MEN'S ROLE IN FAMILY PLANNING DECISION–MAKING IN ZARIA LOCAL GOVERNMENT AREA, KADUNA STATE, NIGERIA

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ABSTRACT

The purpose of this paper is to assess the role of men in family planning in Zaria Local Government Area of Kaduna State. A total of 408 copies of questionnaires were administered using purposive sampling technique, of which 354 were found useful for analysis. Data were analyzed through percentages and Chi square tests. Among the findings is that inspite of high knowledge of FP at 97.7%, only 34.2% of the respondents are currently practicing FP. The study shows that 61.2% of men participate as joint decision makers in the practice of FP. More so, the Chi square analysis (X^2) revealed a significant association between Ethnicity and marital status with P values of 0.000 each; religion and income with P values of 0.020 and 0.022 respectively, have statistically significant association with who makes the decision to practice family planning. Family planning programmes in northern Nigeria should focus on Muslim men. Religious leaders should be involved in clarifying misconceptions on issues regarding family planning.

Key words: Family Planning, Men, Reproductive Health, Role, Zaria.

INTRODUCTION

Men's potentially positive role in family planning (FP) has often been neglected because of the negative attitudes many men may hold towards birth control. In the industrialized world, men frequently use the availability of effective female contraceptives as an excuse for not using any birth control themselves. In the Third World, some men still insist on having the sole right to decide whether and when to have a child; many deny their wives access to contraception because they fear it will encourage promiscuity (Stokes, 1980). Everywhere, there are men who oppose birth control and a woman's changing roles in society because it takes from them, their power to father an unlimited number of children and seems to leave them with a diminished position in the family (Ibid). Most couples operate under the unilateral decisions influenced by the kinship group or lineage concerns. Ordinarily, a woman does not stand alone in confronting her husband; usually she confronts him only when supported by her husband's relatives, especially his parents, or by her own relatives (Isiugo-Abanihe, 2003).

Reproductive health (RH) practitioners have recognised that failure to target men has weakened the impact of FP programmes because men can significantly influence their partners' RH decisions and use of health services especially in societies where women do not possess the same decision making power as men. FP programmes in Nigeria have remained female oriented but because of their subordinate status, women are often not able to make their decision alone regarding FP or health care (Char *et al*, 2009). As such understanding the role of men in family welfare is critical to the success of FP anywhere in the world.

Men's involvement could be essentially prominent in the individual couple's FP effort. It is assumed in the African context that women do not have control over their own reproductive behaviour. Most studies carried out in Nigeria and other African countries (Mbizvo and Adamchak,

1991; Oni and MacCarthy, 1991; Isiugo-Abanihe, 1994; Lasee and Becker, 1997) have all asserted the domineering position of men in reproductive health matters. According to these studies, men are dominant decision makers within the family.

In Zaria Local Government Area, Islam is the major religion with Christianity and other traditional religions forming a minority group. Among the Hausa/Fulani which is the dominant ethnic group in the study area, men dominate familial and social relations, including production and reproduction. By paying the bride prize, a man secures rights over his wife and her children; a wife is expected to bear children as her contribution to the continuity and viability of her husband's lineage. Irrespective of a man's status, age or accomplishment, he remains the head of the family even if his wife subsequently rises to a position of influence in society, she acts as his subordinates.

According to tradition and religious doctrine, men have a higher status in the home and society. Planning the family for economic reasons is abhorred in the Islamic belief. However, the Hausa culture and Islamic religion do not object to child spacing and discourage short birth intervals. This is supported by the Qur'anic verse that encourages women to breastfeed for complete two years, for the health of both mother and child. This will give the mother time to recover before the next pregnancy and the proper growth of the newborn. Nonetheless, women still have closely spaced births; and with early marriage deeply rooted in the Hausa custom, so many young girls are unable to complete even primary school education. This therefore raises the question of the role of men play in FP despite the widespread understanding of child spacing in Islam. The aim of this paper therefore, is to assess the role men play in the practice of family planning in Zaria LGA. The objectives include: to characterize the sources of information for FP; analyze spousal responsibility for FP services; and examine the relationship between socioeconomic characteristics and FP among couples in the study area.

STUDY AREA

Located on a plateau at a height of about 2200 feet above sea level in the centre of northern Nigeria, Zaria lies between latitudes11^0 13" and 11^0 10" North and longitudes$7^0$30" and $7^0$68" East of the Greenwich Meridian (Mortimore, 1970). Zaria LGA is located in the northern part of Kaduna State, bordered by Makarfi LGA on the northeast, to the east by Soba LGA, to the west Giwa LGA and to the south by Igabi LGA (see figure 1).

The plains on which Zaria is situated are part of the vast undulating plains scenery which extends almost unbroken from Sokoto to Lake Chad and beyond, and from the south of Kaduna to the Tigueddi scarp near Agades. Zaria possesses a tropical continental climate. The continentality of its climate is more pronounced during the dry season, especially December to January. Zaria lies within a region which has a tropical savanna (Aw) climate with distinct wet and dry seasons. While the wet season occurs from May-October, which is the high-sun period; the dry season which is practically rainless occurs during November to April (Mortimore, 1970).

The urban area of Zaria is made up of the old walled city, the colonial township, Tudun Wada, Sabon Gari and Samaru village. The old-walled city, known as 'Birnin Zaria' or Zaria-City serves as the political, administrative and market centre. Zaria's economy is primarily based on agriculture. It is an important centre for the marketing and processing of agricultural products. Zaria LGA has the second largest population in Kaduna State of 408,198 with 210,900 are males and 196,090 females (NPC, 2009). The indigenous people are generally referred to as 'zazzagawa' or 'zagezagi', and they constitute 'Hausawa' and 'filani. They speak Hausa and Fulfulde - the major languages across northern Nigeria and some sub-Saharan African countries. There are other ethnic minorities such as Yoruba and Igbo among others, who have come as immigrants from the western, eastern and other parts of the country. Islam is the major religion with Christianity and other traditional religions forming a minority group. Despite being an administrative, commercial, transportation and manufacturing centre; it is Zaria's educational function that today most influences its character and gives it distinction as an urban settlement.

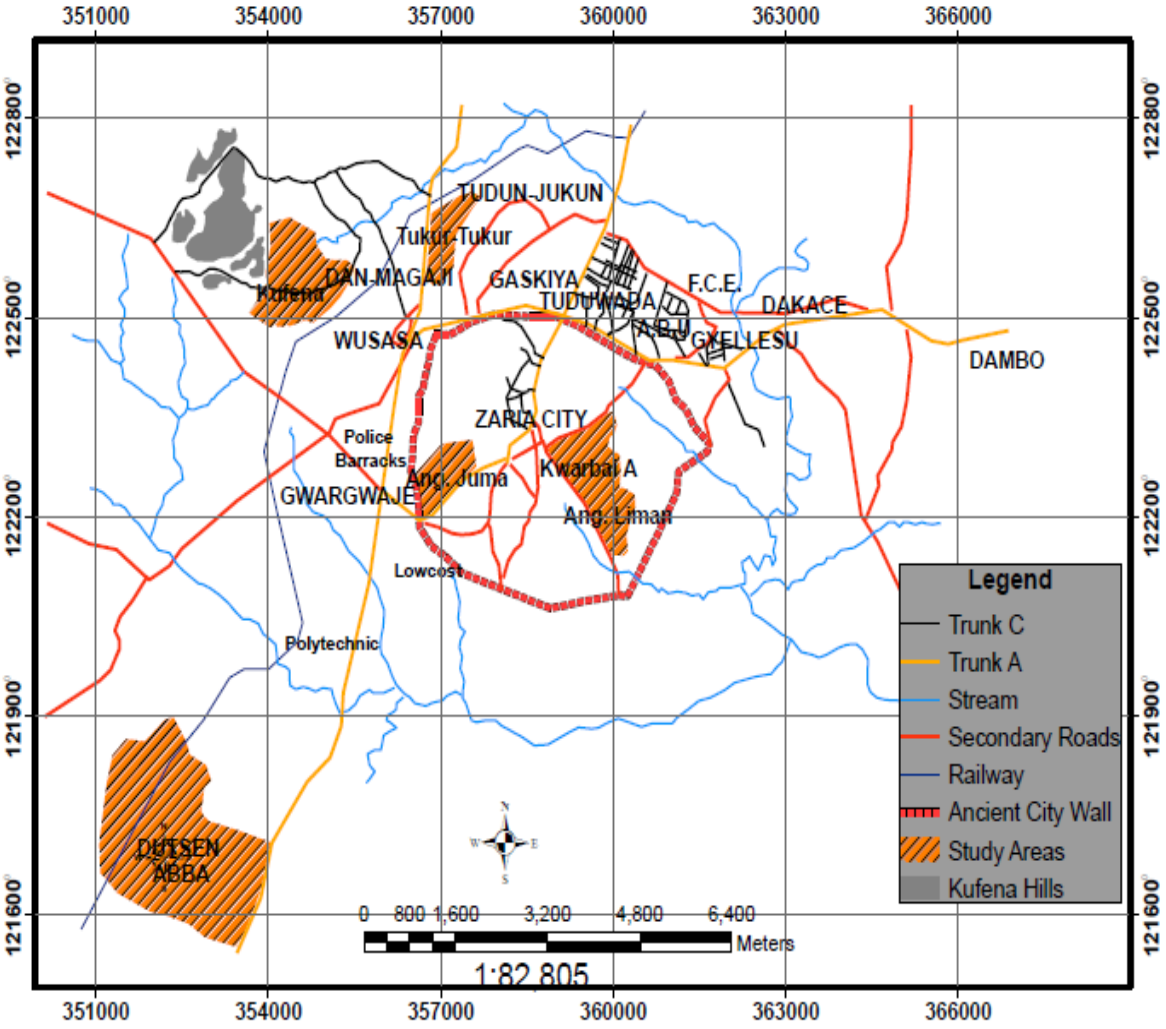

FIG.1: Map of Zaria Local Government Area Showing Study Areas

SOURCE: Adapted and Modified from the Administrative Map of Kaduna State

The most important central place activity of all is education, for which Zaria is the greatest centre of northern Nigeria (Abubakar, 2012).The diverse socioeconomic and cultural setting of Zaria provides an adequate rationale for examining men's role in family planning decision-making. This will not only provide a basis for comparison with other parts of Nigeria but also an avenue for intervention in ensuring maternal and child health in northern Nigeria.

MATERIALS AND METHODS

Zaria LGA has a population of 408,198 (NPC, 2009) with 13 administrative wards. There are six wards within and seven wards outside the city wall. Arranging these wards alphabetically, the even numbered wards were chosen, from within and outside the city wall to ensure geographical spread. This gave a total of six wards which are: Angwan Juma, Kwarbai A, Limancin Kona, Dutsen Abba, Kufena and Tukur Tukur.

A sample of 0.1% of the total population of the study area was taken, giving a total of 408 respondents. The 408 questionnaires were distributed uniformly among these selected wards, with 68 in each ward. The reason for this is due to the non-availability of population figures for each ward from the available 2006 census results. These copies of questionnaire were administered using the purposive sampling technique, which only targeted those respondents who were willing to be part of

the survey. Chi square analysis was used to determine the relationship between socioeconomic and demographic variables and family planning. Other results were presented using descriptive statistics.

RESULTS AND DISCUSSION

Demographic and Socio-economic Characteristics of Respondents

Age, Sex and Religion of Respondents

Data on age of respondents reveals that the age group 25-29 years has the highest proportion of 20.1%, followed by age group of 30-34 years with 19.8% and 50+ years have the lowest distribution of 2.3%. About 82.5% of respondents are Muslims and only 17.5% are Christians. The result is as expected since Zaria LGA is located in the northern part of the country which has a predominantly Muslim population.

The Hausa/Fulani, being the largest cultural group in the study area constitute 77.1% of the respondents, followed by 8.5% each of Yoruba and northern minority ethnic groups. The table also shows that 91.8% of the respondents are married and 5.9% are single. The incidence of divorce and separation appears rather low (1.4%) in Zaria LGA which suggests a fair stability of the marriage institution. About 57.6% and 18.1% of the respondents have attained Tertiary and Secondary education respectively; only 0.6% has attained adult literacy education.

Knowledge and Use of Family Planning

About 97.7% of respondents reported they have been told or have heard of family planning (Table 1). This corroborates the finding of the NDHS (2008) report where 72% of all women and 90% of all men know of at least one FP method. Umoh's *et al* (2012) study in Uyo also had similar result where knowledge of FP by respondents was 92.6%. The wide spread in knowledge of FP may be related to education, intensive campaign in the media (as the Nigerian government is putting immense effort in providing information about FP programmes, thus people are becoming more exposed to FP issues), and the state of the economy (harsh economic conditions) etcetera.

Table 1: Knowledge and Use of Family Planning

	Frequency	Percentage
Knowledge of Family Planning		
Yes	346	97.7
No	8	2.3
Total	**354**	**100**
Use of Family Planning		
Yes	121	34.2
No	209	59.0
No Response	24	6.8
Total	**354**	**100**

Source: Field Survey 2010

Table 1 also shows that only 34.2% of the respondents are currently using a FP method. Although knowledge of FP is very high, its use appears to be low. The result corresponds with Ekpo's (2011) finding in Kaduna where 32.0% of respondents were currently using FP methods against 59.1% who were not using any FP method. It is very important to know that there is a wide gap between knowledge and use of FP methods. Considering the wide gap between the proportion of population that has ever heard of FP 97.7% on the one hand, and the proportion that is currently using (34.2%) on the other, some doubts may be cast on the reliability of the responses on the question

under review. It is obvious that some of those who reported having heard of FP may find it difficult to admit currently using a method. Generally, questions on the practice of FP seem to attract a high degree of 'no' response. Given the moral background of many (who live in rural settings), a sense of guilt normally surrounds the practice of FP.

Family PlanningDecision Making

It is very important to know who makes the decision to practice FP, especially in patriarchal societies where the final say is given to men. Irrespective of couples' socioeconomic characteristics, Figure 2 shows that 61.2% said the decision to practice FP was made jointly by husband and wife, because FP responsibility lies on both spouses. However, 22.3% of the respondents reported that FP decision is the husband's responsibility, because he rules and is the breadwinner of the house. This must be seen in the context of the traditional Hausa society where men are expected to have absolute control of their households; including the practice of FP or child spacing and women are expected to respect their husbands' decisions.

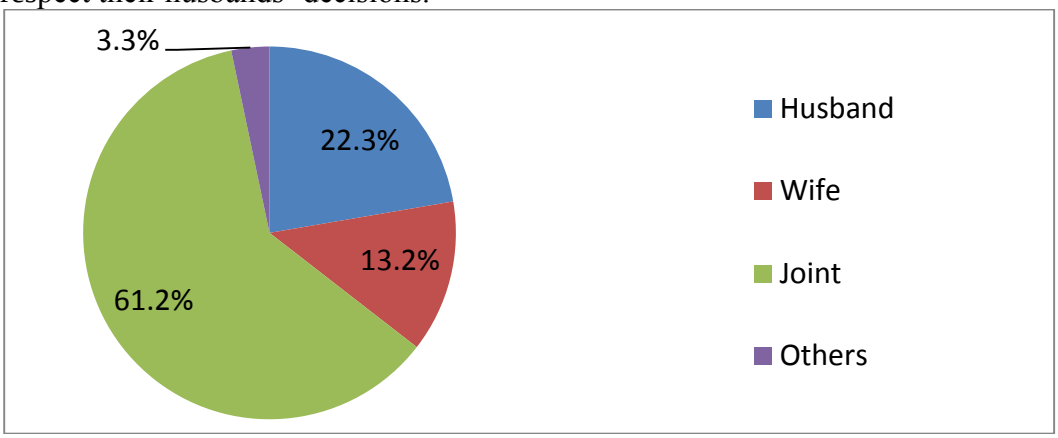

Figure 2: Percentage Distribution by Decision on the Practice of Family Planning
Source: Field Survey 2010

The wife takes such decision in 13.2% of the cases, even if she has to do it secretly, since she is directly affected. Only 3.3% said the decision is made by medical professional or the mother-in-law.This finding does not concur with that of Ekpo (2011) in Kaduna where 29.1% of the respondents reported joint decision making, followed by husband alone with 26.0%. This could be due to the fact that women were the only respondents in Ekpo's study.

Payment for Family Planning Services

Information on who obtains family planning services is very important because it reveals who is in support of practising FP. Figure 3shows 41.0% of husbands and 30.2% of wives paid the bills for FP services. The high percentage of husbands paying for FP services is not surprising since men are economically more advantaged than women; especially in a society where religion and culture have made men to be the providers of the home and some women are not even allowed to work to earn their own salary except with their husbands' approval. Ekpo (2011) found that 43% of husbands paid the bills for FP services and 30.4% said payment was made jointly in a study in Kaduna.

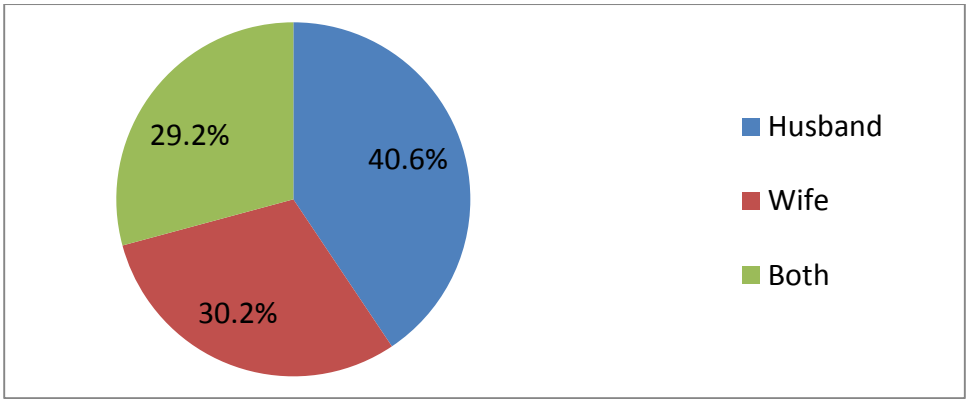

Figure 3: Percentage Distribution of Respondents by Who Pays for FP device
Source: Field Survey, 2010

Decision Making on Desired Number of Children

Figure 4 shows that 53.1% of the respondents make joint decision on the number of children they desire and 29.7% said it is made by husband. This corroborates the NDHS (2008) report where 47.3% of the respondents think that decision on the number of children to have should be made jointly and 43% by husband. Decision making about fertility is often controlled by the husbands, women in many African societies are yet to gain autonomy that would enable them make decisions on the number of children they want (Morgan and Niraula, 1995).

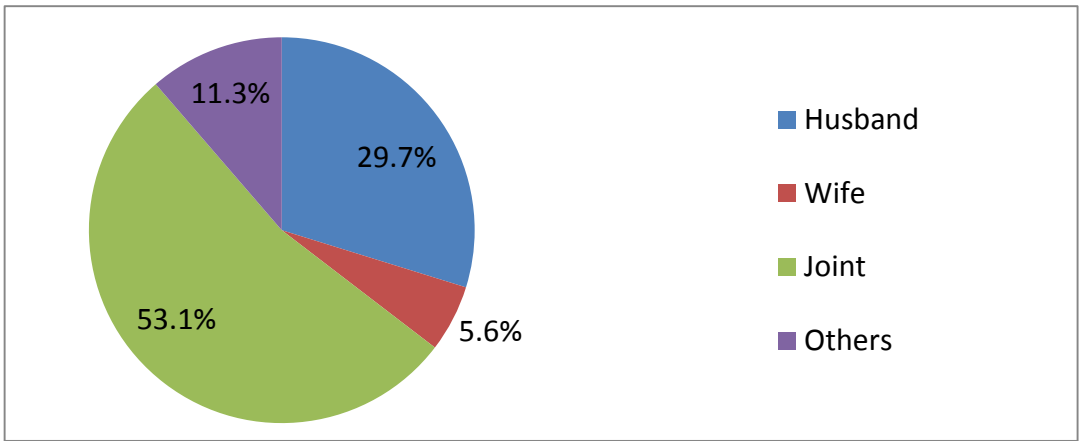

Figure 4: Percentage Distribution of Respondents by Decision Making on Desired Number of Children
Source: Field Survey, 2010

Socio-economic Variables and Family Planning Decision Making
Age and Family Planning Decision Making

Couples' joint decision is highest among respondents age 45-49 and 40-44 years with 77.8% and 71.4% respectively. Joint decision making is high and suggests that couples are involved in

discussing FP matters together. The statistical analysis of X^2= 21.279, df=21, P=0.442 does not show a significant relationship between age and who makes the decision to practice FP (Table 2)

Table 2: Relation between Age and Family Planning Decision Making

Age group	Husband only	Wife only	Joint	Others	Total
15-19	3(30.0)	0(0.0)	7(70.0)	0(0.0)	**10(100.0)**
20-24	4(21.1)	3(15.8)	10(52.6)	2(10.5)	**19(100.0)**
25-29	6(25.0)	0(0.0)	17(70.8)	1(4.2)	**24(100.0)**
30-34	7(26.9)	7(26.9)	11(42.3)	1(3.8)	**26(100.0)**
35-39	4(22.2)	3(16.7)	11(61.1)	0(0.0)	**18(100.0)**
40-44	1(7.1)	3(21.4)	10(71.4)	0(0.0)	**14(100.0)**
45-49	2(22.2)	0(0.0)	7(77.8)	0(0.0)	**9(100.0)**
50 +	0(0.0)	0(0.0)	1(100.0)	0(0.0)	**1(100.0)**
Column Total	**27(22.3)**	**16(13.2)**	**74(61.2)**	**4(3.3)**	**121(100.0)**
Calculated X^2=21.279		**df=21**	**P value=0.442**	**Remark=Not significant**	

Source: Field Survey, 2010

According to Table 2, 65.1% and 64.5% of Muslims and Christians make FP decisions jointly and about 25.3% of Muslims and 29.0% of Christians indicate that decision is made by husband and wife only respectively. While Islam confers on the husband sole authority on decision making among the Muslims, the wife has the major say when deciding on FP among Christians, thus Christian women are allowed to take such decisions on their own compared to Muslim women. This confirms the high position of men in Islam and that religion plays an important role in making FP decision. Family planning use remains a deeply sensitive issue that often involves religious or philosophical convictions (Solomon *et al*, 2010). The statistical analysis in the table of X^2 =9.298, df=3, P=0.020 indicates a significant relationship between religion and who makes the decision to use FP.

Marital Status and Family Planning Decision Making

Table 3 shows that the ability of couples to take decisions jointly to practice FP by married respondents is 63.2% and decision by husband only is 22.2%. For singles, the ability of husband or self and others (medical personnel) to make decision is 50.0% each. This implies that FP is mainly practiced by the married; the unmarried may not reveal their use of FP method for fear of discrimination within the society. Decision making by husband only is also higher for married respondents compared to the divorced where women alone or self, make FP decision. This reaffirms the patriarchal system in Nigeria with men being major decision makers even in issues that affect women directly.

Table 3: Marital Status and Family Planning Decision Making

Marital Status	Husband only	Wife only	Joint	Others	Total
Single	1(50.0)	0(0.0)	0(0.0)	1(50.0)	**2(100.0**
Married	26(22.2)	14(11.9)	74(63.2)	3(2.6)	**117(100.0)**
Divorced	0(0.0)	2(100.0)	0(0.0)	0(0.0)	**2(100.0)**
Separated	0(0.0)	0(0.0)	0(0.0)	0(0.0)	**0(100.0)**
Widowed	0(0.0)	0(0.0)	0(0.0)	0(0.0)	**0(100.0)**
Total	**27(22.3)**	**16(13.2)**	**74(61.2)**	**4(3.3)**	**121(100.0)**
Calculated X^2 =28.909		**df=12**	**P value=0.000**	**Remark= Significant**	

Source: Field Survey, 2010

It also reflects women's complete dependence on their husbands due to the lack of right to

decide on the use of FP. About 18% of Nigerian women rely on their husbands' decision to practice FP compared to 1.7% who could make such decision alone (NPC and ORC Macro, 2009). The Chi square test in the table of X^2 =28.909, df=12 and P value=0.000 indicates that the relationship between marital status and who makes the decision to practice FP is statistically significant. This means that marital status positively influences the decision to use FP methods.

Ethnicity and Family Planning Decision Making

Table 4 shows that joint decision making is high across all ethnic groups with 64.2% of Hausa/Fulani reporting joint FP decision making but decision making by husband only is 26.0% among the Hausa/Fulani. Decision making by wife only is lowest (8.3% and 8.6%) among the Northern minority and Hausa/Fulani ethnic groups; which is not surprising as religion and culture in the study area give men more authority on decision making in marital and family life. However, the Southern minority ethnic group and Igbo allow their wives to take such decision on their own unlike the Hausa/Fulani and Northern minority ethnic groups. Generally, most Nigerians, irrespective of ethnic groups, recognize the significance and dominance of men in family life and the society as well (Isiugo-Abanihe, 2003).

Table 4: Ethnicity and Family Planning Decision Making

Ethnicity	Husband only	Wife only	Joint	Others	Total
Hausa/Fulani	21(25.9)	7(8.6)	52(64.2)	1(1.2)	**81(100.0)**
Igbo	1(10.0)	4(40.0)	5(50.0)	0(0.0)	**10(100.0)**
Yoruba	3(18.7)	3(18.7)	9(56.3)	1(6.3)	**16(100.0)**
Northern minority	2(16.7)	1(8.3)	7(58.3)	2(16.7)	**12(100.0)**
Southern minority	0(0.0)	1(50.0)	1(50.0)	0(0.0)	**2(100.0)**
Total	**27(22.3)**	**16(13.2)**	**74(61.2)**	**4(3.3)**	**121(100.0)**
Calculated X^2=47.086	**df=12**	**P value=0.000**		**Remark= Not Significant**	

Source: Field Survey, 2010

The statistical analysis in table 5 further shows a statistically significant relationship between ethnicity and who makes the decision to practice FP (X^2=47.086, df=12, P=0.000), which implies that ethnicity has positive influence on decision making to practice FP. This finding corroborates Duze and Muhammad's (2006) result where 78% of spouses among Hausa and Kanuri agreed that the wife has no say on family size, compared to only 6.7% of Igbo, Ijaw (10.5%) and Yoruba (10.5%). This further confirms the significant role men play in fertility decision making among Hausa people.

Educational Attainment and Family Planning Decision Making

Table 5 shows that 66.7% and 65.4% of respondents with Quranic and tertiary education decide jointly to practice FP respectively. Decision making by husband only is 50.0% for respondents with primary education.

The Chi square test in the table showing the calculated X^2 of 15.675 with degree of freedom of 15 and P value of 0.404 indicates that the relationship between educational qualification and who makes the decision to practice FP is not statistically significant. This implies that education has no positive influence on who makes the decision to use FP methods. This is not surprising in a society where a woman's educational level gives her little room to make such decisions alone. Due to socio-

cultural limitations, women are obliged to respect the wishes of their husbands, in view of the essential position that men enjoy in Nigerian societies.

Table 5: Educational Attainment and Family Planning Decision Making

Educational Attainment	Husband only	Wife only	Joint	Others	Total
None	0(0.0)	1(100.0)	0(0.0)	0(0.0)	**1(100.0)**
Quranic	3(25.0)	1(8.3)	8(66.7)	0(0.0)	**12(100.0)**
Adult literacy	0(0.0)	0(0.0)	1(100.0)	0(0.0)	**1(100.0)**
Primary	2(50.0)	1(25.0)	1(25.0)	0(0.0)	**4(100.0)**
Secondary	8(36.4)	3(13.6)	11(50.0)	0(0.0)	**22(100.0)**
Tertiary	14(17.3)	10(12.3)	53(65.4)	4(4.9)	**81(100.0)**
Total	**27(22.3)**	**16(13.2)**	**74(61.2)**	**4(3.3)**	**121(100.0)**
Calculated X^2 =15.675		**df=15**	**P value=0.404**	**Remark=Not significant**	

Source: Field Survey, 2010

Occupation and Family Planning Decision Making

Further findings reveal that joint decision making to use FP methods is 65.0% and 63.3% among respondents doing business and civil servants respectively. Decision making by husband only is 57.1% for housewives. The calculated X^2 of 23.655 with degree of freedom of 21 and value of 0.310, it indicates that the relationship between occupation and who makes the decision to practice FP is not statistically significant; which means men's type of occupation has no positive influence on who makes the decision to practice FP.

Income and Family Planning Decision Making

Table 6 shows that the ability of couples to make joint decision on family planning is 89.0% for respondents earning 6,000-15,999 Naira respectively.

Table 6: Occupation and Family Planning Decision Making

Occupation	Husband only	Wife only	Joint	Others	Total
Farming	0(0.0)	0(0.0)	5(100.0)	0(0.0)	**5(100.0)**
Civil/public service	13(21.7)	7(11.7)	38(63.3)	2(3.3)	**60(100.0)**
Trading	3(37.5)	1(12.5)	4(50.0)	0(0.0)	**8(100.0)**
Business	4(20.0)	3(15.0)	13(65.0)	0(0.0)	**20(100.0)**
Others	1(12.5)	2(25.0)	5(62.5)	0(0.0)	**8(100.0)**
Student	2(25.0)	0(0.0)	5(62.5)	1(12.5)	**8(100.0)**
Unemployed	0(0.0)	2(40.0)	2(40.0)	1(20.0)	**5(100.0)**
Housewife	4(57.1)	1(14.3)	2(28.6)	0(0.0)	**7(100.0)**
Total	**27(22.3)**	**16(13.2)**	**74(61.2)**	**4(3.3)**	**121(100.0)**
Calculated X^2 =23.655		**df=21**	**P value=0.310**	**Remark=Not significant**	

Source: Field Survey, 2010

Table 7: Income and Family Planning Decision Making

Income	Husband only	Wife only	Joint	Others	Total Row
Did not disclose their income	8(29.6)	3(11.1)	14(51.9)	2(7.4)	**27(100.0)**
N< 6,000	1(25.0)	3(75.0)	0(0.0)	0(0.0)	**4(100.0)**
N6,000 - 15,999	0(0.0)	0(0.0)	8(88.9)	1(11.1)	**9(100.0)**)
N16,000 - 25,999	6(27.3)	4(18.2)	12(54.5)	0(0.0)	**22(100.0)**
N26,000-35,999	3(23.1)	2(15.4)	7(53.8)	1(7.7)	**13(100.0)**
N36,000-45,999	1(9.1)	1(9.1)	9(81.8)	0(0.0)	**11(100.0)**
N46,000 and above	8(22.8)	3(8.6)	24(68.6)	0(0.0)	**35(100.0)**

Total Column	**27(22.3)**	**16(13.2)**	**74(61.2)**	**4(3.3)**	**121(100.0)**
Calculated X^2 =27.981	**df=18**	**P value=0.022**		**Remark=Significant**	

Source: Field Survey, 2010

About 27.3% and 75.0% of those earning 16,000-25,999 and less than 6,000 Naira said it is husband only and wife alone, in that order. Decision making by wife alone is higher for respondents with the lowest income level and decreases with an increase in income. This means that improvement in respondents' income could empower women to make FP decision on their own. The statistical analysis in the table of X^2 =27.981, df= 18, P= 0.022 shows a significant relationship between income and who makes decision to practice FP, which means that higher income gives room to women to participate in FP decision.

RECOMMENDATIONS AND CONCLUSION

The study reveals that decisions to practice FP and the desired number of children by couples are made jointly. The Chi Square analysis also reveals that religion, ethnicity, marital status and income encourage joint decision making as well as decision by husband alone to practice family planning. Involving men and obtaining their support and commitment to family planning is of crucial importance in Nigeria, given their elevated position in the society.

Most decisions that affect family life as well as political life are made by men. They hold positions of leadership and influence from the family unit right through the national level. Male role in FP means more than the number of men who encourage and support their partners to use FP methods. It also means government policy has to be more conducive by developing male-related programmes which include increasing the number of men using condoms and having vasectomies. The involvement of men in family planning would therefore not only ease the responsibility borne by women in terms of decision making in family-planning matters, but would also accelerate the understanding and practice of family planning in general.

Many sub-Saharan African countries are still decades away from attaining lower fertility levels. This continues to threaten the lives of women and children but FP offers hope because it prevents women from having unplanned pregnancies. However, if FP programmes are to accelerate the process of demographic change in Nigeria and Africa at large, then they would require the following:

i. Religious leaders must be involved in clarifying misconceptions on issues regarding family planning, such as FP is aimed at curbing the Muslim population or that FP promotes promiscuity among women etc.

ii. Greater political will from national leaders, which includes more commitment in implementing FP programmes and not just population policies on paper. Husbands should be encouraged to support their wives by giving them permission to visit FP clinics as well as organizing transportation to the clinic, paying for family planning methods and services, and also taking care of children during clinic visits.

iii. Government should provide jobs and increase the income levels of Nigerians, which could improve their standards of living and make people desire smaller family sizes.

iv. Couples should be motivated to space their children beyond two years. This will reduce frequent childbirth and large family sizes that expose women to health problems which can contribute to high maternal mortality.Emphasizing the use of birth spacing to protect the health of mothers and children is effective and will have a better future economically.

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