

# MALE INVOLVEMENT IN FAMILY PLANNING IN NIGERIA: A GENDER PERSPECTIVE

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**NIGERIA**

Master in International Health  
8 March 2010 – 16 February 2017

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A thesis submitted in partial fulfilment of the requirement of the degree of Masters of International Health

By

OGBE OMOTESE EKPEN

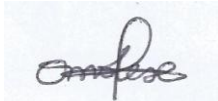
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Declaration:

Where other people's work has been used (either from a printed source, internet or any other source) this has been carefully acknowledged and referenced in accordance with departmental requirements.

This thesis titled, "Male involvement in Family planning in Nigeria: A gender perspective" is my own work.

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## DEFINITION OF KEY TERMS

**Access:** The ability to use something

**Control:** The ability to determine who gets to use something

**Contraceptive prevalence:** Percentage of women of reproductive age group in a union currently using contraception [UNICEF 2014]

**Family planning methods:** Any method that is used to delay pregnancy, prevent or limit pregnancy [UNICEF 2014].

**Female dependent methods:** Contraception methods available to female. Examples include: female condoms, injectables, oral pills, hormonal implants, female sterilization, diaphragm, intrauterine devices, spermicides etc

**Gender:** The socially constructed expectation about how men and women should behave in a particular place and time" [CFC 2009].

**Gender Equality:** A state at which men and women enjoy equal resources, rights and are treated equally [Mukhopadhyay et al, 2013.p.12].

**Gender Norms:** Beliefs and prescriptions that guide what acceptable behaviour of men and women is. They are referred to as "guidelines for social behaviour" [Liverpool School of Tropical Medicine (LSTM) 1998. p. 33].

**Male dependent methods:** Contraception methods available for men e.g. Condoms, vasectomy, withdrawal. [Helzner 1996]

**Male Involvement:** This involves encouraging men to use male-dependent methods and support their partners' use of female-dependent methods of contraception[CFC 2009].

**Masculinity and Femininity:** Attributes and behaviours that men and women are expected to possess. Ideologies of masculinity mainly regard men as superior and promote unequal power difference between men and women.



**Power:** The ability to have the authority to make and act independently on decisions made without any force/control from others [Mukhopadhyay et al, 2013, p.47].

**Sex:** The biological and physical characteristic that differentiates a male and female (LSTM, 1998)

**Standard Days Method:** New family planning method that tracks fertile days a woman can get pregnant and so she avoids unprotected sex from the eight day to the nineteen of her menstrual cycle. It is 95% effective in women with a regular cycle [IRH 2017]

**Structure:** This refers to the social factors like gender, tribe, culture, social status, race, etc that can influence a person's opportunities. [Mukhopadhyay et al, 2013, p. 51]

**Unmet need for family planning:** Men and women (married or unmarried) who want to delay childbearing or stop having children but are not using any family planning method [adapted from UN 2011].

## **LIST OF ABBREVIATIONS**

BCC	Behaviour Change Communication
CFC	Communication for Change
CP	Contraceptive Prevalence
FGD	Focus Group Discussion
FHI	Family Health International
FP	Family Planning
FMOH	Federal Ministry of Health
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IRH	Institute of Reproductive Health
IUD	Intrauterine Device
LGA	Local Government Area
LSTM	Liverpool School of Tropical Medicine
MMC	Male Motivational Campaign
NDHS	National Demography and Health Survey
NIMAGES	Nigeria Men and Gender Equality Survey
NPC and ICF	National Population Commission and ICF
PRB	Population Reference Bureau
RH	Reproductive Health
SDG	Sustainable Development Goals
SDM	Standard Days Method
UN	United Nations
UNAIDS	Joint United Nations Programme On HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VFC	Voices for Change
WHO	World Health Organization

## **ABSTRACT**

Despite renewed commitment to scale up uptake of family planning (FP), Nigeria still experiences a high unmet need and low contraceptive prevalence. Evidence suggests that there is a significant improvement in uptake of reproductive health services and promotion of gender equality when men are involved in family planning. However, Nigerian family planning policy still targets mainly women.

Masculine gender norms have been known to influence men's attitude and behaviour towards their involvement in FP as clients and as partners. This gendered aspect of male involvement in FP has not been explored adequately and remains under-researched in Nigeria.

This study aims to explore how masculinity norms affects male involvement in FP in Nigeria and identify potential strategies that can be adopted in improving male involvement in FP in Nigeria. Using a gender perspective, the study was carried out as a literature review of studies done in Nigeria.

Findings revealed that traditional dominant norms like being the breadwinner and key decision maker were the most popular. Men who mostly adhere to hegemonic norms were more likely to have inequitable relationships where open communication on FP and shared decision making was difficult. There are an increasing number of men who do not conform to hegemonic norms and show a willingness to get involved positively in FP. Programs that want to increase male involvement in FP should therefore use a gender-sensitive approach that promotes gender equality between couples and transforms negative norms to positive equitable norms that favour FP.

Key words: family planning, Nigeria, male involvement, gender norms, masculinity.

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# **1: GENERAL INTRODUCTION**

## **1.1 INTRODUCTION**

Family planning is linked with sustainable development [Population matters, 2016]. Increasing universal access to FP services helps reduce the growth of population globally and reduce poverty. Reduction in fertility rates; unintended pregnancy and unsafe abortions also reduce the burden of public and private expenses on health and other basic services [Cohen, 2012]. However, about 26% of an estimated 867 million women in the developing world have an unmet need for contraception and these women with unmet needs contribute 70% of the developing world's unintended pregnancies [Cohen, 2012]. Evidence has shown that increase in contraceptive prevalence (CP) worldwide helped to reduce maternal mortality by about 53% between 1990 and 2008 [United Nations (UN), 2011].

In 1994, the International Conference on Population and Development (ICPD) advocated for male involvement in reproductive health (RH) [UN, 1995]. Evidence shows that there is a significant improvement in uptake of RH services; improvement in women's RH and promotion of gender equality when men are involved [Rottach et al., 2009].

Despite renewed commitment to scale up uptake of FP, Nigeria still experiences a high unmet need of FP and low CP [Federal Ministry of Health (FMOH), 2014]. With the current CP at about 15% for any FP method and 10% for modern methods, there has only been a little progress in increasing CP from 6% in 1990 [FMOH, 2014]. Current Nigerian FP program managers still target mainly women and FP services are usually provided in maternal and childcare centres [FMOH 2014].

Several literatures in Sub-Saharan Africa have suggested that men often oppose their partner's contraceptive use [Dugheon and Inhorn 2004; Population Reference Bureau (PRB) 2011; Kabagenyi et al., 2014]. Such generalizations may stem from the fact that most African societies regard FP as a woman's affair. But not all men oppose contraception [Orji et al. 2007; Ijadunola et al., 2010]. According to reports in the 2013 Nigeria demography and health survey (NDHS), gender norms can positively or negatively influence men's involvement in family planning [National population commission and ICF international (NPC and ICF), 2014b].

During the author's work as medical officer, husband's disapproval was one of the main reasons reported by pregnant clients for not adopting FP. She observed that men's family planning needs were not being met and that gender norms may be preventing men from getting involved constructively in contraception. Thus the author's interest in this subject was cultivated.

Male gender norms are the socially constructed expectation about what acceptable behaviour for men is and it often influences masculine identity and behaviour in men. Evidence suggests that men's perception about masculine gender norms influence their attitude and behaviour towards FP for themselves and their female partners [Dugheon and Inhorn, 2004].

Exploring the masculinity norms that can positively or negatively influence male involvement in FP is therefore very relevant. Since these masculinities affect FP behaviour, it is important to gain understanding of the dominant and alternate notions of masculinity that are being expressed by Nigerian men and its impact on contraceptive use. This gendered aspect of male involvement in FP has not been explored adequately and remains under researched in Nigeria [Oladimeji, 2008; Odimegwu and Adedini, 2013; Voices for Change (VFC), 2015].

This desk study intends to explore male involvement in FP in Nigeria from a gender perspective. The study is based on a hypothesis that gender norms and the resulting masculinities impact on male involvement in FP. A framework that analyses how masculinity norms influence male involvement in FP in the Nigerian context is used. Strategies that have been adopted based on understanding gender norms will be highlighted. The findings of this study will serve as a knowledge base for future research in addressing unmet need for FP in Nigeria. It will also help policy makers/health service providers gain insight about innovative ways to use positive gender norms (like being a supportive and responsible husband) to increase uptake of FP and consequently lead to better reproductive outcomes for men and women. The next section highlights the background and problem statement.

## **1.2 BACKGROUND AND PROBLEM STATEMENT**

### **1.2.1 NIGERIAN CONTEXT**

Nigeria has a projected population of about 175 million people and annual population growth of about 3.2% [FMOH, 2014]. Christianity and Islam are the two main religions in the country with mainly Christians in the south and

Muslims in the north. Its Gross Domestic Product (GDP) per capital is about 4% and more than two-thirds of its population live in extreme poverty [FMOH, 2014]. Nigeria's economy is mainly driven by its oil reserves. But the dwindling prices of crude oil, Boko-haram terrorism in the North East; and the resulting reduction in foreign investments have caused economic growth to slow down.

Nigeria is currently in recession and inflation has increased significantly with the northern region having worse health indicators. Major challenges in the health sector include reduced budget for health and shortage of skilled health workers. All this has affected the health of many Nigerians adversely. Nigeria records high rates of maternal mortality (145 per 100,000 live births) and morbidity with high rates of infant mortality (78 per 1,000 live births) [United Nations Children Fund (UNICEF), 2014]. A woman's risk of dying from pregnancy and childbirth in Nigeria is as high as 1 in 13 [WHO, 2015]. These poor maternal health statistics may be related to the low contraceptive prevalence rate the country experiences. Refer to Annex 1 for a table with current maternal health statistics.

### **1.2.2 FAMILY PLANNING IN NIGERIA**

In Nigeria, FP services are usually targeted towards women with little focus on men or male-dependent methods [Ijadunola et al., 2010; Abubakar, 2012; Ukeagwu, 2014]. Despite nationwide increase in availability of FP commodities and services, Nigeria experiences a low contraceptive prevalence. The 2013 NDHS report states that only about 10% of women of reproductive age group in a union use a modern method of contraception [NPC and ICF 2014b]. A low CP rate is an indicator of poor control of population growth and lack of women empowerment [Creangan et al., 2011].

The FMOH designed a policy to scale up FP in 2014 with a goal to increase CP (for any method) to 36% by 2018 [FMOH 2014]. One of the common reasons cited by females for not using FP is husband's opposition [NPC and ICF, 2014b, Ukeagwu, 2014]. Refer to Annex 3 for figure 3: reasons for non-use of FP. However, the FMOH plan did not target the male half of the population. More so, with the high level of non-use and discontinuation of contraceptive by Nigerian women, it seems quite impossible to achieve this goal if alternative cost effective strategies that involve men are not developed [FMOH, 2014]. This is a problem that needs further assessment if unmet needs are to be met.

### **1.2.3 WHY INVOLVE MEN?**

Men have been often times reported as one of the main obstacles to better RH outcomes for women and blamed for either preventing women's use of FP services or discontinuation of contraceptives [United Nations Population Fund (UNFPA), 2010]. Traditional gender norms result in unequal power relations between men and women and reward men with significant power over women's access and control of FP resources. It is therefore imperative for FP policy/programs to involve men positively.

Secondly, methods like withdrawal, male condom and standard day method (SDM) need cooperation from both partners to be effective. Even female dependent methods like injectables, implants, intra uterine devices (IUD) and oral pills can be influenced by men who usually have to provide money to procure commodities or treat side effects [Esplen, 2006]. Men can and do influence contraception either directly or indirectly so they should be targeted by FP interventions [Dugheona and Mchorn, 2004]. Thirdly, men need to receive health education on FP benefits, types, effectiveness and side effects because men are usually the main decision makers in the home and so can prevent their partners from accessing FP-information, products and services [CFC, 2009]. Men involved in FP can also show support by exhibiting gender equitable behaviour like communicating with their spouse on FP; making joint FP decisions or by giving their partner the opportunity to exercise her RH rights [CFC, 2009].

Contrary to assumption that only women are constrained by inequitable gender norms, men are also negatively affected. Like women, societal expectations of men's behaviour have negative health implications for men. This is not to make excuses for men but dominant masculinity norms put a lot of pressure on men to act aggressively or take risk that may cause him to oppose partner's use of contraception and also view seeking FP information/services as a sign of weakness [Esplen, 2006].

Lastly, from a human rights perspective, men should be involved because they also have right to information about RH. They should be recognised as potential FP clients who have contraceptive needs.

## **1.3 OBJECTIVES AND RESEARCH QUESTIONS**

### **1.3.1 IDENTIFYING THE GAP**

In recent times, gender frameworks have been used to analyse RH problems but the focus has been mainly on females and their vulnerabilities [UNFPA, 2006]. Although some studies have explored the role of males in FP, few studies in Nigeria have tried to identify the masculinity norms that can act as barriers to male involvement in FP [Oladimeji, 2008; Odimegwu and Adedini, 2013; VFC, 2015]. This background further emphasizes the relevance of this thesis.

With the rapid population growth, evidence-based strategies that can increase CP are needed urgently. The male half of the population represents a huge resource waiting to be tapped into. Since evidence from other parts of Africa has affirmed that male involvement in RH can help improve health outcome when viewed from a gender perspective [Blake, 2010; PRB, 2011], more research (which is the backbone of policy implementation) is needed to investigate this trend in the Nigerian context.

Findings from this thesis will help fill the gaps in our understanding of how gender norms influences men's attitude and behaviour towards contraception. It will enable policy makers; FP programmers and researchers recognise how and why they need to reach men and also promote gender equality in the planning and implementation of FP policies and interventions. The next section will highlight the general objective and research questions of this study.

### **1.3.2 GENERAL OBJECTIVE:**

To explore how masculinity norms affects male involvement in family planning in Nigeria.

### **1.3.3 SPECIFIC OBJECTIVES:**

- To explore the prevailing masculinity norms that can influence male involvement in family planning in Nigeria
- To explore how masculinity norms positively or negatively influence male involvement in FP in Nigeria
- To identify what strategies can be adopted based on these masculinity norms in improving male involvement in FP in Nigeria



## **RESEARCH QUESTIONS**

1. What are the masculinity norms that can influence male involvement in family planning for them and their female partners in Nigeria?
2. How do these masculinity norms influence male involvement of men in FP for them and their partners in Nigeria?
3. What potential strategies have been adopted based on these masculinity gender norms in improving men's involvement in family planning for them and their partners in Nigeria?

## **2: METHODOLOGY**

This study is a desk study literature review. An extensive literature search and analysis of literature using a gender based framework on masculinities and FP was carried out. Connections between masculinity norms and male involvement in FP were identified and interpretations were drawn from it using the framework to answer research questions.

### **2.1 DATA COLLECTION:**

#### **2.1.1 MAPPING AND SEARCH STRATEGY**

A mapping exercise of literature on male involvement in FP was performed to get a quick view on the subject matter that require further research so that research questions can be narrowed down to a specific focus [Pope et al., 2007].

The search was conducted using a systematic approach to select relevant literatures including grey literature from journals, books, dissertations, thesis, government documents and websites from the internet and libraries. Search through the proquest database and Google scholar was conducted. Keywords/search terms used: family planning, contraception, reproductive health, Nigeria, male involvement, gender norms, masculinity norms, gender related factors, male gender norms, masculinities.

Quality of studies chosen was assessed as described by Pope et al. 2007 (Refer to Annex 2). Relevant literature was selected in a purposive way as described by Pope et al. [2007]. This involved choosing studies using the following criteria in table 1 below:

**Table 1: Inclusion and exclusion criteria**

### INCLUSION AND EXCLUSION CRITERIA

1. Studies conducted in Nigeria or from other countries in Sub Saharan Africa (SSA) (with settings similar to Nigeria in terms of low income and high unmet need). These countries with similar settings will be used for comparison too.
2. Studies that used quantitative, qualitative or mixed method were included in order to get a broad and comprehensive understanding of male involvement in FP from a gender perspective.
3. Relevant researches carried out within the last 15 years were included due to paucity of studies on male involvement in family planning and masculinities in Nigeria (noted during mapping exercise).
4. Studies conducted in urban and rural settings.
5. As gender norms are perceived and reproduced by men and women, studies on both sexes (either alone or together) were used.
6. Only studies written in English were included.

#### **2.1.2 DATA EXTRACTION AND ANALYSIS**

Summaries were made of each selected study (Refer to Annex 3 for data description). Data extracted was analyzed using a gender-based framework on masculinities and family planning.

No persons were used for the study as data was gotten from review of literatures. For this reason, ethical approval is not necessary. Documents used for this thesis was acknowledged in the reference section.

#### **2.2 LIMITATIONS**

Firstly, studies available did not always make a distinction between modern and traditional methods of contraception. Although modern methods were prioritised, however due to paucity of studies that met the inclusion criteria, any method of contraception was included.

Secondly, gender is a wide and complex issue (Helzner, 1996). For example, factors that influence masculinity norms were not explored in details as it was outside the immediate scope of the thesis. However, several studies were reviewed and recurring themes on masculinity norms and FP was identified in Nigerian studies and used for analysis.

Thirdly, majority of the qualitative studies included in this thesis have used interviewer administered questionnaires and/or focus group discussions. This may increase bias as men (gendered identity) may want to publicly present themselves as "responsible" when answering these questions in the presence of others and so give answers they think the interviewer will like to hear. Perhaps an in-depth qualitative interview or ethnographic fieldwork would have reduced such bias.

Lastly, although the aim was to get data from different parts of Nigeria, only a few research conducted in the North were available to the author. This is probably because family planning is a sensitive topic in the largely Muslim north making it difficult to recruit persons in these areas. Moreover, persistent conflict in the North East region may have prevented research from being carried out. Data from the 2013 NDHS and NIMAGES carried out by VFC organisation was used to supplement such information. Please refer to annex 4 for a table showing description of selected studies and their study design. Please note that remarkable religious difference exists between the north and south and these differences can also influence the ways in which masculinity norms are constructed towards FP. Notwithstanding, some remarkable similarities in norms exist between the north and south (an example is patriarchal setting).

## **2.3 CONCEPTUAL FRAMEWORK**

Gender framework has been used in this thesis because male gender norms and the manner in which they are expressed (hegemonic and alternate masculinities) can influence men's FP seeking behaviour. Since gender norms are socially constructed and liable to change then negative gender norms that limit men's involvement in FP can be transformed for positive use in improving men, women and children's health. The framework was drawn up by the author after analysing Mankowski and Maton (2010) theory on masculinities and Dugheon and Inhorn (2004) ethnographic study on men and FP.

### **2.3.1 MASCULINITY NORMS**

Masculinity norms refer to the attributes, behaviour and masculine identity ascribed to being male in a society [Greene et al., 2011]. A man's character is often shaped by these socially prescribed expectations of manhood. It can dictate his views, attitude, identity, health seeking behaviour and type of decisions he makes [UNFPA, 2006]. It can also influence the dynamics between him and his female partner.

Men learn through socialization, peer pressure and social institutions like the family, community, schools, media, health institutions, religious places and governments and they are actively involved in constructing what is acceptable and what is not [Mukhopadhyay et al., 2013]. Dugheon and Inhorn (2004) report that within the household, gender norms often determines who makes decision about family size; whether or not to use FP commodities and services; type of FP to be used; money that is allocated to buying FP commodities or treating side effects if any occurs. In the public sphere, gender norms also inform the ways in which policies are made and also determine how program managers and service providers design programs [Connel, 2005].

Most literatures have tagged masculinity norms as negative and destructive [Esplen, 2006]. Masculinity norms are not always unhealthy but the fact that men are conditioned to strictly abide by rigid rules all the times and pressured to emulate certain traits to prove their manhood makes it negative. Masculine norms like those that promote being responsible and protecting loved ones can make a man avoid taking risks and make better choices for himself and members of his family. Norms that are less dominating and are egalitarian can be tagged as gender-equitable norms. On the other hand, gender-inequitable norms are those that promote sole decision-making, sexual prowess, risk taking and aggression towards women. Gender-inequitable norms are quite prevalent and have been documented in African studies [Orji et al., 2007; Odimegwu and Adedini 2013; Adelekan et al., 2014].

### **2.3.2 MASCULINITY: HEGEMONIC OR ALTERNATE**

Masculinity is both a norm and an identity [Greene et al., 2011]. There are multiple forms of masculinities but hegemonic 'dominant' masculinity usually subordinates the other alternative forms and prevents men from showing the other less dominant alternate identities [Ruxton, 2004].

Hegemonic masculinities are usually gender-inequitable in nature as it places men on an advantageous position over women. According to Ruxton (2004), hegemonic masculinity thus places men with more power (for example the rich and highly educated men) over women and other subordinate men (gay men, ethnic minorities, disabled, or even poorer men). Even the “weaker or marginalised” men in society also exhibit this hegemonic trait and may seek to have same power [Ruxton 2004].

Alternative forms of masculinities are usually gender-equitable and do not seek to subordinate others. Every man has the ability to be caring and behave in ways that are not injurious to their health and other’s health (women and children) [Kaufman, 2004]. Some men have been more open to being loving and caring husbands and fathers. Recognising that men do not always conform to these rigid gendered differences also implies that men can be involved as part of the solution to increasing uptake of family planning. Although change is difficult and may progress slowly, when men begin to understand the influence that these traits have on their health they are more willing to change [Greene et al., 2011; VFC 2015]. It is against this background that the framework uses masculinity norms as a basis to understand how men experience and view family planning. Other social factors like social class, wealth, tribe, age, level of education interact with gender norms to determine how an individual perceives and expresses these norms at different levels and in different situations [Connell, 2005].

### **2.3.3 MASCULINITIES AND ITS EFFECTS ON BEHAVIOUR**

Clinical psychologists, Mankowski and Maton (2010) presented four assumptions which serve as a platform for understanding how masculinity affects man’s behaviour and experience. These assumptions will be drawn upon in this thesis and modified into questions about men’s involvement in FP. There is a paucity of local research linking masculinity norms to men’s RH behaviour in Nigeria [VFC, 2015]. It is therefore useful to know whether these assumptions authored by western psychologists are applicable in the Nigerian context. It will be interesting to see to what extent they apply to male involvement in family planning in the Nigerian context.

**Table 2: Mankowski and Maton assumptions on masculinity.**

ASSUMPTIONS	QUESTIONS ARISING
Men strive <b>to prevent being looked upon as female or feminine.</b>	<ul style="list-style-type: none"> <li>• What masculinity norms affect Nigerian men's willingness to be involved in FP?</li> </ul>
Men <b>like women are also disadvantaged by gender norms</b> , as they have to act in rigid way (that do not allow them much space) to prove their manhood among fellow men and their female counterparts.	<ul style="list-style-type: none"> <li>• How do masculinity norms influence men's access to information and FP services?</li> </ul>
Men are usually viewed by most societies as <b>privileged ones who seek to oppress women including "fellow weak" men.</b>	<ul style="list-style-type: none"> <li>• How do masculinity norms influence Nigerian men's decision making behaviour on FP?</li> </ul>
Men <b>are powerful and powerless at the same time.</b>	<ul style="list-style-type: none"> <li>• How does men's ability/inability to fulfil masculinity norms influence Nigerian men's allocation of resources to FP?</li> </ul>

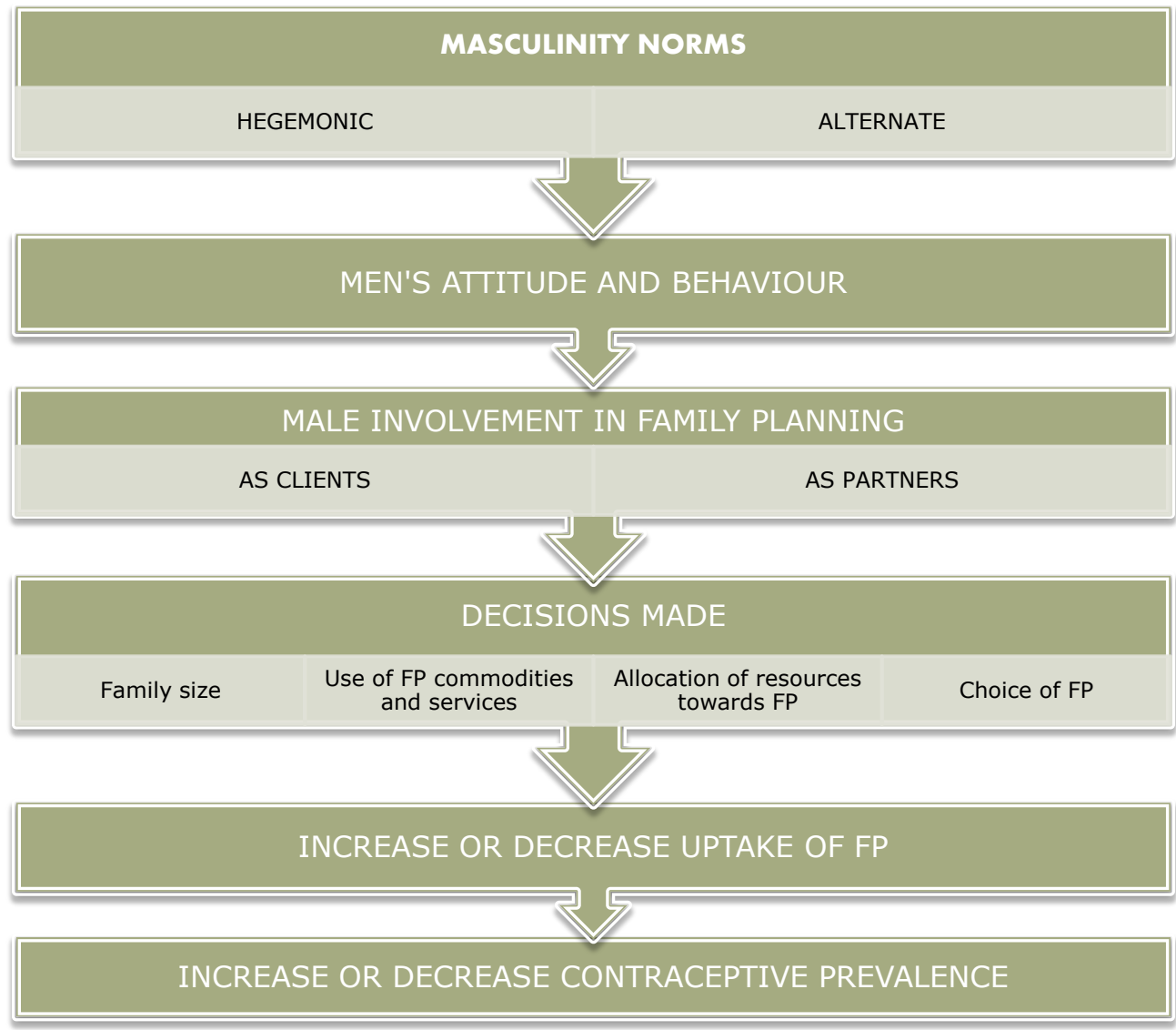
### **2.3.4 FRAMEWORK FOR IDENTIFYING MASCULINE NORMS AND HOW IT AFFECTS FP.**

Barker and Ricardo (2005) report that there are several African masculinities. Masculinities were subdivided into two groups for the purpose of this thesis. The hegemonic masculinities which are less gender-equitable and the alternate masculinities which are more gender-equitable in nature.

It considers two specific areas where men can be involved: as clients and as supportive partners. The framework assumes that notions of masculinity influence men's involvement in FP by influencing their attitude and behaviour at decision making level. Two main masculinities are considered: hegemonic and alternate. The decisions included in the framework are: a) family size b) use of FP c) the choice of FP d) allocation of resources towards FP.

These norms can serve as either limiting or motivating factors to male involvement in FP, and will eventually result in either an increase or decrease in uptake of FP products and services depending on how and what decision is taken.

Figure 1: Conceptual framework showing how masculinities affect male involvement in FP [Adapted from Mankowski and Maton 2010, Dugheon and Inhorn [2004].





### 3: MASCULINITIES AND MALE INVOLVEMENT IN FAMILY PLANNING

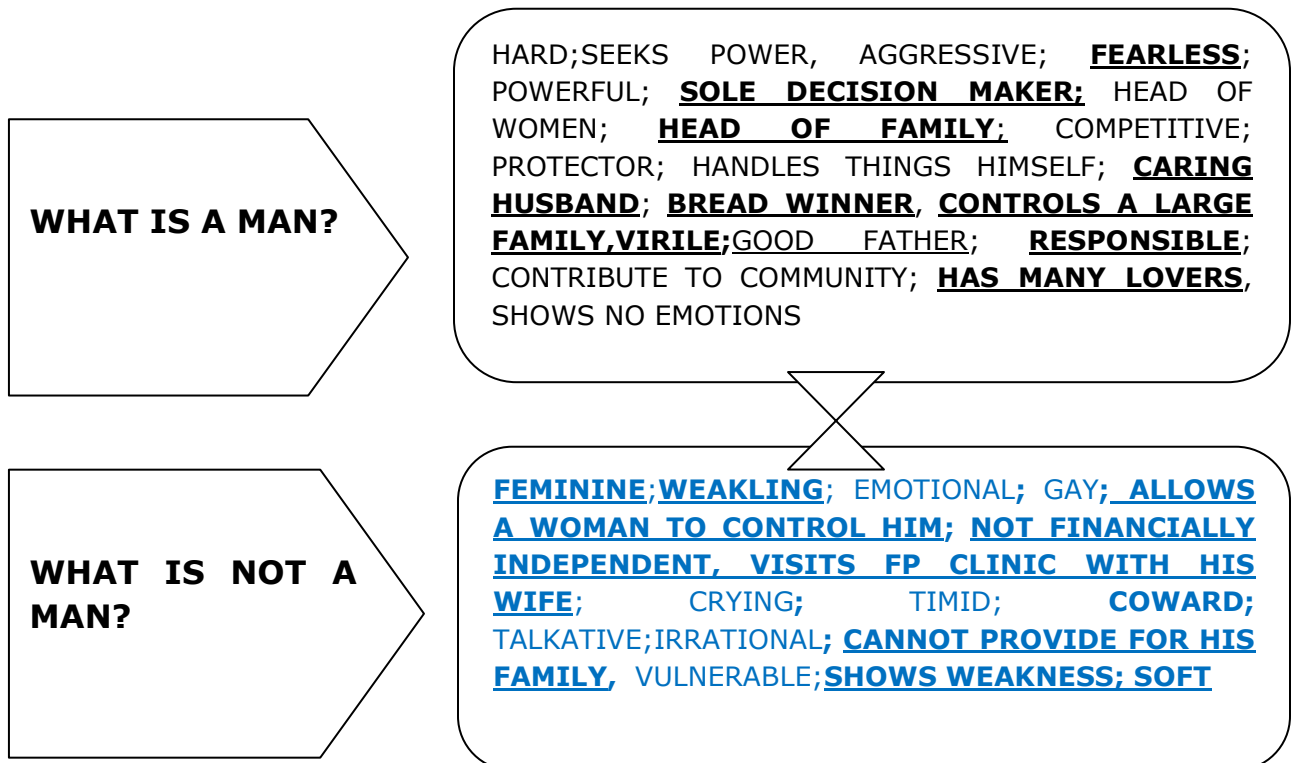
*"I see myself as somebody with many responsibilities; somebody who excels in life, who should work hard to ensure that he, maintains that superiority as a man. Igbo culture attaches much importance to being a man. So I live up to that expectation and it gives me a very bold heart to achieve whatever I want to achieve. I must go to a great extent to achieve it. So I must do everything to defend that manhood". Excerpt of interview with middle aged Nigerian Igbo man. [Odimegwu and Adedini (2013), p.5711]*

#### 3.1 MASCULINITY NORMS IN NIGERIA

*"That one is not a man. Is he a man? When he does whatever his wife tells him to do?"  
 "(Adult male) Odimegwu and Adedini (2013) p.5714*

A wide range of norms have been associated with being a Nigerian man. Although there are some cultural differences, common themes identified in several studies [Odimegwu and Adedini, 2013; Aransiola et al., 2014; Orisaremi and Elubo, 2012 and VFC, 2015] are listed in the diagram below.

**Figure 2: Attributes attached to manliness and non-manliness**



Some of the most popular norms identified in the studies reviewed have been underlined. In 2015, NIMAGES report revealed that being a tough man(i.e. ability to do things himself and not ask for help<sup>1</sup>), breadwinner and key decision maker were the most widespread masculinity norms associated with being a man [VFC, 2015]. This was closely followed by high sexual prowess.

As head of the home, men were expected to be strong and take care of their problems without asking for help. More than 2/3<sup>RD</sup> of the study participants expected men to make decisions involving all the family members and provide financially for the family [VFC, 2015]. Marriage was also described as a starting point for manhood as men paid dowry and had to start controlling a family. Most of the respondents defined a real man as a man who is able to control his partner. This is similar to findings from Odimegwu and Adedini (2013) study on masculinities where real men were described as controller of women.

Although gender-inequitable behaviour like male dominance and violence towards women were perceived as the norm during the quantitative aspect of NIMAGES, a contrasting picture was seen during the FGDs. Health-promoting masculine norms were also mentioned like being responsible, respectful and protecting those that you love and this was observed in other studies [Odimegwu and Adedini, 2013; Adelekan et al., 2014, VFC, 2015]. Upon reflecting on the health impact of these norms, some men (including those who had reported that they adhered to traditional dominant norms) acknowledged that their health-seeking behaviour was negatively influenced by these rigid societal expectations. They reported that they were not able to always act in gender-equitable ways because of the way that their peers would treat them. Men also blamed the present economy for making it difficult for them to fulfil the role of breadwinner or have many lovers. More so, some norms were observed to be conflicting with each other; like being responsible and having several lovers or being caring and yet unemotional.

This is quite similar to Odimegwu and Adedini (2013) study where some participants described masculine norms as almost impossible to fulfil. In addition, majority of the men agreed that alternate masculinities that were less dominating and more gender equality friendly were increasingly becoming a popular trend [VFC, 2015]. For instance, it was reported in the NIMAGES report that 7 in 10 men were in reality making joint decisions in the home.

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<sup>1</sup>Asking for help (mumu) is sometimes regarded as being weak in some Nigerian cultural language

Another common masculinity norm expected men to be virile and have good sexual prowess. One male participant of a FGD said “a man is known as a man when he has kids from different women” [Odimegwu and Adedini 2013 p.]. This suggests that having many kids was seen as a validation or proof of sexual potency. Similarly, masculinity has been strongly linked with sexuality in other studies [Odimegwu and Adedini 2013;VFC 2015].

Overall, there seems to be no fixed masculine behaviour in Nigerian men as men negotiated through a spectrum of different masculinities from gender equitable ones to gender inequitable characters. The NIMAGES report identified 3 types of men using the gender equality scale. Men who strongly valued the traditional dominant masculinities which controlled women and obeyed rigid norms; men who did not value it (alternate) and men who moderately (that is did not fully accept the terms of rigid hegemonic norms) valued both but at varying degrees depending on the issue being discussed. Results from the quantitative aspect of NIMAGES suggested that majority reported having moderate views [VFC 2015]. Three in 10 men and 2 in 10 men believed that dominant hegemonic gender stereotypes were too rigid and not healthy respectively and so did not fully ascribe to it [VFC 2015]. This faction believed that a man should be caring, treat his wife as an equal and shun violence.

### **3.2. FACTORS INFLUENCING CONSTRUCTION OF MASCULINITY**

Masculinity is socially constructed and learnt from childhood [Connel, 2005]. African culture usually socialises boys to be physically and emotionally strong, financially independent and shun feminine traits in order to be seen as a man [Ricardo and Barker, 2005]. Young Nigerian boys usually look up to their fathers or other male elders/public figure as the standard for measuring the ideal man (Odimegwu and Adedini 2013).The family, school, religious place of worship and media were often cited as the main sources of socialisation of masculinities in the Nigerian studies reviewed.

Patriarchal structure (which gave males more privileges) and religion were found to be the dominant factors that shape the construction of masculinity [VFC, 2015]. Religion was found to favour the enactment of hegemonic norms as both Muslim and Christian respondents asserted that religion dictated that males should dominate while females should be submissive [VFC, 2015]. Almost all the NIMAGES participants claimed that the gender stereotypes which assigned a man as dominant and a woman as submissive were created by God.

This rigid norm was observed more in the north as Islamic doctrines tended to be more gender restrictive for women than their Christian counterparts [VFC 2015].

On the other hand, being formally educated and residing in an urban area was found to encourage alternate masculinities that were gender-equitable [VFC 2015]. Even the harsh socio-economic context was also impacting on the evolving masculinities as some men reported that it was unrealistic to embrace a norm that expected them to be breadwinners or sole providers [VFC 2015]. Therefore, dominant traditional masculinity cannot be applied to all and has the ability to change.

### **3.3 MASCULINITY NORMS THAT INFLUENCE MALE INVOLVEMENT IN FAMILY PLANNING**

This section looks at how the four assumptions of masculinity apply to Nigeria, and how they affect men as clients and as partners in FP.

#### **3.3.1 AVOIDING FEMININITY**

*"I think the major problem we have with our involvement in family planning is that it is a women's activity." Male older. Adelekan et al, 2014.p.6.*

Recent studies that assessed men and women's views regarding gender roles revealed that pregnancies (including unintended pregnancies) and childcare were usually seen as the domain of women [(Odimegwu and Adedini 2014; Ukeagwu, 2014; VFC 2015)]. If motherhood is viewed as women's issue; it's not surprising that FP will be seen as same. This norm therefore has negative impact on men's involvement because it hinders men from participating actively in it.

#### **MEN AS CLIENTS**

African men including Nigerians have reported that they do not want to be labelled as effeminate [Barker and Ricardo, 2005; Schuiler et al. 2004, Odimegwu and Adedini 2013]. By assigning FP role to women, society deliberately excludes men from it and so information about FP may not reach men. Some men believed using FP was not their responsibility. This reason has

been cited as explanation for some men's reluctance to get involved in family planning directly as clients [Abubakar 2012; Adelekan et al., 2014; Ukeagwu 2014]. One study showed that only about half of the 90% of respondents who reported approval of FP were currently using it [Ijadunola et al, 2010]. Moreover, the posters on the walls of FP clinic usually associate women with FP rather than both men and women, this observation was made by the author herself during her clinical rotation in the FP department.

### *MEN AS PARTNERS*

Results from Nigerian study showed that majority of the men were not willing to attend a clinic either alone or with their wives [Ijadunola et al 2010]. Similar findings were found in studies done in Tanzania and Uganda [Schuller et al, 2011; Kabangenyi et al, 2014]. A Nigerian study found that about 60% of the male respondents would not accompany their wives to the FP clinic because it was located in a woman's centre. In another study, a male FGD respondent reported that the FP clinic had mainly female staff and this prevented him from going inside the clinic [Adelekan et al, 2014]. However, not all men were against visiting the clinic with their spouses, as about 30% of the respondents in a survey reported that they had already attended FP with their spouses [Ijadunola et al, 2010]. Similarly, in the south-eastern part of Nigeria, about half of the participants were willing to follow spouse to the FP clinic [Orji et al, 2007]. This supports the belief that there are men who exhibit alternate and less traditional masculinities for the sake of their health and that of their family.

### **3.3.2 OPPRESSING WOMEN**

*A man in Igbo land is known by the number of wives, children he has, and how he exercises leadership in his household. He must show strength of character, not emotional or irrational or allow himself to be dominated by women (Adult Male, 55, rural) Odimegwu and Adedini 2013 p. 5714].*

Nigerian men often control women's access to health information and services [VFC2015]. Several studies conducted in Nigeria and other parts of Africa has confirmed that the socially acceptable relationship between couples expects women to be submissive and men dominant [Orji et al, 2007; Adelekan et al, 2014, Barker and Ricardo 2005]. A gender analysis of NDHS 2013 conducted by

FMOH revealed that in Nigeria, women's rights to make decisions regarding their RH have been relegated to the background [NCP AND ICF 2014a].

### *MEN AS CLIENTS*

Men can make decisions on sex and FP without communicating with their spouse. Studies in Nigeria have shown that its men who decide the timing and frequency of sex [Aransiola et al., 2013; Ukeagwu 2014]. Although evidence favour sole decision making, masculinities are evolving and more men are beginning to make RH decisions with spouse. Orji et al. (2007) study revealed that majority of the male participants was inclined towards joint decision about FP. Even NIMAGES showed that about 6 in 10 men were willing to share decision making on the use of contraceptives with their wives [VFC, 2015].

Furthermore, some African men have reported difficulty with asking for FP information from female health workers because it makes them uncomfortable discussing details of sex with a woman [Kaida et al 2005; Mukankundiye, 2011; Kabagenyi et al., 2014] however this is not the norm in Nigeria. Nigerian studies reveal that it is the attitude of the staff especially female staff, which Nigerian men seem to be concerned about. Men usually feel entitled to power over women [Adelekan et al., 2014]. This might make FP clinics run or staffed by mainly women ineffective for counselling males especially when these staff have no training on counselling men for FP [Institute of reproductive health (IRH) 2014]. The superior status men occupy in society might make them expect to be given preferential treatment [Adelekan et al., 2014]. This hegemonic tendency to view women as a subordinate could negatively influence men's willingness to obtain FP services in clinics run by female staff.

### *MEN AS PARTNERS*

*"Have discussed family planning with my wife because have told her I do not want more than three children..." Young Male. Adelekan et al, 2014 p.6*

It has been documented in several Nigerian studies that failure to control one's family is paramount to failure as a man and such men often face ridicule from their peers or community members [Ijadunola et al, 2010; Odimegwu and Adedini, 2013; Adelekan et al, 2014]. Gender equitable relationship characterised by open communication about sex, fertility preferences and contraception between partners have been known to result in good RH outcomes

like increased uptake of RH services [Ruxton 2004]. In the Nigerian setting, poor communication resulting from the unequal power dynamics within marriages has negatively influenced some men's ability to support their partner's use of contraception. However, some studies also seem to show that Nigerian men report that they discuss FP issues with their partner [Adelekan et al., 2014, Ijadunola et al., 2010; VFC 2015]

Interestingly, evidence shows that communicating with spouse should not always be equated with joint FP decision making especially when the man holds all the power [Esplen 2006, CFC 2009]. One example of this might be seen by microscopically dissecting the comment in box above. A young male participant (who seems to be supportive of smaller family size) uses the expression 'I' which shows that even when the discussion is held with wife, the choice of contraception used is solely his decision. In this regard, service providers need to carefully tailor their FP promotional messages to encourage men's involvement without reinforcing men's dominance over women. When men are targeted because they are the key decision makers, there is a chance that dominant masculine norms will be reinforced.

Another popular norm that negatively influenced supporting partner's use of contraception in most Nigerian studies reviewed was the notion that contraception encourages married women to cheat on their husbands. This notion is widespread in our setting and in other SSA countries [Orji et al., 2007; Ijadunola et al., 2010; Schuller et al., 2011]. A promiscuous wife is a source of disgrace and ridicule to her husband. Therefore, when FP is perceived as a tool to promote women's independence, some men will probably be against it. Odimegwu and Adedini (2013) study in the eastern part of Nigeria revealed that most of the masculinity norms are centred on dominating women. Norms that associate men with being breadwinner, head of the family and key decision maker fuels this attitude.

Gender norms in Nigeria expects women to get consent before enquiring or using FP from her spouse because he is the head of the family [Adelekan et al 2014]. Without consent from their spouses, some women who would like to use FP may be unable have access to it. Whitehead (2006) and Carrigan et al. (1985) asserted that it is wrong to assume that men always dominate women. This is true in Nigeria because in Aransiola et al. (2014) study findings, women have found ways to control their spouses or make their husband do what they want. One female participant mentioned that some women approach the subject

of FP when he is in a good mood or seek counsel from elders in the family like mother-in-law or elderly relatives. In extreme cases, women may covertly use FP (e.g. injectables) [Orisaremi and Alubo, 2012;Aransiola et al., 2014,].

### **3.3.3 MEN AS A DISADVANTAGED GROUP**

*"It would be better if we get involve in FP so thatwe can get to increase our understanding of whatit entails." Young participant. Adelekan et al, 2014. p. 4*

Evidence in Nigeria has suggested that men are also made vulnerable by masculinity norms which socialise them to bear pain and to take risk thus affecting their health seeking behaviour negatively [VFC, 2015]. In a bid to prove their manliness, men are often pushed by societal and peer pressure to act in certain ways that they know may not be beneficial to them and their partners [Odimegwu and Adedini, 2013; VFC, 2015].

#### *MEN AS CLIENTS*

Masculinity norms reinforced by health institutions and policy makers discourages (directly and indirectly) use of FP among men. Health system factors increases their vulnerability when it fails to recognise men's reproductive health needs. In Nigeria, it seems women have more opportunities to hear about the benefits of FP than men because FP services are traditionally located in places where men do not visit frequently like obstetric clinics.

More so, most of the widely promoted FP commodities available are female dependent methods and some Nigerian men are aware of this disadvantaged position [Adelekan et al., 2014; FMOH, 2014].This was evident in a study where some male participants expressed frustration at the lack of FP centres that can suit their needs [Adelekan et al., 2014]. There are only a few male dependent methods (condom and vasectomy) available. Although the male condom was the most popular with men, reason for using condom may have been for protection against sexually transmitted infection (STIs) and not primarily for FP. The popularity of the condom in Nigeria is apparently from its advertised benefits in reducing HIV.

The use of male sterilisation or vasectomy was virtually nonexistent (even in urban areas where these services were available]. Only 0.1% of the men



surveyed in the 2013 NDHS had used a permanent method [NCP and ICF 2014b].

### *MEN AS PARTNERS*

*"My wife had used family planning in the past but she had to stop it because I did not support her and this was because I know that family planning is dangerous for women." Adelekan 2014 p.6*

The desire to appear strong and unemotional may contribute to the poor support that men give their partners [Odimegwu and Adedini, 2013; Adelekan et al., 2014]. Some men who lack info about FP may not want to appear ignorant in front of their wives [Oyediran et al., 2002]. As there are so many misconceptions surrounding FP side effects, adequate information is needed to dispel these myths.

The 2013 NDHS reported that discontinuation rates have continued to increase among women because of failure of FP method [NPC and ICF 2014b]. Adverse side effects are common reasons for discontinuation but the side effects usually mentioned were usually incorrect. This suggests that if men made informed choice about FP, they would have fewer misconceptions about side effects and support partner's use of it.

### **3.3.4 POWERLESS AND POWERFUL**

*"You have to provide accommodation for your family, provide the needed protection to your family and food also, pay school fees for your children and siblings and meet up with other responsibilities. When you are doing these, people say that you are a man." Participant. Odimegwu and Adedini et al., 2014 p.5715*

Mankowsky and Maton (2010) and Carrigan et al. (1985) both assert that men feel powerful and exhibit this power in society which is awarded to them strictly because of their gender. This means that they are expected to have authority as men. Yet they may lack other structural factors that determine availability of power like good socio economic status and education that are outside of gender. This is a stressful aspect of their masculinity as they feel powerless and frustrated as their ability to fulfil expected breadwinner roles at home is limited (especially for the poor and unemployed).

## *MEN AS CLIENTS*

The high level of unemployment and economic recession has made it difficult for men to singlehandedly fulfil the breadwinner role in Nigeria [VFC, 2015]. This dilemma has also been reported by respondents in other studies [Orisameri and Alubo 2012; Adelekan et al., 2014]. Since income is a strong determinant of status and power, poor men who cannot fulfil breadwinner role may feel ashamed that they have failed. This feeling of powerlessness has been associated with indulging in social vices [alcohol abuse, violent behaviour, stealing] either to make money or escape from reality [Greene and Levack 2010]. For example, in Odimegwu and Adedini (2013) research, some youths reported using alcohol or getting high as a way of coping. Alcoholism and depression in men is on the increase in recent times [VFC 2015]. These risky habits and/or disease can make men ignore or under prioritise their health [Green and Levack 2010]. Thereby, compromising their RH needs and it may hinder such men from getting involved in family planning.

## *MEN AS PARTNERS*

The feeling of loss of control over their circumstances might also make some men violent towards their spouses [Esplen 2006, Blake, 2010]. Evidence in Nigerian studies suggests that some men use violent behaviour to compensate for their inability to fulfil their expected roles [VFC 2015]. Violence can be used to show manliness and authority in relationships [Esplen 2006]. Domestic violence is quite common and tolerated in Nigerian culture [VFC 2015]. Approximately 3 in 10 ever-married women have faced abuse from their spouses [NPC and ICF 2014a]. Meanwhile, 2/3rds of NIMAGES respondents reported that women should tolerate violence from their partners. Aransiola et al. (2014) reported that some women were afraid to demand for FP from their partners because of fear that he would beat them. Thus, violence is a strong barrier to FP.

However not all men subscribe to this violent norm. Masculinity norms in Nigeria are quite contradictory because they also expect a man to be a good husband and father [VFC, 2015]. This is a role that requires some form of display of emotions (affection) and care. For example, one participant in a Nigerian study stated that the reason for supporting his wife's use of FP was to show affection to her [Adelekan et al., 2014]. Men who exhibit such traits like being caring and showing love to partner are more likely to be supportive of FP.

### **3.4 MASCULINITY FACTORS THAT INFLUENCE MEN'S FAMILY PLANNING DECISION MAKING.**

Research conducted on local masculinities suggests that African males' ability to make decisions regarding their health and that of their partners is significantly influenced by their adherence to the different masculinity norms they negotiate through on a daily basis [Ruxton, 2004; Van Eerdewijk, 2005; Blake, 2010]. Men's FP decision-making behaviour is an important aspect of the framework as it provides insight to which aspects of FP, men are involved and how programmers can garner men's support and use of FP effectively. Below is a gendered analysis of findings from studies reviewed. How certain FP-related decisions are influenced by norms will be discussed below:

#### **3.4.1 DESIRE TO HAVE A LARGE FAMILY SIZE**

According to the 2013 NDHS, an average Nigerian woman's total fertility rate (TFR) is about 5.5 [NPC and ICF, 2014b]. In recent times, studies have suggested that more men are beginning to express a desire to curb their family size [Orji et al., 2007; Adelekan et al., 2014]. However, TFR from the different zones in Nigeria shows that only marginal changes have occurred, with only a 0.2 reduction in TFR in the last 5 years [NPC and ICF, 2014b]. This falls short of the national FP policy which aims to reduce TFR by 0.6 every 5 years [FMOH, 2014].

The desire to have a large family has been associated with hegemonic norms. Odimegwu and Adedini (2013) and Adiri et al. (2010) findings affirm that the need to have many kids is also related to men's desire to earn respect among his fellow men. Research conducted in both the southern and northern part of Nigeria has affirmed that children (especially males) are seen as a source of prestige [Adiri et al., 2007; Odimegwu and Adedini, 2013;]. This is depicted in Odimegwu and Adedini (2013) study, where a participant stated that a real man usually controls a large family. Although they may not have the means to care for this large family, such societal pressure might make men disapprove of contraception.

In contrast, some men do not associate large families to manhood. These men reported a willingness to use family planning in order to reduce family size and health risk on wife [Ijadunola et al, 2010; Orji et al., 2007; Adelekan et al., 2014; Odimegwu and Adedini, 2013]. These men may not necessarily be a majority but they are increasing in numbers. Ijadunola et al (2010) study revealed that men who were younger and well educated seemed to align

themselves with this school of thought. Exposure to westernised culture through education and media coupled with the increasing costs of providing for large family has been cited as a reason for desiring fewer children [Adelekan et al., 2014; VFC, 2015,].

#### **3.4.2 USE OF FP**

Overall, despite increasing awareness of FP amongst men, use of FP is still low. Oyediran et al. (2002) study on use of FP amongst men revealed that about 2/3rds of men reported that they had used contraception in the past. According to his study, factors that positively influenced decision to use were being educated and residing in an urban area. This is quite similar to the 2013NDHS report and Orji et al. (2007) study where those living in urban area reported using FP more than those in rural area. This could be because urbanisation has created avenues for men to be exposed a wide range of westernised masculinities that favour a smaller family size and joint responsibility in caring for kids. Structural factors like poverty have also contributed to men's refusal to adhere to the norm [Ukeagwu, 2014].Oyediran et al. (2002) study also suggested that being counselled by a health worker also increased the likelihood that men will decide to use contraception.

#### **3.4.3 CHOICE OF FP**

Even after deciding to use FP, men may have some difficulty deciding which method suits them and their masculinities adequately. When men perceive that FP method will reduce sexual satisfaction for either them or their partner, they may choose not to use it. This was observed in a study in Uganda, where men believed that condom reduces enjoyment [Kabagenyi et al., 2014].This means that as clients, men may avoid methods that they believe interferes with their manliness. In most places in Africa, men have strongly rejected using vasectomy because it is a permanent method of contraception and often times perceived as a form of castration thereby taking away their manhood [Ijadunola et al., 2010;Mukankundiye, 2011].

Misconceptions about female-dependent methods have also limited men's support for FP in their partners. Men are expected to protect their family and so if they believe FP is not good for their spouses there is a tendency to reject its use. Although FP messages are not targeted at men routinely, their role as decision maker and/or breadwinner places men in a position to choose the FP method used by the couple. Some side effects like cessation of menstrual flow, heavy bleeding and weight gain have been linked with contraceptives. This can

prevent persons who have not received adequate counselling about FP to disapprove of it [CFC, 2009].

Natural methods like SDM which is dependent on timing may prove difficult in relationships where communication about sex and FP is limited. Gender inequitable masculinity norms in this case acts as a barrier to communication between partners as unequal power dynamics in gender relations may deny women ability to convince men to choose or support a particular FP product.

#### **3.4.4 ALLOCATION OF RESOURCES**

*“Family planning is entirely women’s affairs and nothing concerns we their husbands except to give them money for it if necessary.” male participant . Adelekan et al. 2015 p.4*

The breadwinner role is increasingly being shared between men and women [VFC 2015]. Despite these realities, studies reviewed have suggested that whether or not men are sole providers or share decisions with spouses, most times men dictate how money is spent in the household. According to VFC (2015), only 2 in 10 men report that they share decision about household spending. It was observed that men opined that it was their duty to provide money for their spouse contraception. Although paying for FP is good, most men feel that should be their only involvement in FP [Oyediran et al, 2002; Adelekan et al., 2015].

In Nigeria, the FMOH supplies some FP commodities (injectables and condoms) free of charge at public health centres [FMOH 2014]. However indirect costs like transport to health facility, cost of opening a case file and treating side effects still remain. More so, nationwide survey indicates that majority of FP users get FP products from the private sector where they pay out-of-pocket [NPC and ICF 2014b]. When men are ignorant about the cost benefit of using FP, convincing them to pay for it in the present economic conditions may be difficult. Some men may be unable to afford costs of buying condoms consistently.

Masculine norms can act as both motivators and barriers to FP. Norms that are not hegemonic or inequitable have a tendency to encourage positive male involvement in FP. In the next chapter, potential strategies based on understanding masculinity norms will be discussed in details.

## **4: POTENTIAL STRATEGIES TO INVOLVE MEN IN FP**

If we are to effectively involve men in FP, evidence confirms that gender sensitive interventions which have been known to improve male involvement in RH are needed.

### **4.1 GENDER MAINSTREAMING STRATEGIES**

Gender mainstreaming involves integrating gender into every aspect of a project from the planning phase to the evaluation phase. When the impact of gender norms, relations and role on achieving projects' goals are identified such programs are 'gender aware'' [PRB, 2011]. There are several different approaches that gender aware programs can take. These approaches are:

#### **4.1.1 GENDER EXPLOITATIVE**

This approach involves the use of prevailing gender norms and inequities to achieve programs goal. This approach therefore reinforces rigid stereotypes and may promote gender inequality. For example, when a project in Zimbabwe used macho men images that depicted men as sexually aggressive to promote condom use [FHI, 2012]. Such project can further encourage masculine norms that favour violence in men.

#### **4.1.2 GENDER ACCOMODATING**

This technique identifies the prevailing gender norms and its possible impact on the intervention without making any effort to change them; rather the program adapts its objectives to make up for the negative effects of the norms[PRB, 2011]. For instance, promoting condoms use by targeting men in areas where most women cannot negotiate for condom use. Although this approach recognises gender inequitable norms, it does not challenge men's dominant position in society [FHI, 2012]

#### **4.1.3 GENDER TRANSFORMATIVE**

This approach does not only identify unequal dynamics between men and women but also challenges gender inequitable norms by setting objectives that can reduce these inequities [PRB, 2011]. This approach encourages men and women to reflect on the negative effects of their beliefs and behaviour and seek to change them. For instance, when a contraceptive commercial portrays a couple deciding to use a condom together. This questions dominant masculinity norms that views men as the main decision maker and encourages joint decision making by couples [FHI, 2012]. Gender experts have advocated that

projects should adopt gender transformative strategies that discourage harmful gender norms while promoting gender equitable alternatives [PRB, 2011; FHI, 2012].

Gender transformative projects might either engage men only or women only. Men only projects would usually focus on changing men's notions of masculinity and challenging harmful norms effects on men women and other members of society. While those involved with women, would usually seek to empower women so that the gap between men and women be reduced in projects.

#### **4.1.4 GENDER SYNCHRONISING APPROACH**

Gender synchronising approach is a relatively new method used to integrate gender into programs. It involves combining both men and women gender transformative projects simultaneously or one after the other [Greene and Levack, 2010]. Projects that are gender synchronised have more opportunities than the gender transformative approach because it promotes equitable gender relations and transforms norms that make both sexes vulnerable to poor RH outcomes [Greene and Levack, 2010]. An example of a transformative project is one that aims to reduce dropout rate of girls from schools by starting up only-girls school while a gender synchronised approach may additionally target fathers too by encouraging them to register their kids in school [Greene and Levack, 2010].

#### **4.2 CASE STUDY: MEN AS CLIENTS**

In this section, two case studies will be highlighted. These two examples from African countries are useful because the context is quite similar. Like Nigeria, these countries are male dominated with low contraceptive prevalence. Another remarkable similarity is the influence of religion on male involvement in FP and gender norms that encourage sole decision making in men. These interventions used a gender transformative approach that sought to change popular opinions on masculine norms and FP.

##### **4.2.1 MALE MOTIVATIONAL CAMPAIGN (MMC) IN GUINEA**

The male motivational campaign was a nationwide FP intervention which was carried out in Guinea and evaluated by the John Hopkins University Centre for Communication Programs(Blake and Babalola, 2002). Ninety eight religious leaders and 1045 respondents were randomly selected from 55 randomly

selected enumeration areas. The main objective of the intervention was to increase contraceptive prevalence by using behaviour change communication (BCC) strategy. It was designed to meet the health needs of Guinea citizenry (predominantly Muslim country which had low CP rate of about 4 % and high TFR of 5.5).

It was targeted towards religious leaders and married men respectively. Prior FGDs and expert interviews had revealed that religion and husband's opposition were the main barriers to use of contraceptives so the plan was to educate religious leaders on FP and debunk the perception that Islam does not support FP. Like Nigeria, common male gender norms in Guinea included: men as sole decision makers; large family size depicts wealth; FP encourages infidelity and FP is a woman's issue.

Conferences were organised for religious leaders (Christian and Muslim). Different print materials with verses from the Koran/bible that supported FP were presented to them. This was followed up by a drama which emphasised Islam and its relationship with reproductive health.

A large variety of media program on FP was used to emphasise the usefulness of FP to married men and other members of the community. Posters, audio CDs, TV and radio programs were used to encourage men to communicate with their spouses on FP. A popular comedian promoted the campaign using a popular slogan 'I talk to my wife on family planning, how about you?' Service providers were also given educational materials and leaflets to use for counselling and distribution to clients.

#### *IMPACT OF THE PROJECT*

Evaluation of the project revealed that there was positive impact on the perception of FP and increased knowledge of FP methods, side effects and effectiveness from 77% to 99% among religious leaders (Blake and Babalola, 2002). Support for FP use increased among the leaders, however, perception about vasectomy remained the same as leaders believed Islam was against it. Spousal communication on FP among religious leaders also increased from pre-project value of 40% to 95% at evaluation and positive attitude towards smaller family size increased. However, there was only a slight increase in use of FP from 9% to 11%. Notwithstanding, a large number of religious leaders



who were initially non users reportedly decided to use FP personally in the future [Blake and Babalola, 2002].

The number of married persons who knew about FP also increased and more men approved of FP after the study (55% to 69%). Communication on FP between couples also slightly improved as participants reported increased talking about FP with their spouses. The figure rose from about 20% to 25%. The number of men using FP did not increase but the females using FP increased from about 40% to 50%. Although men's FP use did not increase, the perception towards use among men who had never used FP before the intervention increased.

### **4.3 CASE STUDY: MEN AS PARTNERS**

#### **4.3.1 INTEGRATING STANDARD DAYS METHOD INTO FP PROGRAM**

Integrating SDM into Family Planning Program was conducted in several countries which included Guatemala, Democratic Republic of Congo, Rwanda, India etc [IRH 2014]. It was organised by the Institute of Reproductive Health and sponsored by USAID. Its main goal was to increase male involvement in FP by increasing men's knowledge about FP and promoting better communication between men and their partners.

The strategies were designed based on evidence that male gender norms served as barriers to open communication about FP between spouses; relegated women to a lower power status thereby limiting her ability to negotiate sex and FP service providers did not provide male friendly services.

Males were used as facilitators and several methods were used to engage men. They included: media pictures depicting couples rather than just women in FP, male focussed radio messages talking about disadvantages of large families and the financial, social and health-related benefits of using contraception. In addition, facilitated discussions in groups on gender norms and family planning were conducted using male volunteers and dramas were aired in areas where men were known to socialise. Furthermore, service providers were trained on how to counsel men on FP methods and render couple counselling while acknowledging the power dynamics in relations between men and women as it concerned fertility preference. The health workers were made to critically reflect

on the influence of norms and other structural factors that reinforced the view that contraception is a woman's issue [IRH, 2014].

### IMPACT OF THE PROJECT

There was increased male participation in FP. Across all countries, knowledge and correct use of SDM was reported to have increased. Women reported that they got better support for and discussion on FP from partners. It was also noted that the intimacy between couples improved. For example in India, about 90% of the females reported that the men were more caring and more open to discussing FP with them [IRH 2014]. Some male participants also acknowledged the importance of recognising the supportive part they could play and stated that they were not ashamed of it.

## 4.4 LESSONS LEARNT FROM CASE STUDIES.

Below is a table showing a summary of the strategies used in both case studies and their impact:

**Table 3: Gender sensitive strategies and its impact on FP decisions.**

FP DECISIONS	STRATEGY		IMPACT		REMARKS	
	MALE MOTIVATIONAL CAMPAIGN	STANDARD DAYS METHOD	MALE MOTIVATIONAL CAMPAIGN	STANDARD DAYS METHOD	MALE MOTIVATIONAL CAMPAIGN	STANDARD DAYS METHOD
Family size	Conference and videos for religious leaders to promote smaller families	FP education to men and importance of making decisions on family size together as a couple	Favourable attitude plus intention to reduce family size	More women were involved in discussion/decision making about family size	Religious leaders seemed better predisposed to using FP for child spacing rather than reducing family size	Using radio messages to promote smaller family size is a good strategy because it reaches men irrespective of social class or education.
Use of contraception	Use of male ambassador	Media messages that	Some increase in use of FP	Increased usage of SDM was	At least there was a	By garnering men's support

	or like a popular celebrity to promote male involvement in FP	promote use of SDM by males	among religious leaders No change among married men.	reported	reported increase in intention to use FP in the future among the men	ort, more couples will be confident in using SDM.
Allocations of resources towards FP	nil	Men were taught about the cost benefits of investing in FP	nil	Joint decision making about FP and resources among couples	Not applicable	SDM encourages communication as it requires cooperation from both couples
Choice of FP	Religious leaders encouraged to promote male methods.	SDM was introduced to men by male users and service providers were trained on how to counsel men on SDM	Religious leaders supported male use of FP but not permanent method like vasectomy	More men understood their role in FP especially SDM and were willing to use the method and support their spouses.	religious leaders can serve as ambassadors to promote the method they used	Women who do not have a regular cycle may not be able to use this method even when spouse is motivated..

In sum, both the MMC and SDM program used gender transformative approaches that sought to transform religious and gender norms that disapproved of men's involvement in FP. It used several channels to change popular opinions on masculine norms. In both cases, some success was recorded. Overall, both campaigns were able to achieve some of their objectives since it increased positive attitudes towards contraception and discouraged gender norms that limited FP support. However, some negative perception remained unchanged as regards vasectomy (as seen in MMC). It is important to continually sustain communication messages through multiple channels if change in men's attitude is needed [IRH 2014].

## 5: DISCUSSIONS, CONCLUSION AND RECOMMENDATIONS

### 5.1 DISCUSSION

#### 5.1.1 MASCULINITY NORMS IN NIGERIA

The three dominant norms identified as the most popular were: the need to appear tough; be the sole decision maker and play the role of bread winner in the home. Other common hegemonic norms were wielding authority over women and having the view that women are not equal partners. These dominant norms did not encourage male involvement in FP. Alternate masculine norms identified included showing affection/empathy for loved ones, being responsible, protecting family and sharing decision making. Generally, most men with alternate masculinities enacted more gender equitable behaviour that favoured male involvement in family planning. Refer to table 5 for a summary of masculinity norms and its influence on male involvement in FP.

Masculinity is very fluid as most men negotiate between both hegemonic and alternate masculinities depending on the situation on ground. For instance, they might be willing to engage in FP if a male friendly environment is available or if the activity is one that does not threaten their manhood in front of others.

[Table 4: Masculinity norms and its influence on male involvement in FP](#)

GENDER NORMS THAT MEN SUBSCRIBE TO: HEGEMONIC MASCULINITIES	INFLUENCE ON MALE INVOLVEMENT IN FP	
	AS CLIENTS	AS PARTNERS
<b>A man is the sole decision maker</b>	<ul style="list-style-type: none"> <li>Increases men's FP-decision-making power</li> </ul>	<ul style="list-style-type: none"> <li>Some men force their partners to use FP</li> <li>do not encourage equitable decision making with partner</li> </ul>
<b>A man is the bread winner of the home</b>	<ul style="list-style-type: none"> <li>Men who are not breadwinners were likely to enact poor FP-seeking</li> </ul>	<ul style="list-style-type: none"> <li>Men may not grant their partners' financial access to FP services if they</li> </ul>

	behaviour	don't think FP is beneficial or safe.
	<ul style="list-style-type: none"> <li>decreases access to FP clinic during working hours</li> </ul>	
<b>A man should not be engaged in activities seen as feminine</b>	<ul style="list-style-type: none"> <li>decreases access to female-dominated FP clinics</li> <li>FP clinic do not target men as potential clients</li> <li>Few male contraceptives are available to men</li> </ul>	<ul style="list-style-type: none"> <li>Decreases willingness to attend FP clinic with their wives for couple counselling</li> <li>Men may support partner's use of FP but are unwilling to use FP themselves.</li> </ul>
<b>A real man controls a large family</b>	<ul style="list-style-type: none"> <li>Decreases willingness to use FP methods themselves</li> </ul>	<ul style="list-style-type: none"> <li>Oppose spouse's contraceptive usage</li> </ul>
<b>Children bring prestige</b>	<ul style="list-style-type: none"> <li>Decreases support for smaller families</li> </ul>	<ul style="list-style-type: none"> <li>Oppose FP use by spouse</li> </ul>
<b>Man should control woman</b>	<ul style="list-style-type: none"> <li>Superiority complex make it harder to seek help about FP from female staff</li> </ul>	<ul style="list-style-type: none"> <li>Women need consent before using FP</li> </ul>
<b>ALTERNATE MASCULINITIES:</b>		
<b>A real man should be caring</b>	<ul style="list-style-type: none"> <li>Increases willingness to use FP to show love to spouse</li> </ul>	<ul style="list-style-type: none"> <li>Increases support for and cooperation with partner</li> <li>Favours discussion with partner on fertility and FP preferences</li> </ul>
<b>A real man should be responsible</b>	<ul style="list-style-type: none"> <li>Favours use FP to prevent unintended pregnancies and birth spacing</li> </ul>	<ul style="list-style-type: none"> <li>Increases support for and cooperation with partner on FP use</li> </ul>
<b>A real man should protect his family</b>	<ul style="list-style-type: none"> <li>Seeks info on FP to prevent the ill effects that come with poor child spacing and having many kids</li> </ul>	<ul style="list-style-type: none"> <li>Supports partner's use of FP if convinced that its safe.</li> </ul>

### **5.1.2 MASCULINITY NORMS AND FAMILY PLANNING**

Dominant hegemonic norms which were not FP-friendly was found to be publicly accepted in the Nigeria context. However, there was a discrepancy between what men reported and how men behaved in privacy of their homes. This proves that the general assumption that men always oppose FP is false. Masculinity is indeed evolving as men are beginning to embrace some more gender equitable norms in spite of the presence of a culture that favours hegemonic masculinities and religious norms which hold gender inequitable views. This may indicate that the society is at a point where the men have better opportunities to access information about FP benefits for them and their families.

However, it is important to note that although having alternate gender-equitable view was usually associated with being supportive of FP, this was not always the case. Protecting the spouse from harm was one norm that was FP - friendly if the men believed contraception was safe. In other cases, men who adhered to gender-equitable norms usually favour equal decision-making and better communication. These factors encourage increased uptake of family planning by promoting mutual respect for each person's choice and need. However, in spite of the high number of joint decisions being reported by men in the studies, findings indicate that men may still be largely in control of FP decision making as they usually have the final say on FP matters. This supports the view that encouraging joint decision on contraception on its own is not enough to promote healthy outcome for women's RH and gender equality if the evolving alternate masculinities only allows women to make an input but does not favour equity in decision making. If indeed women's right to decide for themselves is being encouraged then decision making that is fair and equitable should be encouraged. This shows that gender equality is an important ingredient for positive RH.

Interestingly, being the sole decision maker was a barrier to contraception mostly when the men were against FP. Some men who supported smaller families seemed to impose FP on their spouses. Thus suggesting that FP did not always promote equitable relationships and strategies that are gender accommodative may in the long run reinforce gender inequality as men may use their control over women to force them to use FP. This is why the IGWG has called for the use of gender transformative and gender synchronised strategies that challenge and transform negative masculinity norms and

encourage positive male involvement in FP without abusing women's right [PRB 2011].

Men supported smaller family size because the cost of providing for their families was rising. This could present an opportunity to educate men about the need for smaller families during couple counselling as FP has long term economic benefits for the family. Furthermore, women were found to share the role of financially providing for their families.

Failure to counsel men on FP meant that men are not making informed choice on FP thereby leading to poor outcomes for themselves and their partners. Fear of side effect or misconception about the adverse effect of FP was one recurring theme that negatively influenced decisions on FP. Thus emphasising the need for male friendly centres and adequate information about FP tailored to reach men starting with those men who were already displaying gender-equitable alternate norms or in support of FP. Program managers and health service providers need to focus on ways to reach men with correct information about side effects as this seems to be an important reason for non-use that was not reflected in the gender framework.

Apart from a fear of side effects, religion also intersected with masculine gender norms and FP in two ways. Firstly, religion was found to have a strong influence on FP-seeking behaviour as some Christians and Muslims respondents believed that their religion was not in support of FP. Secondly, respondents believed that religious norms dictated that the men and women are not equal and so men should be in charge of women. Thus religious leaders should be involved as ambassadors to support FP since many people look up to them for guidance. This could promote more men to publicly support FP and display alternate masculinities that favour contraception.

Other factors that also intersected with norms were receiving formal education and living in an urban area. Men who had been formally educated and resided in urban areas were found to be more likely to emulate gender-equitable behaviour that could favour positive involvement in FP. There is need for in-depth research on factors influencing masculinity in Nigerian setting.

### **5.1.3 GENDER-RELATED STRATEGIES TO INVOLVE MALES IN FAMILY PLANNING**

Various studies have affirmed that the change from the norm cannot be transformed overnight and gender norms change is a slow process. Gender accommodative strategies (for example, encourage men to get involved in FP as protectors of the family) therefore seem much more feasible as the first practical steps to take towards gender equality and males' FP use in Nigeria. But this should then to be closely followed by gender transformative approaches which challenge the inequality in decision making. Such strategies need to garner the support of religious and political leaders and try to change societal views (including service providers and program managers) that still believe that FP is a female's domain. Simultaneously, FP clinics in Nigeria should be made more male-friendly and service providers trained to be gender-sensitive when delivering services.

Males often assess their masculinities from their peers and other males in society. More males should be employed to work in FP clinics. If a massive campaign on male involvement in FP is carried out using male role models especially religious leaders and male celebrities that support men's involvement in FP, less people will probably associate FP with being feminine. Since masculinities are relational, gender synchronised interventions that also address the impact of femininity norms in making women submissive and unable to have open communication with men is indeed relevant but more research (preferably a qualitative one) is needed to understand the barriers to male involvement in FP.

It is important for campaign on FP to address misconceptions about FP side effects and also discourage men from being violent. These campaigns should target the community as a whole. Men can be made to recognise the harmful effect of such violent masculine norms on their health and relationships during FP sessions. Discussions on how to embrace and enact non-violent masculinities that encourage gender-equitable attitude and behaviour should be included.

Finally, findings from this thesis have affirmed that masculinity norms influence decisions on family size, use of FP and choice of FP. It also affects the ability of men to access FP information that yields informed choice and to have equitable relationships where there is open communication and shared decision making. Men who mostly adhere to hegemonic norms are more likely to exhibit negative attitudes towards male involvement in contraception. Such men are therefore



less likely to use male methods consistently and support partner's use of FP. Programs that want to reduce unmet need should focus on using a gender sensitive approach that promotes gender equality between couples and transforms negative norms to positive equitable alternate norms that favour FP.

## **5.2 CONCLUSION**

Findings from this study have shown that Nigerian men are the key decision-makers on fertility and family planning issues and they influence women's access to and use of FP yet they are not targeted by FP providers in Nigeria. There are an increasing number of men who do not conform to hegemonic norms and show a willingness to get involved positively in FP.

Furthermore, a complex picture showing that gender norms do not act alone as major barrier to male involvement in FP in Nigeria emerged from this thesis. In Nigeria, gender norms that promote inequity in decision-making intersect with religious norms (that support inequity) and health system factors which when combined discourage men from sharing responsibility in using FP as clients or as supportive partners. Fear of side-effect when viewed from a gender perspective showed that even men who do possess equitable alternate masculinities may not support FP use in their partners in bid to protect their loved ones.

A gender sensitive approach (not just to include "men" to the blueprint or FP project guidelines) is therefore needed to involve men more proactively in FP so that they can make informed choices. More needs to be done to encourage open communication and equitable joint decision-making with their spouse. Overall, evidence has suggested that FP itself can lead to gender equitable relations and women empowerment since it promotes shared decision making and open communication. Coordinated and contextually appropriate gender transformative initiatives that promote more gender equitable norms is required.

## **5.3 RECOMMENDATIONS**

This thesis argues that family planning programs in Nigeria needs to shift focus from targeting just women to both men and women and find ways to involve men positively in FP. This section presents the recommendations on how to improve the contraceptive prevalence in Nigeria.

### **5.3.1 POLICY MAKERS/FEDERAL MINISTRY OF HEALTH**

The current national family planning policy needs to be revised. Gender sensitive policies that promote male involvement in FP as potential clients needs to be included. More so, guidelines should focus on key areas in RH that can serve as entry points for engaging men. For instance, creation of male-friendly family planning centres outside of maternity clinics; In-service training of health staff on gender and its link with FP and how to give contraceptive counselling to couples and staffing of government clinics with male nurses are recommended.

The FMOH should advocate for support from religious leaders by educating them so they can enlighten their members on the benefits of using FP and share positive messages that the Quran and bible is not against contraception.

Positive male involvement in FP cannot be effective in the presence of gender inequalities. Therefore, FMOH should liaise with the other sectors/ministries to advocate positive norms that real men possess gender equitable attitudes and behaviour. Educational policies that encourage greater responsibility for males in RH and discourage discrimination of women should be created and implemented. Policies should work to reach the next generation by using a school curriculum that promotes gender equity and discourages violence against women.

### **5.3.2 PROGRAM MANAGERS AND RESEACRHER**

Program managers and RH researchers who design RH interventions should initially use gender accommodative approach that will serve as the first step in promoting male involvement in FP. This includes: targeting men with FP messages; organizing workshops or group sessions where men are informed about FP and can discuss freely; nationwide health promotion messages to sensitise and reorientate the public about the benefits of male involvement in FP using mass media and encourage joint responsibility of men in reproduction and child care.

Gender accommodative projects should be followed by transformative programs. Gender transformative projects will be more likely feasible in urban areas where new alternate gender equitable norms are emerging. These projects should focus on challenging harmful hegemonic norms using behaviour change campaigns. Couple counselling rather than individual counselling should be used to make men better clients and partners in FP. These sessions should include discussions that advocate for gender equality. Alternate norms should

be encouraged by allowing men reflect on the negative effects of abiding by rigid sets of norms that pressure them into poor health seeking behaviour. Posters and print materials that portray positive images of men and women (e.g. celebrity couples) using FP should be seen in FP centre.

Researchers should carry out more in-depth research on factors influencing masculinity and the gender-related barriers to male involvement in FP. Ethnography studies can serve as a useful tool for understanding the barriers men face. Researchers also need to carry out long term evaluations on the impact of gender sensitive interventions in this setting.

### **5.3.3 HEALTH WORKERS/SERVICE PROVIDERS**

Service providers at the federal, state and local government level should receive gender sensitive training on barriers that may prevent successful uptake of contraception and how to overcome them without worsening men's domination over women.

Men's access to FP can be improved by making FP centres more male friendly by displaying positive attitudes to men who visit the clinics; having an extended opening time and using male service providers who target the male clients.

Family planning information and services should involve the community as a whole not only be made available in maternal centres. Other places in the hospital and community where men visit like STI clinic, urology, general practice clinics, barber shops, football viewing centres and club/village meetings can be used to offer FP information and services.

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## ANNEX 1

**Table 5: MATERNAL HEALTH STATISTICS OF NIGERIA**

<b>Health indicator</b>	<b>Statistics</b>
Maternal mortality rate (reported)	550 per 100000 live births
Contraceptive prevalence 2008- 2012	17.5%
Life expectancy at birth(2012)	52.1 years
Unmet need for FP(2011)	18.9%
Total fertility rate	5.5
Infant mortality rate (2012)	78 per 1000 live births

Source: UNICEF, 2014

## Annex 2

### BOX 1: Criteria for assessing quality of studies used

Box showing assessment for ensuring quality of studies selected.[pope et al 2007]
<p>Does the study have clear study aims and research questions</p> <p>Does the study have a good design and adequate description of how sample were selected, location and settings, limitations and rationale.</p> <p>Does the study have description of how well the data was collected, transcripts of interview, context in which data was collected</p> <p>Does the study have a clear connection between conclusion and interpretation of findings</p> <p>Does the study have a good report that clear and transparent and discusses bias and errors addressed</p> <p>Does the study show that it has addressed ethical issues adequately</p> <p>Has the study documented its work adequately</p>

## Annex 3

**Table 6: Data Description**

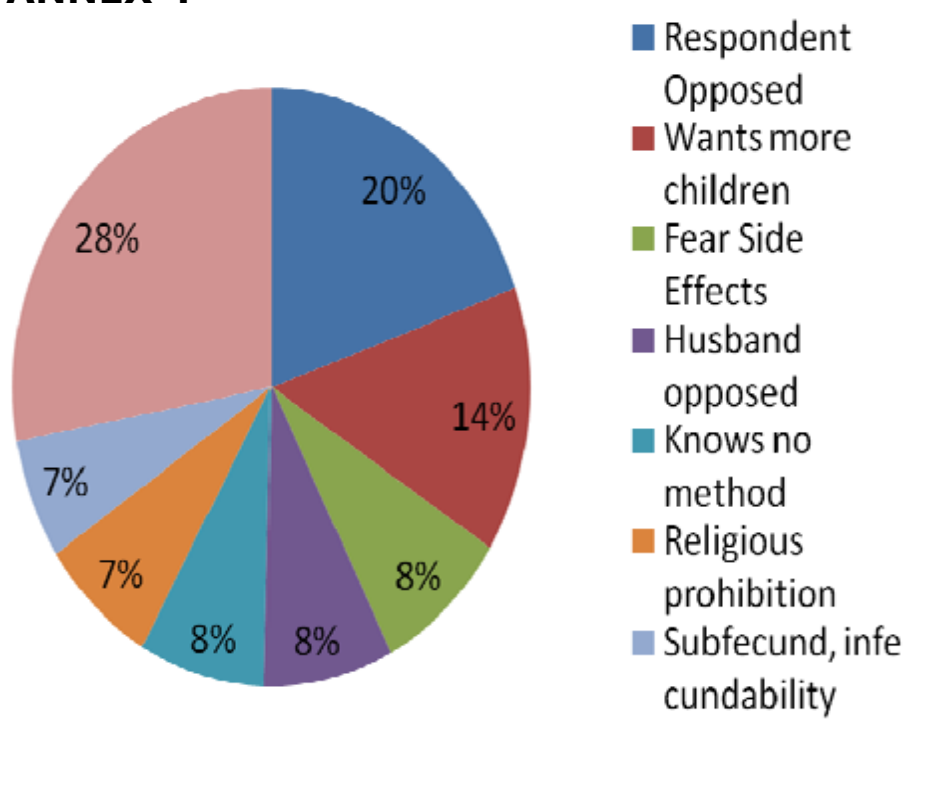
Author/Year of publication/Title	Type of publication	topic	Country	methodology	Observations/quality
Adiri et al. 2010  Fertility behaviour of men and women in three communities in Kaduna state, Nigeria	journal	FP	Nigeria	Cross sectional survey. quantitative	It does not answer the reasons for wanting more kids.
Ijadunola et al. 2010  Male involvement in FP decision-making in Osun state	African journal for reproductive health	FP	Nigeria	Cross sectional quantitative/qualitative  Agree/disagreed scale was used to assess attitude or perception of men towards their role in FP  In-depth interview with	Sample size was not adequate, however with only few studies in this regard, it was included and observations were noted.  Although study concluded that male involvement was low in Osun state, quantitative studies do not examine why it is so but provide a good base for qualitative studies.

				service providers	
Ukeagwu 2014 Male Involvement in Family Planning in some selected Rural Communities in Enugu East Local Government Area, Enugu State, Nigeria	Dissertation	FP	Nigeria	Quantitative study in using systematic random sampling to select respondents	Study was carried out in rural areas and low male involvement was noted.
Odimegwu and Adedini, 2013  Masculinities and health in Nigeria: vulnerability, options and indifference	journal	gender	Nigeria	Qualitative study in urban and rural areas of south east  In-depth interviews of community leaders; FGD of men One urban and one rural Not only married men (sexually active adolescent boys were included) pretested	Data was collected in 2005 and like culture, masculinities is always evolving. However, the issues identified in the result is still important to my work and falls within my inclusion criteria Good selection process Some FGD groups had one adolescent, middle aged man and elderly in it. In such settings, respondent may say what they think other men expect from them( masculinity is also about how men perceive other men's view of them)
Orji, Ojofeitimi and Olarenwaju 2007.  The role of men in FP decision making in rural and urban areas	Journal	FP	Nigeria	Quantitative interviewer based questionnaire.  Interviewed 370 married men Rural and urban Pretested	Hasty generalizations about men use  Unequal power relations may prevent women from demanding FP
UNAIDS 2001	Report on RH/HIV	RH	Nigeria	Analysis of 12 projects that integrated men in HIV/RH	Useful examples of how to integrate men in RH programs
Oyediran et al. 2002  Factors affecting ever married men's contraceptive knowledge and use in Nigeria	Journal article	FP	Nigeria	Mixed method. Using FGD, in-depth interview and household questionnaires interviewer administered. Married men and	Study noted ever use of FP was higher than current use which shows that people had discontinued. However it did not explore the reason for discontinuance. This would have been useful in understanding the barriers to male involvement in

				spouses were interviewed from the south, west and eastern part of Nigeria. Both rural and urban were surveyed.	FP. There are a wide variety of cultures in Nigeria. So conclusion from this study may not represent the whole country. However they give useful suggestions.  High proportion of men (60%) claimed to use FP. Most of them were depending on female method used by spouse. Use of condom or male method itself was low.
Adelekan, A. et al. 2014  Male involvement in family planning: challenges and way forward	Research article	FP	Nigeria	Mixed method quantitative semi structured questionnaire of 500 men in Osogbo. Four FGD was also carried out.  Cross sectional descriptive survey on married men	Mixed method approach was very useful. Qualitative methods like FGD gave insight as to how men perceive their involvement in family planning.
Aransiola et al. 2014  Women's perception and reflections of male partner and couple dynamic in family planning adoption in selected urban slums in Nigeria: qualitative exploration	Research article	FP	Nigeria	Qualitative method: 16 FGD of men and women (in North and southwest). Married and unmarried men  FGD consisted of 8-12 persons	Useful insights about the gender norms in the north. Since gender is relational, femininity norms reflected here are useful.
NDHS NPC and ICF, 2014	National survey	pop	Nigeria	National survey	Data was not gender sensitive. Survey did not include men in some key aspects of fertility and family planning
Gender in Nigeria. 2014. Data gathered from NDHS 2013	Summary report	Gender	Nigeria	National survey Interviewed men and women of reproductive age	Gender analysis of NDHS 2013

Kabagenyi et al. 2014	article	F P	Uganda	Qualitative FGD	Study highlighted some gender-related barriers to Male involvement
Barriers to male involvement in FP.					
Nigeria family planning blue print/FMOH 2014	Government document	F P	Nigeria	Guidelines on Family planning policy implementation.	Mainstreaming gender by involving men is not indicated as a key strategy. Policy targeted mainly women and female-dependent methods.

#### ANNEX 4



**Figure 3: Common reasons for non-use of FP services in Nigeria (UNFPA 2010)**