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SOCIOCULTURAL FACTORS INFLUENCING MALE INVOLVEMENT IN FAMILY PLANNING IN NIGERIA: A REVIEW OF LITERATURE

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Abstract
Family planning (FP) initiatives most times target women. However, acknowledging the roles of men in FP is vital to achieving Sustainable Development Goal (SDGs) target of universal access to reproductive health by 2030. This study reviewed literature on the socio-cultural factors influencing male involvement in family planning in Nigeria. Health Belief Model (HBM) was adopted as the theoretical framework. The work thematically discussed existing literature on socio-cultural factors influencing male involvement in FP. Authors views served as the basis for the arguments presented. Majority of works reviewed argued that socio-cultural factors such as, religious belief and traditional values promote male dominance and control of family decisions. Also, levels of educational attainment, family income, spousal communication, gender inequality were presented by scholars to have influenced male involvement in family planning. To ensure increased male involvement in family planning, the study recommends that government should setup male-targeted programmes and clinics that take into consideration the cultural context of the country and to encourage men to be involved in FP. Also, there is need to engage community, religious and opinion leaders so that they can advocate for male partner involvement in family planning. Furthermore, education should be promoted and targeted at both women and men to empower them to make informed decisions regarding use of family planning products and services.
Keywords: Education, Male involvement, Factors, Family Planning, Socio-cultural

INTRODUCTION

Family planning is an important aspect of reproductive health that may negatively or positively affect population. As a result of this importance, nations, international agencies and non-governmental organizations (NGOs) spend time and resources to promote family planning. The centre point of health care services in Nigeria is the Primary Health Care (PHC). It addresses the most common problems in the community by providing preventive, curative, and rehabilitative services to maximize health and wellbeing (World Bank, 2011). Family planning services is one of the essential provisions of primary health care in Nigeria (Okeke, 2020).

Family planning (FP) is defined as "the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. Male involvement in family planning refers to all organizational actions focused on men as a distinct group to increase the acceptability and uptake of FP among either sex. It encompasses men's attendance to FP clinics, being involved either in decision making, approving it, or supporting their spouse to use FP (Mulatu et al., 2022). Sociocultural factor is a term related to social and cultural factors, which means common traditions, habits, patterns and beliefs present in a population group. Socio-cultural factors are the largest scale forces within societies and cultures that affects the thoughts, behaviors and feelings of individual members of those societies and cultures, such factors include: education, type of marriage, patriarchy, place of residence, religion, myths and misconceptions etc. (Akintoye et al., 2020).

Throughout the world, especially in developing countries, there is an increasing concern and interest on family planning. The International Conference on Primary Health Care, held in Alma Ata, Kazakhstan, in 1978provided the platform for the mobilization of primary care movement of professionals and institutions, government, civil society groups etc that took it upon themselves to tackle the politically, socially and economically unacceptable health inequalities (including FP) (Federal Ministry of Information (FMI, 2014). However, these inequalities were not eradicated as FP Initiative over the years have tended to concentrate primarily on women, with less attention to men (Harde et al, 2016) until the 1994 International Conference on Population and development (ICPD) and the 1995 Beijing Conference. In its Plan of Action, the ICPD acknowledged that men had been bypassed by Family Planning program and needed to be reintegrated into sharing jointly the responsibility for contraception: it recognized that, appropriate methods for couples and individuals vary ... and ensure that women and men have information and access to the widest possible range of safe and effective FP methods in order to enable them to exercise free and informed choice while recognizing that appropriate methods for couples and individuals vary according to their age, parity, family-size, preference and other factors (United Nations, 1995, ICPD, 1994). In 2015 the United Nations General Assembly adopted the 2030 Agenda for Sustainable Development (SDG) which reaffirmed the commitments of the landmark International Conference on Population and Development, held in Cairo in 1994 (UN, 2020). However, the programmes have not been more stressed by the majority of African countries (Wondim et al, 2022).

WHO (2015) posit that low male involvement in utilization of FP is a global problem for the developed and non-developed countries, both in terms of total utilization and the types of methods utilized. The problem is more acute for developing countries. Sadly, Nigeria is one of the developing countries with lowest male involvement. For instance, male contraceptive prevalence as a component of FP, is 6.8% in Nigeria, 8.3% in Tanzania, 7.9% in Zambia, 23.4% in Gabon, 33.7% in Turkey, 13.6% in India, 35.1% in Congo, Honduras in 13.8%, 35.4% in Peru, 14.9% in Swaziland, 38.7% in Azerbaijan, 15.5% in Bangladesh, 41.5% Armenia (Ross et al, 2017). With regards to male involvement in FP use holistically, Studies done in Bangladesh reported the level of male involvement in FP as 63.2%, New Delhi 72.5%, and in Sri Lanka 74%. In a survey carried out in Olorunda LGA, Osun State, Nigeria, the overall reported involvements among the respondents was found to be 4.8%. (Abubakar et al., 2021).
Miller et al (2016) states that the contribution of FP programmes to reductions in population growth and maternal mortality and morbidity is globally acknowledged. FP programmes have been shown to reduce total fertility rates in developing countries. FP, especially modern methods of FP, are considered to be key health-promoting and cost-effective activities, with the potential to avert approximately 30% of maternal deaths and 10% of childhood deaths (Miller et al 2016). In 2020, an estimated 287 000 women globally died from a maternal cause, equivalent to almost 800 maternal deaths every day, and approximately one every two minutes (WHO, 2023). Sub-Saharan Africa was the only region with a very high Maternal Mortality Rate (MMR) – estimated at 545 maternal deaths per 100 000 live births, approximately 70% of global maternal deaths in 2020 (WHO, 2023). Unfortunately, Nigeria has one of the highest maternal mortality rates in the world; According to WHO report, on trend in maternal mortality rate: '2000-2020' Nigeria had the highest estimated number of maternal deaths, accounting for over one quarter (28.5%) of all estimated global maternal deaths in 2020, with approximately 82 000 maternal deaths (WHO, 2023). These poor maternal health statistics may be related to the low rate of family planning use the country experiences generally (Ogbe, 2017).
Women especially in low- and middle-income countries have been noted to be more involved in FP services than their male partners (Oyefabi et al, 2022). In the African context (including

Nigeria) men are posited as decision-makers and are perceived to be "gatekeepers" and custodians of cultural and traditional practices (Ifeadike, 2015). Male involvement in FP had been very minimal and a great concern for most governments and health policy makers especially in most developing countries. This occurs despite the existence of methods that require direct male involvement such as male condoms, periodic abstinence, withdrawal and vasectomy. Men have often times been reported as the main obstacle to better reproductive health outcomes for women and blamed for preventing women utilization of FP services or discontinuation of contraceptives (Oyefabi et al, 2022). Previous studies have shown that family planning practices in Nigeria were lopsided due to failure to take into account the male partners whose consents are required in most instances before a woman can access health care services due to the patriarchal nature of Nigerian families and societies (Oyefabi et al, 2022). WHO (2023) observed that the socio-cultural factors influencing this low level of involvement include: limited choice of methods; place of residence, education, family income, religion, gender inequality, patriarchy, spousal communication, limited male methods and public health sensitization. If these barriers are addressed there will likely be an increase in demand as well as satisfaction with modern methods of contraception (WHO, 2023). Similarly, a study done by Oyefabi et al, (2022) found that men with higher education tend to be more supportive to their wife's utilization of FP services. The higher the educational status of the husband and his partner, the higher the male involvement in family planning. Also, studies have shown that carefully designed programmes that have used available local male networks to deliver information that create awareness have proven to reduce social tension thereby improving male involvement in FP activities (Adongo et al., 2013).

In spite of this rich body of research, core fertility and reproductive health indicators continue to be calculated using women's data. Fertility rates, contraceptive prevalence rates, and unmet need for family planning, for example, all use women as their base while male participation in FP services promotion and utilization has often been overlooked and neglected. In most states in Nigeria, there are myths and misconceptions about FP by men and this can infringe on the rights of their spouses. Some of those myths and misconceptions include: general sickness, menstrual disturbance, weight gain or weight loss, nausea, weakness etc. It is therefore important to identify and address more of these misconceptions that discourage men from participating in family planning use. Furthermore, previous studies are conducted outside Nigeria setting, while these studies are enlightening, they are in some instances more relevant within their own context. It is then important to examine context specific behaviours when studying a topic such as male involvement in FP use, as these practices are steeped in local cultural understandings, beliefs and norms. There are a limited number of studies which have attempted to reveal the various socio-cultural factors (especially the role of public health enlightenment)influencing male involvement in family planning use in Nigeria. Therefore, to fill this research gap, this study focuses on socio-cultural factors influencing male involvement in family planning use in Nigeria.

CONCEPTUALIZATION OF KEY CONCEPTS

a) Family planning

Family planning, according to World Health Organization (2011), is a way of thinking and living that is adopted voluntarily upon the basis of knowledge, attitudes and responsible decision by individuals and couples, in order to promote health and welfare of the family, groups, and thus, contribute effectively to the social development of the country (WHO, 2011). It is documented that if the existing demand for family planning services were met, maternal

deaths in developing countries could be reduced by 20% or more (Okeke, 2020). FP, has many benefits including economic development, maternal and child health improvement, educational advances, and women's empowerment through career aspirations with control over their fertility desires. Other benefits of family planning include reduced maternal and infant mortality, sustainable development through population control, and enhanced women's participation in the workforce (Amuzie et al. 2022).

b) Family planning Methods

According toTrussell et al, (2018), Hubacher et al., (2015), H.T.A (2022) there are two basic family planning methods available that can be used to prevent pregnancy. They are: Traditional or natural methods
and Modern/artificial methods

Traditional family planning (or 'fertility awareness') is a method of contraception where a woman monitors and records different fertility signals during her menstrual cycle to work out when she's likely to get pregnant (H.T.C, 2022). They include:
a. Rhythm (calendar) method: Women monitor their pattern of the menstrual cycle (includes fertility awareness-based methods, periodic abstinence) (H.T.C, 2022).
b. Withdrawal (coitus interruptus): Man withdraws his penis from his partner's vagina and ejaculates outside the vagina, keeping semen away from her external genitalia (Trussell et al, 2018)

Modern family planning methods are ways in which a person uses a hormonal or non-hormonal product or undergoes a medical procedure to hinder or prevent reproduction from sexual intercourse (Hubacher et al., 2015). They include the following:
a. Female sterilization: This is a permanent contraception method that is done to block or cut the fallopian tubes (also known as tubal ligation). (Hubacher et al., 2015).
b. Male sterilization: Permanent contraception done to block or cut the vas deferens tubes that carry sperm from the testicles to the penis (also known as vasectomy) (Hubacher et al., 2015).
c. Intrauterine devices (IUD): They are small flexible plastic devices containing copper sleeves or wire inserted into the uterus. Some devices steadily release small amounts of levonorgestrel each day. This is usually inserted and removed by healthcare providers. It can be used for 3–5 years depending on the implant (Trussell et al, 2018).
d. Implant: They are small, flexible rods or capsules placed under the skin of the upper arm of a female; it contains either estrogen and progestogen, or progestogen-only. It is inserted and removed by healthcare providers. It can also be used for 3–5 years depending on the implant (Hubacher et al., 2015).
e. Injectable: These are injected into the muscle or under the skin every 1, 2 or 3 months, depending on the type of product (Trussell et al, 2018).
f. Oral contraceptive pill: Contains either estrogen and progestogen, or progestogen-only. They are to be taken daily, preventing the release of eggs from the ovaries (Hubacher et al., 2015).
g. Male condom: This is a sheath or covering that fits over a man's erect penis. It also protects against sexually transmitted infections, including HIV (Hubacher et al., 2015).
h. Female condom: This is a plastic pouch-like device inserted in the vagina before sex that offers clitoral stimulation (Trussell, 2018).
i. Diaphragm and spermicides: The diaphragm is a soft rubber cap that is fitted into the vagina to cover the cervix. It prevents sperms from entering the uterus and must be left for about 6 hours after sexual intercourse. This method is much more effective when used in combination

with a spermicidal cream which inactivates the sperm (Trussell, 2018).

c) Male Involvement in FP

Male involvement in family planning (FP) means more than increasing the number of men using condoms and having vasectomies; male involvement also includes the number of men who encourage and support their partner and their peers to use family planning and who influence the policy environment to be more conducive to developing male-related programmes (Fedrick, 2020). Male involvement in FP is broad and includes men's knowledge of FP, attitude about the use of contraception, communication with partners about FP, choices about appropriate contraceptive methods, giving emotional and behavioral support to their partners' contraceptive use. Male involvement in FP encompasses all organizational activities aimed at men as a discrete group which have the objective of increasing the acceptability and practice of FP by both men and women (Abubakar, 2021).

THEORETICAL FRAMEWORK

This study is anchored on Health Belief Model (HBM). The model was developed by a group of social psychologists Godfrey Hochbaum, Rosenstock Irwin and Howard Becker at the U.S public health services in the 1950`s. This is a psychological model that attempts to explain and predict health behaviours by focusing on the attitudes and personal beliefs of individuals. It was developed to help understand why people did or did not use preventive services offered by public health departments in the 1950`s, and has evolved to address newer concerns (Becker, 1971).Later uses of HBM were for patients' responses to symptoms and compliance with medical treatments. The HBM suggests that a person's belief in a personal threat of an illness or disease together with a person's belief in the effectiveness of the recommended health behavior or action will predict the likelihood the person will adopt the behavior.Ultimately, an individual's course of action often depends on the person's perceptions of the benefits and barriers related to health behavior. (Wayne, 2022).

Howard Becker (1971) looked at the causes of health seeking behaviour. He explained health seeking behaviour based on a belief system. He posits that people`s beliefs shape their health seeking behaviour. These beliefs are in turn shaped by the experiences the people have had in the past, their knowledge system and their socialization patterns.There are six constructs of the HBM. The first four constructs were developed as the original tenets of the HBM. The last two were added as research about the HBM evolved (Wayne, 2022).

Perceived Susceptibility: In the context of family planning, this refers to a man's awareness of the possibility of unplanned pregnancies and their potential impact on his life. Men need to recognize that they are susceptible to the consequences of unplanned pregnancies, including emotional, financial, and relationship challenges, if contraceptive is not used effectively. They should understand that their involvement can reduce the risk of unwanted pregnancies.

Perceived Severity: This aspect involves understanding the seriousness of the consequences of not being actively involved in family planning. Men should appreciate that unplanned pregnancies can have substantial physical, emotional, and financial consequences for both partners and any existing children. This recognition can motivate them to engage in family planning discussions and decisions.

Perceived Benefits: Men should be aware of the benefits of active participation in family planning. These benefits may include improved communication and trust with their partner, the ability to jointly plan for the timing and number of children, and greater control over their reproductive future. Highlighting these advantages can encourage men to take an active role.

Perceived Barriers: It's crucial to identify and address the barriers that hinder men's involvement in family planning. These barriers could include cultural norms, education, misconceptions about family planning, concerns about side effects, or fear of judgment. By addressing these barriers through education and awareness campaigns, it will be easier for men to participate in family planning use.

Cues to Action: Encouraging cues to action is important. This can involve healthcare providers promoting family planning discussions during routine check-ups, offering informational materials, or conducting community-based awareness programs. These cues can prompt men to take action in terms of learning about and using family planning methods.

Self-Efficacy: Men need to believe in their ability to actively engage in family planning. This includes understanding different family planning methods, knowing how to access them, and having open and respectful discussions with their partner about family planning goals. Educational programs and support can enhance men's self-efficacy in this regard. Men have their own beliefs, perceptions, and barriers related to family planning. These barriers will be elaborated below as socio- cultural factors influencing male involvement in family planning use.

The major critique of health belief model is that It does not account for a person's attitudes, beliefs, or other individual determinants that dictate a person's acceptance of a health behavior. Also, it does not take into account behaviors that are habitual and thus may inform the decision-making process to accept a recommended action (Wayne, 2022).

MAJOR SOCIOCULTURAL FACTORS INFLUENCING MALE INVOLVEMENT IN FAMILY PLANNING

Men are known to be culturally dominant and are expected to meet the sociocultural expectations and values attached to women and marriage (Kriel et al., 2022).

a) Myths/misconceptions and male involvement in family planning use

Male methods of FP, in particular, are surrounded by myths and misperceptions. Traditional beliefs still impact negatively on FP thus limiting community male involvement and access to reproductive health. There are cultural beliefs and practices that may hinder male partner involvement in contraceptive uptake. For instance, it is believed in some cultures that man reincarnates after the life on earth(Ukaegbu, 2014). The cultural belief has gone a long way in preventing men to get involved in family planning, example vasectomy, with the notice that if they are rendered sterile in this life, they will come again in their next world as impotent human beings and will not be able to reproduce. Then some others believe that vasectomy is equal to castration which impairs sexual functions. And still more misinformation includes the ideas that vasectomy will make the man fat or weak or less productive (Ukaegbu, 2014). Some other concerns were related to the use of oral contraceptives and injectables, which were seen to be the most dangerous. These misconceptions were particularly pronounced among those with limited access to health care facilities. These misconceptions could stem from a general lack of knowledge and could be attributed to men having limited access to correct reproductive health information (Nmadu et al, 2019; Ukaegbu, 2014). These false beliefs about contraceptives methods can limit choices, causing men to avoid effective methods due to unfounded fears thereby leading to adverse health outcomes for both men and women.

b) Level of educational attainment and male involvement in family planning use

Educational stages are subdivisions of formal learning, typically covering early childhood education, primary education, secondary education and tertiary (or higher) education. A study done by Oyefabi et al, (2022) found that men with higher education tend to be more supportive to their wife's utilization of FP services. The higher educational status of the husband and his

partner was positively associated with male involvement in family planning. The possible explanation is related to the fact that educated men will more likely have good knowledge of family planning which initiates them to involve in family planning. Moreover, educated women may initiate their partner to discuss family planning and reproductive health issue which might encourage the male to be involved in family planning (Wondim et al, 2022). Higher education provides better access to health information through varied electronic, print, and social media. Continuous access to quality health information is a driver to making informed decision about utilization of health services (Oyefabi et al, 2022). However, educational disparities can result in reduced access to health care services including family planning clinics. Men with no or lower levels of education maybe less likely to seek out FPservices. Thus, attainment of higher levels of education will likely lead to better access to FP service,guidance and promotion of male involvement in FP use

c) **Public health sensitization and male Involvement in Family Planning use**

Kriel et al (2019) asserts that providing adequate, accurate and contextually acceptable information is crucial to improving men's attitudes and understanding towards FP use. Despite the 2016 SADHS reporting that most people of reproductive age in South Africa has some FP information, the data from this study showed that the current provision of FP information is inadequate. Most male participants lacked a clear understanding about FP methods, their mechanism of action and related side-effects. This resulted in misconceptions and myths about side-effects and the reported concern that FP methods could harm male partners (Kriel et al., 2019). Social marketing has used television and radio advertising campaigns focusing on condoms - to increase public enlightenment of the effectiveness of condoms, reduce embarrassment when purchasing or negotiating condom use, and increase use of condoms. Social marketing can challenge social norms and help overcome barriers to acceptability of contraceptive use. The three social marketing programs here generally aimed to increase awareness of contraceptive methods overall and address method-specific challenges, information and service provision and gender norms and equality (Hardee et al., 2016).

d) **Family Income and male involvement in family planning use**

Family income is an important factor that affect FP. Despite their earnest intentions, many a time, mothers living in the below poverty line families and in a joint family structure, have to overcome various constraints before seeking preventive or curative healthcare services for their children (Ghosh et al, 2013). Studies also indicate that women whose husbands have higher status occupations are more likely to use Maternal Health Care Services (MHCS) especially family planning services. This is because such occupations are usually associated with greater wealth, making it easier to bear the costs of healthcare. However, various other studies have shown that women are less likely to utilize FP when they do not have personal control over finances, suggesting that an interaction between autonomy and family wealth produces FP service utilization (Okeke, 2020). Even when formal fees are low or non-existent in health facilities, there may be informal fees or other costs that pose significant barriers to FP use. These costs can be a barrier to men in low income families. Men maybe less willing to contribute to these expenses, prioritizing immediate financial concerns over family planning which leads to unintended pregnancies.

e. Gender inequality and male involvement in family planning use

Equity in gender relations and responsible sexual behavior highly stresses the need for men's active involvement in family planning. The interest in increasing active male participation in fertility regulation is two-fold, to balance reproductive health care more evenly between men and women and to increase the overall level of active users of fertility regulation (Anyango, 2019). Unequal gender norms and other power dynamics restrict men from accessing and using

family planning. Menmay perceive that health facilities are not male-friendly, feel uncomfortable discussing fertility preferences and contraceptive methods with their partners, or be influenced by norms that say family planning is the woman's responsibility. Given these realities, engaging men is imperative to ensure women and men can access and use family planning, and to continue to change unequal gender and power dynamics. Their engagement improves not only women's health and wellbeing, but also the health of men and their children (DeGraw, 2021). Also, changing societal norms that encourage gender inequality in FP use and Involving health care providers and community leaders in promoting gender-equitable practices is crucial in improving male involvement in family planning use.

f. **Spousal communications and male involvement in family planning use**

Inter-spousal communications are very important in FP use. Spousal communication on contraception and reproductive goals is an important intermediate step on the path to eventual adoption and sustained use of FP services and it suggests that the couple has an egalitarian relationship. Decision about using family planning and fertility control measures are not entirely individual decision. Studies have shown that couples who discuss the number of children they desire or the use of family planning are more likely to use a contraceptive and achieve their reproductive goals than those who do not (Oyefabi et al, 2022, Anango, 2019). Lack of desired communication between spouses reduce male involvement in FP utilization. In recent years, over half (52%) of currently married women said they had not discussed with their husbands about family planning in Bangladesh (Ukaegbu, 2014). Furthermore, poor communication can result to inconsistent or incorrect use of contraceptive methods, increasing the risk of unintended pregnancies

e) Inadequacy of male method of contraceptives and male involvement in FP use

The inadequacy of male method of contraceptives has caused considerable media attention surrounding a recent breakthrough, in the development of a male birth-control pill. Despite a variety of female contraceptive options, male contraceptive options are limited to withdrawal, condom and vasectomy. Condoms have high failure rates and surgical vasectomy is the surgical removal of sperm ducts. Limited access to a more diverse set of male-led methods was cited as additional motivation for men's disapproval of family planning. The permanence and irreversibility of vasectomy was noted, in particular, as inacceptable among men and consistent with losing one's masculinity (Kabagenyi et al, 2014). Making more family planning options available for males other than depending on female options, will likely improve their involvement and further reduce the incidence of unintended pregnancy.

f) Religious belief and male involvement in FP use

Religious belief is a major cultural factor affecting the use of FP methods. Some religious beliefs of people are against male participation in family planning. Religion and culture play a pivotal role in people's views and decisions about family planning. Adherents of religions that favour large family size are characterized by lower use of contraception. Artificial family planning is a crime to some religions example Roman Catholic denomination in Christian religion do not believe in artificial family planning of any type such as the practice of vasectomy and condom is prohibited by males (Anango, 2019, Ukaegbu, 2014). Also, the Muslims believe in a man marrying multiple wives as many as four. They believe that Children are a gift from Allah, and the number of children one has is according to his will. This encourages gender inequality and deprivation of women's right and empowerment. Virtually 100% of Somalis are Muslim, though they practice in varying degrees. Since a great majority of Somalis are Muslim, cultural norms and religious norms are often indistinguishable. Some believe modern methods are allowed by analogy, e.g., the Prophet Muhammad used what was available to him in his time, so Muslims now can use what is available to them, others believe

that barrier methods are acceptable (condom, diaphragm) but hormonal methods are not because they interfere with a woman's natural state/system. Sterilization (tubal ligation, vasectomy) is widely considered unacceptable in Islam because it does "permanent harm" to a person (Anango, 2019, Ukaegbu, 2014). When men are hesitant in family planning involvement as a result of religious belief, the risk of unintended pregnancies can increase, potentially leading to economic, emotional, and health-related challenges for couples and families. Hence, it is important to engage with religious leaders and institution, provide accurate information that aligns with religious teachings when possible, and promote respectful and open dialogue that respects individuals' religious convictions

g) Patriarchy and male involvement in family planning use

The patriarchal system is characterized by power, dominance, hierarchy, and competition. Thus, patriarchy is a system of social structures and practices, in which men dominate, oppress and exploit women. Many societies have a patriarchal structure and without approval of men, women have very little choice in their contraception. In a patriarchal community, like Somali refugee community, men as the husband in a family have an important say in decision-making about family size, the spacing, maternal health and general level of reproductive health in the family (Anango 2019). As the FP service delivery system is largely female-oriented, there are very limited opportunities for men to receive FP information from service providers, and hence because they cannot receive FP information, they cannot make proper judgments regarding the same. Thus, any family planning programme that isolates men is bound to have minimal impact (Anango 2019, Ukaegbu, 2014).

h) Age and male involvement in family planning use

Men's sexual and reproductive health needs differ along the course of life depending on their age, whether they are adolescents, beginning to explore sexual relationships, sexually active and adults. According to Najafi et al, (2013) men and women aged 20-24 have the highest contribution to the Total Fertility Rate and low fertility is observed among women aged 15-19 due to the introduction of free Universal Primary and secondary Education, which has kept girls in school, resulting in delayed marriages. Okigbo (2015) posit that age had a statistically significant effect on men's contraceptive use, with higher levels of use at younger and older ages.Okigbo (2015), also reported that contraceptive use among young men is similar to that of older men. This could be the result of the likelihood of younger men being single, and older men being less likely to want more children than other married men.

MEASURES FOR IMPROVEMENT OF THE LEVEL OF MALE INVOLVEMENT IN FAMILY PLANNING

According to Kwawukume et al (2022) several interventions can be used to address barriers in the uptake of FP services in this setting. Family planning programmes need to target men at all levels of health promotion and education with their partners to reduce misconceptions about FP methods to increase acceptance. Men's participation is crucial to help reduce misconception about side effects of contraceptive methods. Therefore, FP family programs need to target men at all levels of the service. Their involvement will also lead to women's empowerment to increase effective contraceptive use and continuation to improve better health outcomes in reproductive health. User experiences indicate that text messages provide a novel way to raise awareness, promote behavior change and address myths and socio-cultural norms (Kwawukume et al, 2022).

Mass media has long been used to promote family planning and is considered a promising intervention, while use of social media is more recent and is considered emerging. This type of programming, including media and advertising campaigns carried out via radio, television, newspapers, billboards, brochures, and social media sites, such as Facebook, can address men's use of contraceptive as well as to increase men's support for their partners' contraceptive use. They can shift the perception that family planning is a women's affair. They can also address gender norms and equality in family planning and contraceptive use (Hardee et al., 2016).

DISCUSSION

Traditional gender roles and cultural norms and patriarchal nature of Nigeria societies, often place the responsibility for family planning on women, where men are seen as the primary decision-makers in the family, as a result, men may perceive family planning as a woman's duty and feel less inclined to actively participate. This low participation of men can lead to unintended pregnancy which in most cases lead to maternal morbidity and mortality. This is explained by the health belief model adopted as the framework of this study. In this sense, males need to recognize that they are susceptible to the consequences of unplanned pregnancies, maternal morbidity and mortality including emotional, financial, and relationship challenges, if they do not actively involve in decisions and actions related to FP. In Perceived Barriers, addressing the socio-cultural factors that may prevent men from participating in family planning, such as myth and misconceptions, levels of educational attainment, family income,spousal communication, gender inequality, religious belief and patriarchy.Poor communication can lead to misunderstandings and misconceptions about family planning methods, their safety, and side effects. Also, men with lower levels of education may have limited access to accurate information about family planning methods, leading to a lack of knowledge about their options and benefits.This can result in reluctance or resistance to male involvement in FP use.Furthermore, the roles of public health sensitization were emphasized. When family planning information is readily available to men at the right time and at the right place, they will involve in FP use. Gender inequality may lead to disparities in the availability of reproductive health services and family planning resources. Differing religious beliefs about family planning can lead to conflicts within relationships. Men who hold negative views may pressure their partners to conform to these beliefs, resulting in tension and reluctance to use contraception. Byaddressing these factors and creating supportive environments, men will be encouraged to be actively involved in family planning decisions and improve overall reproductive health outcomes for both partners and their families.

CONCLUSION

This review of literature suggests that a number of socio-cultural factors affect male involvement in family planning use. Myth and misconceptions, levels of educational attainment, family income, spousal communication, gender inequality, religious belief and patriarchy, all play a role in determining the level of male involvement in family planning. To ensure increased male involvement in family planning use, this study suggest that it is important to promote male targeted policies that will enhance male involvement in family planning use.

RECOMMENDATIONS

1) The government should setup well-planned male-targeted programs and clinics that take into consideration the cultural context of the region and encourage men to be involved in FP services

2) There is need to engage community, religious and opinion leaders so that they can advocate for male partner involvement in family planning
3) Government should invest resource in researches that can bring to fore, more FP options such as hormonal male methods of FP. This will help to increase their level of participation
4) The government and non-governmental organizations should make efforts to improve family planning practices, through FP sensitization campaigns and improved educational measures at the medical centres, hospitals and at strategic places to create awareness and address the misconceptions about family planning.

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