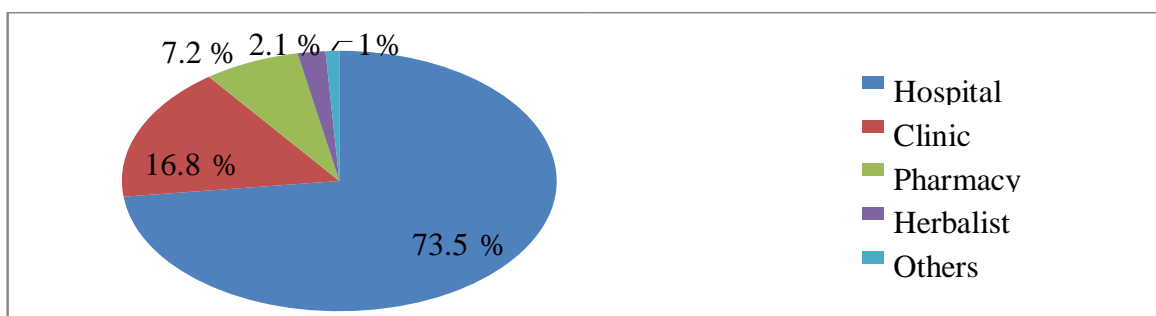


Figure 6: Percentage Distribution of Respondent by Sources of FP Services

This is not surprising as Kaduna North has many government and privately owned hospitals that offer FP to its people. This finding does not agree with that of Mamman (2002) in Kaduna where 37.5% obtained services and supplies from a hospital and 37.2% go to clinics. It also does not

corroborate with Tyoden’s (2017) result in Kaduna North where general and teaching hospitals make up 39.2% and 32.8% respectively. This could be because some respondents could not differentiate between a hospital and clinic.

Satisfaction with Family Planning Services/ Methods

Current users were asked whether they were satisfied with the existing FP services offered to them at their supply centers. Satisfaction here means effectiveness of methods, whether users get appropriate counseling and adequate attention at service centers.

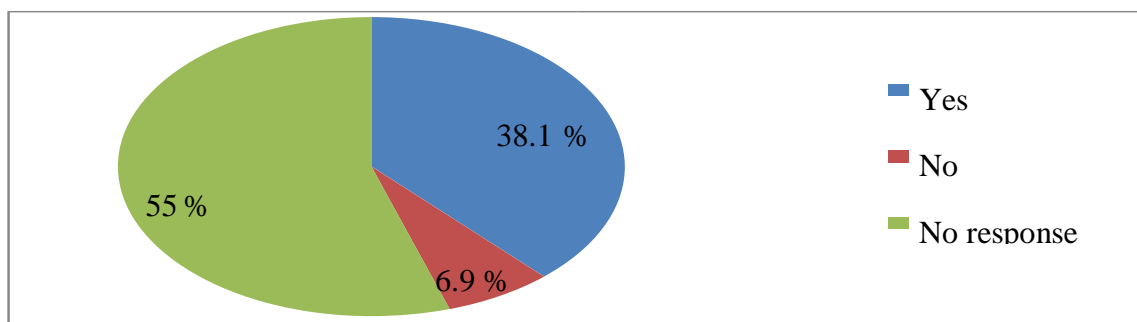


Figure 7: Percentage Distribution by Respondents’ Satisfaction with Family Planning Services/Method.

Figure 7 reveals that only 38.1% of current users were satisfied with FP services and a high percentage of 55.0% did not respond at all. This could be because the respondents did not experience changes that were yet to be noticed. This indicates low number of respondents who are satisfied with FP services/methods offered at health centre, which means that more has to be done by government medical personnel to provide clients with adequate services.

Socio-economic Variables and Knowledge of Family Planning

Age and Knowledge of Family Planning

Table 4, shows relationship by age and knowledge of FP. It reveals that knowledge of FP is highest (100.0%) among respondents of 15-19, 30-34 and 35-39 years and lowest (70%) for age group 50+. This shows that knowledge decreases as age increases. According to Oyediran et al (2006), age and education were identified as key to family planning.

Table 4: Age and Knowledge of Family Planning

Age group	Have heard	Have not heard	Row Total
15-19	42(100.0)	0(0.0)	42(100.0)
20-24	44(95.7)	2(4.3)	46(100.0)
25-29	67(97.1)	2(2.9)	69(100.0)
30-34	75(100.0)	0(0.0)	75(100.0)
35-39	45(100.0)	0(0.0)	45(100.0)
40-44	42(97.7)	1(2.3)	43(100.0)
45-49	25(96.2)	1(3.8)	26(100.0)
50+	5(70.0)	2(30.0)	8(100.0)
Column Total	345(97.7)	8(2.3)	354(100.0)
Calculated X²=5.408	df=7	P value=0.610	Remark=Not significant

The X2 result in table 4, does not show a significant relationship between age and knowledge of FP since the P value is greater than alpha at 0.05. However, the high knowledge of FP in the study area might be as a result of government’s effort to publicize and create awareness of FP programmes in rural and urban areas especially through the mass media.

Religion and Knowledge of Family Planning

Table 5, shows the relationship between religion and knowledge of FP. It indicated that 98.0% of Muslims and 97.0% of Christians have heard of FP. The statistical analysis does not show a significant relationship between religion and knowledge of FP since the P value (P=0.573) is greater than alpha at 0.05.

Table 5, Religion and Knowledge of Family Planning

Religious group	Have Heard	Have Not Heard	Row Total
Muslims	275(97.7)	6(2.2)	292(100.0)
Christians	60(96.8)	2(3.2)	62(100.0)
Column Total	335(97.7)	10(2.3)	345 (100.0)
Calculated X²=0.317	df=1	P value=0.573	Remark=Not significant

This means that religion has no positive influence on respondents’ level of awareness of FP. This is due to intensified effort by the Nigerian government to provide its population with the required FP information.

Marital Status and Knowledge of Family Planning

Table 6, shows the relationship by marital status and knowledge of FP. It reveals that awareness of FP is highest (100.0%) among respondents who are single, divorced and widowed. The statistical analysis in the table shows a significant relationship between marital status and knowledge of FP (P=0.000). This shows that there is a significant relationship between marital status and knowledge of FP. This further shows that knowledge is higher among currently unmarried respondents compared to those in marital union. It also shows that marital status positively influences knowledge of FP.

Table 6: Marital Status and Knowledge of Family Planning

Marital Status	Have Heard	Have Not Heard	Row Total
Single	21(100.0)	0(0.0)	21(100.0)
Married	318(97.8)	7(2.2)	325(100.0)
Divorced	4(100.0)	0(0.0)	4(100.0)
Separated	1(50.0)	1(50.0)	2(100.0)
Widowed	2(100.0)	0(0.0)	2(100.0)
Column Total	364(97.7)	8(2.3)	354(100.0)
Calculated $X^2 = 21.277$	df=4	P value=0.000	Remark=Significant

Educational Attainment and Knowledge of Family Planning

Table 7, shows the relationship by educational attainment and knowledge of FP. It indicates that awareness of FP is 100.0% and 50.0% among respondents with tertiary adult literacy education respectively. Thus, knowledge is improving with enhancement in educational qualification. Education exposes people to innovations and new ideas, thereby helping to spread information very fast. This agreed with Olawepo and Okedare (2003) that says education relates positively to levels of acceptability of FP as it offers better understanding among the people. Therefore, with improved level of education there is an increase in awareness of family planning. The statistical analysis of P=0.003 in table 7 shows a significant relationship between educational attainment and knowledge of FP.

Table 7: Educational Attainment and Knowledge of Family Planning

Educational Attainment	Have heard	Have not heard	Row Total
None	4(80.0)	1(20.0)	5 (100.0)
Quranic	56(93.3)	4(6.7)	60(100.0)
Primary	18(94.7)	1(5.3)	19(100.0)
Adult literacy	1(50.0)	1(50.0)	2(100.0)
Secondary	63(96.9)	1(3.1)	64(100.0)
Tertiary	204(100.0)	0(0.0)	204(100.0)
Column Total	346(97.7)	8(2.3)	354(100.0)
Calculated $X^2 = 18.155$	df=5	P value=0.003	Remark=Significant

meaning there is a significant difference between educational attainment and knowledge of FP because the P value is less than 0.05

Socio-economic Variables and Use of Family Planning

Age and Current Use of Family Planning

Table 8, shows relationship by age and current use of FP. It is only natural that couples begin to plan their family after having a first or second child. However, it is important to know that FP methods are not only used to limit family size but for child spacing. Current practice of FP is 47.5% among age group 20-24 years closely followed by 39.1% for age group 35–39 years. However, it is lowest (14.3%) for age 50+ years (Table 8). This implies that the use of FP methods is more prevalent among the middle age group; with the older group declining to practice FP. This could be due to the fact that older women who have reached menopause have no need for FP or declining sexual activity among older men. The relationship between age and current use of FP methods is statistically significant (P= 0.000)

Table 8: Age and Current Use of Family Planning

Age group	Using	Not Using	Row Total
15-19	10(26.3)	28(73.7)	38(100.0)
20-24	19(47.5)	21(52.5)	40(100.0)
25-29	24(35.8)	43(64.2)	67(100.0)
30-34	26(38.8)	41(61.2)	67(100.0)
35-39	18(39.1)	28(60.9)	46(100.0)
40-44	14(34.1)	27(65.9)	41(100.0)
45-49	9(37.5)	15(62.5)	24(100.0)
50+	1(14.3)	6(85.7)	7(100.0)
Column Total	121(36.7)	209(63.3)	330(100.0)
Calculated $X^2=31.172$ df=7 P value=0.000 Remark=Significant			

This means that there is significant relationship between age and current use of FP since the P value of 0.000 is less than alpha at 0.05. The finding does not correspond with that of Solomon et al (2017), where age groups of 35-39, 30-34 and 40-44 years had the highest proportion of current use of FP with 10%, 5.6% and 5.0% respectively. This could be because their study concentrated on contraceptive use among women in three different communities in northern Nigeria.

Religion and Current Use of Family Planning

Table 9, shows relationship by religion and current use of FP. It reveals that 29.7% and 74.5% of Muslims and Christians are currently practicing FP respectively. This is an indication that Christians practice FP more than Muslims in the study area. This is due to the fact that it is only the Roman

Catholics among Christians, who strongly object FP compared to Muslims who view FP as birth control used to limit fertility. The Chi square test shows a significant relationship between religion and current practice of FP ($P=0.000$), (Table 9). This further reaffirmed Ekpo’s (2011) finding which showed that 40.2% and 29.1% of Christians and Muslims were practicing FP. No doubt, religion plays an essential role in the lives of people and has great impact on the acceptance or rejection of family planning in any society, especially in Nigeria where people are deeply rooted in their religious beliefs.

Table 9: Religion and Current Use of Family Planning

Religious group	Using	Not Using	Row Total
Muslims	83(29.7)	196(70.3)	279(100.0)
Christians	38(74.5)	13(25.5)	51(100.0)
Column Total	121(36.7)	209(63.3)	330(100.0)
Calculated $X^2=33.837$	df=1 Pvalue=0.000 Remark=Significant		

There is significant difference in the relationship between religion and current use of FP because the P value is less than 0.05

Ethnicity and Current Use of Family Planning

Table 10, shows the relationship by ethnicity and current use of FP. Igbo have the highest percentage of usage with 83.3%, followed by Yoruba (64.0%). Only 31.0% of Hausa/Fulani are currently using a FP method. The statistical analysis shows a significant relationship between ethnicity and current practice of FP ($P=0.000$), (Table 10). This is not surprising in a society where Islam and the Hausa/Fulani cultures object FP and encourages having large family sizes. This corroborates with the findings of Duze and Muhammad (2006), where they found that Muslim Yoruba in the south west have a positive attitude towards FP when compared to the Hausas of northern Nigeria.

Table 10: Ethnicity and Current Use of Family Planning

Ethnicity	Using	Not Using	Row Total
Hausa/Fulani	81(31.0)	180(69.0)	261(100.0)
Igbo	10(83.3)	2(16.7)	12(100.0)
Yoruba	16(64.0)	9(36.0)	25(100.0)
Northern minority	12(42.9)	16(57.1)	28(100.0)
Southern minority	2(50.0)	2(50.0)	4(100.0)
Column Total	121(36.7)	209(63.3)	330(100.0)
Calculated $X^2=20.377$	df=4Pvalue=0.000Remark=Significant		

There is a significant difference in the relationship that is observed statistically between ethnicity and current use of FP since the P value is less than 0.05

Marital Status and Current Use of Family Planning

Table 11, shows the relationship by marital status and current use of FP. It reveals that 50.0% each of singles and divorced respondents are currently practicing FP, followed by 36.8% of those married. However, none of the respondents who are separated and widowed are currently practicing FP because even if they are unmarried, people would not want to be regarded in the society as being sexually promiscuous. The statistical analysis of P=0.570 in the table does not show a significant relationship between marital status and current practice FP; which is an indication that marital status does not have a positive influence on the practice of family planning.

Table 11: Marital Status and Current Use of Family Planning

Marital Status	Using	Not Using	Row Total
Single	2(50.0)	2(50.0)	4(100.0)
Married	117(36.8)	201(63.2)	318(100.0)
Divorced	2(50.0)	2(50.0)	4(100.0)
Separated	0(0.0)	2(100.0)	2(100.0)
Widowed	0(0.0)	2(100.0)	2(100.0)
Column Total	121(36.7)	209(63.3)	330(100.0)
Calculated $X^2=2.930$ df=4 P value=0.570 Remark=Not significant			

Educational Attainment and Current Use of Family Planning

Table 12, shows the relationship by educational attainment and current use of FP. About 43.3% of respondents with tertiary education are practicing family planning, followed by 37.3% of those with secondary school education. FP use is increasing with improvement in educational qualification. The statistical analysis of P=0.003 shows a significant relationship between education and current practice of FP (Table 12). This clearly means that a minimum of secondary school education, as the critical level of educational attainment is required for effective utilization of FP. Education is a strong influential factor on FP use because it exposes people to information, provides knowledge and better understanding of the desire to use FP methods. The tremendous effect of educational improvement on the use of FP is also related to its role of empowering individuals to make rational decisions and understand that it is possible to control fertility using FP methods. This further supports the notion that the greatest obstacle to rapid change in unfavorable attitudes towards FP is illiteracy that has lead to misconceptions about the aim of FP programmes. Solomon et al (2017) in their study in northern Nigeria also found that women with higher levels of education exhibited greater awareness and utilization of family planning.

Table 12: Educational Attainment and Current Use of Family Planning

Educational Attainment	Using	Not Using	Row Total
None	1(20.0)	4(80.0)	5(100.0)
Quranic	12(20.7)	46(79.3)	58(100.0)
Adult literacy	1(50.0)	1(50.0)	2(100.0)
Primary	4(21.1)	15(78.9)	19(100.0)
Secondary	22(37.3)	37(62.7)	59(100.0)
Tertiary	81(43.3)	106(56.7)	187(100.0)
Column Total	121(36.7)	209(63.3)	330(100.0)
Calculated $X^2 = 18.015$	df=5	P value=0.003	Remark=Significant

The results show that there is a significant difference between educational attainment and current use of FP since the P value is less than 0.05

Income and Current Use of Family Planning

Table 13, shows the relationship by income and current use of FP. It indicates that 32.1% of the respondents who did not disclose their income are using FP. However, 53% of the respondents earning 46,000 Naira and 25% of respondents earning N6,000 - 15,999 use FP methods. The middle and high income earners are leading in FP.

Table 13: Income and Current Use of Family Planning

Income	Using	Not Using	Row Total
Did not disclose their income	27(32.1)	57(67.9)	84(100.0)
N< 6,000	4(26.7)	11(73.3)	15(100.0)
N6,000 - 15,999	9(25.0)	27(75.0)	36(100.0)
N16,000 - 25,999	22(38.6)	35(61.4)	57(100.0)
N26,000-35,999	13(28.9)	32(71.1)	45(100.0)
N36,000-45,999	11(40.7)	16(59.3)	27(100.0)
N46,000 and above	35(53.0)	31(46.9)	66(100.0)
Column Total	121(36.7)	209(63.3)	330(100.0)
Calculated $X^2 = 12.238$	df=6	P value=0.032	Remark=Significant

This indicates that there is a significant difference between income and current use of FP since the P value of 0.032 is less than alpha at 0.05. High income motivates people to desire good standards of living, which could be achieved by having smaller family sizes.

Income and Reproductive Health Decision Making

Table 14, shows the relationship by income and reproductive health decision making. This indicates that the ability of couples to make joint decision on family planning stood the highest of 68.8% for

respondents earning 46,000 and above while Decision making by wife alone is higher for respondents with lower income level 16,000- 25,999 and decreases with an increase in income. The statistical analysis shows a significant relationship between income and who makes decision to practice FP, $P= 0.022$, which means that higher income gives room for better discussion and decision on the reproductive health with regard to FP.

Table 14: Income and Reproductive Health Decision Making

Income	Husband only	Wife only	Joint	Others	Total Row
Did not disclose their income	8(29.6)	3(11.1)	14(51.9)	2(7.4)	27(100.0)
N< 6,000	1(25.0)	3(75.0)	0(0.0)	0(0.0)	4(100.0)
N6,000 - 15,999	0(0.0)	0(0.0)	8(88.9)	1(11.1)	9(100.0)
N16,000 - 25,999	6(27.3)	4(18.2)	12(54.5)	0(0.0)	22(100.0)
N26,000-35,999	3(23.1)	2(15.4)	7(53.8)	1(7.7)	13(100.0)
N36,000-45,999	1(9.1)	1(9.1)	9(81.8)	0(0.0)	11(100.0)
N46,000 and above	8(22.8)	3(8.6)	24(68.6)	0(0.0)	35(100.0)
Total Column	27(22.3)	16(13.2)	74(61.2)	4(3.3)	121(100.0)
Calculated $X^2=27.981$ df=18 P value=0.022			Remark=Significant		

The results shows that there is significant relationship between income and reproductive health decision making because the P value of 0.022 is less than alpha at 0.05.

CONCLUSION AND RECOMMENDATIONS

Population is a subject that evokes strong emotions, conscious and subconscious. So, it is not surprising that it is an area where political debate tends to be rather passionate. However, there is a need for persistent drive against those social customs, beliefs, and traditions which belittle the importance of family planning in the society. Involving gender role is of crucial importance in Kaduna north, most decisions that affect family life should be made by both males and females. Gender role in FP means more than the number of only men or only women who encourage the use of FP methods. It also means government policy has to be more conducive by developing male-related programmes. The involvement of gender in family planning would therefore not only ease the responsibility borne by or women or only men in terms of decision making in family-planning matters, but would also accelerate the understanding and practice of family planning in general.

This research found out that an intervention that encourages and supports dialogue and communication about gender norms and sexuality can shift gender relations and positively influence family planning use. The role that men plays in decision making was strong coupling with their religion belief, ethnicity and cultural belief. Involving gender role is of crucial importance in Kaduna north LGA, most decisions that affect family life should be made by both males and females. The

involvement of gender in family planning would therefore not only ease the responsibility borne by or women or only men in terms of decision making in family-planning matters, but would also accelerate the understanding and practice of family planning in general. However, if FP programmes are to accelerate the process in Kaduna north, then they would require the following:

1. Greater political will from the local government officials, which includes more commitment in supporting family planning programmes, is needed and not just population policies on paper.
2. There should be spousal communication on FP matters, where both gender can come up with reasonable mutual decision on reproductive health issues. This will help facilitate transition to lower fertility.
3. The Kaduna North Local Government leaders should encourage western education, this will empower women to make rational decision and enhance the effective utilization of FP.
4. Couples should be motivated to space their children beyond two years. This will reduce frequent childbirth and large family sizes that expose women to health problems which can contribute to high maternal mortality.

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