

**CONTRACEPTIVE DECISION-MAKING IN NORTH CENTRAL NIGERIA**

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## ABSTRACT

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Globally, contraceptive technologies have been critical to improving the reproductive lives of women. This thesis examined the decision-making processes among couples in Kwara State, Nigeria. It began with the premise that contraceptive decision-making is a complex process that involves an array of actors and structural forces that operate and intersect at different levels to influence decision-making. Using a mixed method qualitative approach, this thesis used interviews (semi-structured and Key informant), Focus Group Discussions and participant observation as research tools to provide a nuanced exploration of contraceptive decision-making.

The promotion of smaller families by the State served as a precondition for contraceptive discussions collectively within the population and individually within the household. Contraceptive knowledge proved insufficient in guaranteeing use, as the decision to use contraception is not a rational process. Decision-making is gendered and this thesis argued that spousal communication is critical to the use of contraception and involved a series of non-linear conversations that occur at different stages in the reproductive life course of a couple. These conversations stressed the role of external influences and highlights the effect friends and family have on the decision making process. Economic and sexual triggers were identified as life events necessary to move spousal communication from the household to the public domain of service provision.

Making informed choices on the method of contraception used highlighted some of the challenges faced in providing quality contraceptive services and how women's bodies are differentiated and 'modernised' based on location. This thesis suggests that in order to make improvements to women's reproductive lives, bodies need to be understood more broadly in relation to the gender dynamics between couples, the community (family/friends and service providers) and service provision (the State, service providers and the international community).

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## LIST OF ABBREVIATIONS

CPR	Contraceptive Prevalence Rate
DAWN	Development Alternatives for Women with a New Era
FGDs	Focus Group Discussions
FOMWAN	Federation of Muslim Women’s Association of Nigeria
GAD	Gender and Development
ICPD	International Conference on Population and Development
IMF	International Monetary Fund
IUCD	Intrauterine Copper Device
IUS	Intrauterine System
LAM	Lactational Amenorrhea Method
LGA	Local Government Area
MDGs	Millennium Development Goals
NCWS	Nigerian Council of Women’s Societies
NDHS	Nigerian Demographic and Health Survey
PMS	Patent Medicine Store
PMVs	Patent Medicine Vendors
PoA	Programme of Action
SAPs	Structural Adjustment Programs
SRH	Sexual and Reproductive Health
SSA	Sub-Saharan Africa
TFR	Total Fertility Rate
UN	United Nations
UNFPA	United Nations Population Fund
WB	World Bank
WEDO	Women’s Environment and Development Organization
WID	Women in Development

## CHAPTER 1: INTRODUCTION

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### 1.1 Introduction

Aliya<sup>1</sup>, a woman in her mid-thirties, was preparing her meat products for sale in the evening as we approached her house. Mama Twins and I had scheduled the interview with her at around noon because Aliya had two shifts during which she sold meat at the local market. She had six pregnancies and five living children, four of whom were boys who lived with her, and one daughter who was fostered by her sister-in-law. Aliya motioned me to sit down on the bed while she and Mama Twins sat on the chairs. The interview began lightly at first and, gradually, Aliya situated herself within multiple local and global discourses on population growth, reproductive health, and development. Her lived experiences made her part of many things. Firstly, she was part of the proportion of Nigerian women who used contraception. In this respect, she had struggled to find a method of contraception that worked well for her. She was one of a number of women that had accessed multiple forms of contraception, such as the implant and injections from the public sector, as well as oral contraceptive pills from the local Patent Medicine Vendors (PMVs). Secondly, and unfortunately, Aliya had contributed to the statistics for under-five mortality as one of her children had passed away. Thirdly, she contributed to the percentage of women who had used contraception without their husband's knowledge and, finally and perhaps most critically, she had been physically abused when her husband found she had chosen to access contraceptive services without his knowledge.

Aliya's experiences illustrate some of the complexities of contraceptive decision-making in this society and, like the other narratives in this thesis, highlight the interactions between women's agency and the structures that govern their lives. The overarching aim of this thesis is to analyse these interactions in more detail and provide a nuanced understanding of contraceptive decision-making. This is important because the use of contraception is critical to improving the reproductive health status of women in Nigeria (Yeatman 2015). Given the global advances in

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<sup>1</sup> Pseudonym

health that have contributed to the decline in maternal mortality rates around the world, a disproportionately high amount of Nigerian women still die due to pregnancy-related causes every year (NPC & ICF Macro 2014). This situation is even more acute in Kwara State where the rate of maternal mortality exceeds the rates for Nigeria as a whole (Kwara State Government 2010).

This thesis argues that women have to navigate a myriad of structural influences to achieve their reproductive goals, as evidenced by Aliya's experience with using contraception. These structures operate in multiple ways to influence the outcome of reproduction. These structures are inherently gendered and, this thesis, therefore, treats the decision-making process as gendered also. It applies this notion, firstly, in critiquing existing discourses on population growth, reproductive health and development policies and the precedents set by these discourses in framing contraceptive knowledge and behaviour globally, nationally and locally. Secondly, in exploring the household dynamics that have a bearing on decision-making, this thesis teases out the complexity of spousal communication and the use of contraception as identified in the existing literature on family planning. Focus is placed on the extent to which spousal communication remains at the level of the household and examines the factors that allow fertility discussions to move from the household to the level of service provision. Thirdly, the role of service providers is examined and linked back to the global structures that have, in many ways, fostered an environment in which they dominate service provision in developing countries like Nigeria. This thesis argues that the types of contraceptive methods made available serve as a precondition for contraceptive knowledge and the idea of making informed choices at the point of service provision.

A mixed qualitative method approach was adopted to understand fertility behaviour and capture women's varying experiences of negotiating fertility preferences and contraceptive use in the household, as well as in the areas of service provision where medical practices and other structures influence the choice and use of contraceptive technology. The triangulation of different types of qualitative data allowed for an aggregation of multiple narratives that illustrated the fluidity, complexity and multi-scalar ways in which contraceptive decision-

making takes place, as well as for policy recommendations on ways to approach and scale up the use of contraceptive services.

## **1.2 Background**

Since the 1950s, the world's population has experienced many drastic social, economic and political changes that have impacted in the areas of population growth and reproductive health (UN 2014a; Bongaarts 2015). The world's population has risen steadily over the years, and in 2012 the population grew past the 7 billion mark. This growth in population has by no means been evenly distributed, as reports show that most of the population growth occurred in developing countries (UN 2014a; Bongaarts 2015). Nigeria is one of nine countries that have between them, been projected to account for more than half of the world's population by 2050 (UN 2014a). Its rate of population growth has, increased by 0.2% since the 2006 census to 2.8% in 2014, and the current population is estimated at 183 million (NPC & ICF Macro 2014). Also, by 2014 46.9% of the population of Nigeria lived in urban areas. This is expected to increase to an estimated 58.3% by 2030 and 67.1% by 2050 (UN 2014a). Natural population growth contributes a larger percentage of urban population growth in SSA (Tacoli 2001; UN 2014a). Although the Total Fertility Rate (TFR<sup>2</sup>), currently at 5.5, is well above replacement levels, Nigeria's fertility has slowly declined from 6.0 over the past two decades (NPC & ICF Macro 1992, 2014). However, this suggests that women in Nigeria are still bearing children above replacement levels even when the global average has declined by more than half.

High fertility rates reflect of the status of women's reproductive health and are associated with a higher risk of dying due to child birth and poor access to family planning (Cleland *et al.* 2006; Bongaarts 2015). Contraceptive use among married women in Nigeria is currently at 15%, with use of modern methods of contraception at 10% (NPC & ICF Macro 2014). This low rate is surprising given the high levels of contraceptive knowledge among men (95%) and women (85%) (NPC

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<sup>2</sup> The Total Fertility Rate is the sum of Age Specific Fertility Rates (ASFRs). ASFRs are compared across 5-year age groups for women of reproductive age. Thus, the TFR is the number of births a woman would have if she bore children according to the current ASFR i.e. the total number of children a woman would have in her lifetime (Hamilton 2015 p.76).

& ICF Macro 2014). This large difference between the knowledge and use of contraception is more visible in the northern regions than in the southern regions of the country, and varies accordingly to both educational levels and wealth (NPC & ICF Macro 2014). Notwithstanding this gap between knowledge and contraceptive use, the unmet need for family planning has improved slightly from a figure of 20% in 2008 to just 16% in 2013 (NPC & ICF Macro 2009, 2014).

The gap between knowledge and use of contraception has spawned research that identified spousal communication as a key factor in the use of family planning (Bankole & Singh 1998; Wolff *et al.* 2000; Blanc *et al.* 1996; DeRose *et al.* 2004; Oyediran *et al.* 2006; DeRose & Ezeh 2010; Berhane *et al.* 2011; Binyam *et al.* 2011; Link 2011). This acknowledgment was in part, due to the growing recognition of the importance of men in improving women's ability to use and access contraception in developing countries (Ngom 1997; Dodoo & Frost 2008; Frost & Dodoo 2009). However, while some have used mixed methods (see Wolff *et al.* 2000; Binyam *et al.* 2011), most of these studies are quantitative ones (see DeRose & Ezeh 2010; Link 2011). Moreover, no detailed studies have been conducted in Nigeria to examine the nature of spousal communication among couples in the household and to focus on the communication and decision-making process since Bankole & Singh's research in 1998. Furthermore, no detailed study in Nigeria has holistically examined decision-making among couples in the household and at the level of service provision in a single study.

Internationally, the world has committed to the issue of population growth through a series of conferences that have linked rapid population growth with under development (Hartmann 1995). Here, the divide between poorer nations with rapid population growth and wealthier nations with population growth rates at or below replacement level reflected the influence and control of the narratives around the problem of rapid population growth. This, in turn, influenced the interest in, and provision of development support for, reproductive health issues by wealthier nations to developing countries. Consequently, these conferences set out the frameworks for the creation and implementation of population policies in many developing countries including Nigeria (Hartmann 1995; Bandarage 1997; Correa

2008). Nationally, Nigeria responded to its rapid population growth with the creation of its first explicit population policy in 1988. This policy document was a crucial milestone in framing family planning service provision and the research agenda for family planning in the country. Shaped by the discourse of rapid population growth, the policy document contained targets for reductions in the TFR, population growth rates, and other fertility-related indicators including contraceptive use (Federal Republic of Nigeria 1988; Adegbola 1995; Obono 2003; Adegbola 2008).

The 1994 International Conference on Population and Development (ICPD) represented a paradigm shift in the discourse on population growth and development, particularly because it included a sexual and reproductive health component that focused on rights and a more conscious approach to the use of family planning (Petchesky 1995; Hartmann 1995). Sexual and Reproductive Health (SRH) plays a crucial role in achieving sustainable development and this theme was reflected in the ICPD policy recommendation that called for universal access to reproductive health by 2015 (UN 1994). Similarly, Nigeria introduced a new policy in 2004 that echoed the sustainable development narrative and included goals for improving reproductive health and reducing population growth. This policy also acknowledged emerging issues, such as HIV/AIDS and gender inequality that have impacted on sexual and reproductive health and development (National Population Commission 2004; NPC & ICF Macro 2009).

The use of contraception in Nigeria is a controversial and divisive topic. This controversy echoes some of the conventional arguments that dominated at the ICPD (Cohen & Richards 1994). Fertility in Nigeria, as with other Sub-Saharan African countries, needs to be understood with recourse to the role of interconnecting social structures and belief systems. For example, Caldwell & Caldwell (1987) argue that these structures, particularly religion and culture, grant a different set of rewards and entitlements for high fertility. These rewards are, often in conflict with global development discourses, particularly in the area of rights, and lead to situations where a beneficial health promotion strategy like contraception is

rejected. This is because contraceptive use is located between conflicting global and local constructions of women's bodies (Tamale 2008).

The global construction of women's bodies is also visible in the research and design of contraceptive technology. Contraceptive technology is typically designed by men and implemented on women's bodies to control the outcome of reproduction (Bandarage 1997; Clarke 1998; Takeshita 2011). As this thesis will reveal, contraception disciplines the body globally and locally because its use involves some kind of surveillance over the body (Foucault 1997a; 1997b). Globally, discipline works to create desires and specific solutions to development issues such as maternal mortality and rapid population growth (Clarke 1998; Takeshita 2011). Within the context of these issues, contraceptive technology creates new sub-identities among women for surveillance within such solutions - those who use contraception, those who do not use contraception and those who choose modern methods over more traditional methods of contraception. Locally, discipline operates through religion, culture and gender rather to resist global desires and identities by controlling sexuality and reproductive outcomes among women at a micro-level (Sawicki 1991, 1999). In the absence of more detailed studies in Nigeria that examine the different scales of contraceptive decision-making, this thesis explores the complexities between these global and local linkages and examines agency in the decision to use contraception within these structures.

### **1.3 Study area**

Kwara State is one of the six states that form the North-Central geopolitical zone in Nigeria (Figure 1.1). The Yoruba people are the predominant ethnic group in the State, with ethnic minorities consisting of Nupe, Fulani and Bariba groups (Kwara State Government 2012). Kwara State was chosen as the research site for the following reasons. The State is rapidly growing and has poor reproductive health and maternal mortality indicators, the effects of which can be seen in the current increase of 0.6 on the TFR of 4.5 recorded in 2009 (NPC and ICF Macro 2009, 2014). Most women in Kwara State have been shown to lack the opportunity to exclusively make decisions regarding their healthcare, which includes the use of family



planning (NPC & ICF Macro 2009). Currently, the State has a contraceptive prevalence rate of 40.2% (27.7% for modern methods), while 12.2% of currently married women have an unmet need for family planning (NPC and ICF Macro 2014). These figures exist against a backdrop of maternal mortality rates in the state of 980 per 100,000 women, much higher than the current estimate for the country as a whole of 576 per 100,000 women (Kwara Government 2010; NPC and ICF Macro 2014).

**Figure 1.1: Map of Nigeria showing the six geopolitical zones.**



Source: Nigerian Demographic and Health Survey 2013

There is a body of work spanning many decades on the fertility practices and preferences of the Yoruba ethnic group (Oni 1985; McCarthy & Oni 1987; Oni & McCarthy 1991; Feyisetan 2000; Bankole 1995; Ogunjuyigbe *et al.* 2009; Oyefara 2012; Oyediran *et al.* 2006). A few of these studies have looked at spousal communication within this ethnic group (Oyediran *et al.* 2006; Ogunjuyigbe *et al.* 2009), while others have examined the subject within other ethnic groups in the country (Iklaki *et al.* 2005; Izugbara *et al.* 2010; Okwor & Olaseha 2010). Collectively, they highlighted the importance of spousal communication about fertility preferences on the use of family planning. There are studies that have examined the use of family planning among different subgroups of people in Kwara State (Oni & McCarthy 1991; Anate 1995; Olawepo & Okedare 2006; Olatinwo *et al.* 2001; Olugbenga-Bello *et al.* 2009; Abiodun & Balogun 2009), but there is very little evidence in the literature at the level of couples and households with regards to family planning in Kwara State. There is also a dearth of published knowledge regarding the fertility practices and preferences of the Nupe ethnic group. By researching Kwara State, this thesis addresses these gaps and also contributes to knowledge of fertility preferences and contraceptive decision-making in Nigeria as a whole. Overall, it can be concluded that there is therefore a clear need to examine contraceptive decision-making at different levels in Kwara State.

#### **1.4 Research Aim**

The primary aim of this research is to explore contraceptive decision-making in North-Central Nigeria using Kwara State as a case study. In acknowledging the multiple levels at which decision-making operates, this thesis uses mixed methods to address the following objectives of this study:

- 1) To explore men's and women's experiences of negotiating contraceptive intentions as couples:
  - a) To understand the ways in which the dynamics between couples affects decision-making regarding contraceptive use;
  - b) To understand how men and women discuss fertility intentions and how these discussions are influenced by power relations, structures and institutions that govern the household;

- c) To explore the impacts of social networks on the uptake of contraceptive technology.
- 2) To investigate if and how contraceptive intentions are implemented:
- a) To explore couple's agency through the examination of the triggers and/or life events that influence the enactment of contraceptive decisions.
- 3) To examine the role of the State in contraceptive service provision:
- a) To explore the role of the State and supporting NGOs in the decision-making process;
  - b) To investigate informed contraceptive decision-making and client-provider interactions that are critical to the use of contraceptive technology.

### **1.5 Thesis structure**

This section of the chapter provides an outline of the rest of the thesis. The previous sections of this chapter provided a brief background and justification for the thesis and introduced the context within which contraceptive decision-making will be discussed in this thesis. The rest of this section indicates the contents of the remaining chapters of the thesis.

Chapters Two and Three constitute reviews of the literature and are positioned in this thesis to provide a scalar analysis of the structures within which contraceptive decision-making are located. These two chapters argue that contraceptive decision-making must be understood within the global and local structures that influence contraceptive use in the household and at the point of service provision. The theoretical and conceptual framework used within this thesis is examined in Chapter Two. The chapter considers the concepts of biopower and governmentality that are useful in understanding how women's bodies are framed within the discourse on the links between population growth, development and reproductive health. It focuses the discussion specifically on the ways in which women's bodies are constructed and controlled as solutions to sustainable development. These solutions interfere with the private realm of the household and therefore, this

chapter also theorizes women's bodies and fertility practices within the structures and institutions that influence their agency within the household.

Chapter Three reviews the existing literature on contraceptive use in Nigeria. It begins by looking at the historical context of high fertility rates and population growth in Nigeria. By so doing, it provides an analysis of women's fertility within the locus of population policies in Nigeria that illustrates the socio-cultural context of fertility practices in the country. The implications of these fertility practices on reproductive health and sustainable development are emphasized. The link between the impact of neo-liberal agendas and the increasing polarization, privatization and reliance on development assistance for service provision is established within family planning service provision in Nigeria.

Informed by the discussions in Chapters Two and Three, Chapter Four discusses the research design and methodology that were used to operationalize the research questions using mixed methods. The methods used included interviews (semi-structured and key informant), Focus Group Discussions (FGDs), and participant observation. This chapter also discusses some of the methodological issues that had to be addressed during the 10 months of fieldwork in Edu and Ilorin East Local Government Areas (LGAs) in Kwara State and emphasizes issues of positionality and ethics.

Drawing on the concept of the household set out in Chapter Two, particularly in relation to the structures and institutions that confer various entitlements to men and women, Chapter Five examined the dynamics and interactions between couples that had a bearing on reproductive behaviours that includes the use of contraception. The chapter begins with gendered analysis of the general decision-making process among couples, highlighting couple dynamics and the fluidity of the interactions between men and women. Male dominance over reproductive choices was established in this chapter and clandestine use of contraceptive services was revealed as consequences of male dominance over reproduction and women's agency regarding contraceptive use.

Chapter Six builds upon the findings of Chapter Five by examining how couples negotiate the use of contraception. The chapter specifically explores the communication process in spousal communication and the timing at which communication occurs. The role of informal social networks which includes family, friends and other members of the community was explored, building upon the findings in Chapter Five. The remainder of the chapter then examines the events or triggers behind the agency of contraceptive use and highlights the role of poverty and sexuality in the use of contraception among couples in Kwara State.

Chapter Seven takes the research into the area of service provision and examines the role of the State and service providers in the decision-making process. The chapter makes links between the role of international development agencies and state governments in creating desires and setting the tone for contraceptive decisions in the household. It builds on some of the findings in Chapter Five and Six by analysing the construction of women's bodies, particularly those living in Ilorin East. Drawing largely on data from the research diary and key informant interviews, this chapter investigates the idea of choice and informed decision-making within contraceptive service provision.

Chapter Eight reviews the key findings of Chapter Five, Six and Seven and how they address the objectives of the research. The chapter synthesises and summarizes the different aspects of the research and discusses the academic, policy and methodological contributions made by the research.

## **CHAPTER 2: THEORETICAL AND CONCEPTUAL FRAMEWORK**

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### **2.1 Introduction**

This chapter provides the theoretical and conceptual foundations for this research. It is imperative to understand reproduction as a global process that brings together the individual, the state and the global as interrelated forces that work simultaneously in relation to each other (Browner & Sargent 2011). This thesis calls for a better understanding of the relationship between global and local discourses surrounding population growth, development and reproductive health. This chapter aims to highlight the global narratives and local realities that shape the reproductive rights and lives of women in Nigeria and does so by examining decision-making at macro (state), meso (household) and micro (couple) levels.

Section 2.2 examines the Foucauldian concepts of Biopower and governmentality in relation to the global construction of women's bodies and the creation of contraceptive technologies as techniques of control. Section 2.3 then situates the biopolitics of contraceptive use within the discursive framings of the links between population growth, development and reproductive health. The section argues that these discursive framings provide the global socio-historic context that forms a macro-level analysis of the decision-making process. These debates influence support for reproductive health as a development priority internationally and also at a national level.

Since reproductive decisions are not made in isolation, Section 2.4 explores the household as a site with structures that confer different rights and entitlements to men and women. The section therefore locates fertility decision-making within the locus of households in Nigeria. Also, the household is explored in relation to its permeability to influences, both global and local, that govern people's behaviour. It pays attention to gender as a structure exploring women's agency in the use of contraception. Section 2.5 places emphasis on structure and agency as useful concepts in understanding contraceptive decision-making.

## **2.2 Biopower, governmentality and contraceptive technologies**

Foucault's understanding of discourse is used in this chapter to identify discussions around contraceptive use within development. *Discourse* in this Chapter explores the subjective and institutionalised ways of thinking, ascribing meaning and constructing knowledge (Weedon 1997). The knowledge produced manifests itself in structures that operate in the interconnections between knowledge and power (Foucault 1970). Contraception is embedded within the discourse on population growth, development and reproductive health. Proponents for or against the use of contraception use these discursive framings to control, gain power and constrain the production of alternative forms of knowledge (Cheek 2008). In Foucauldian terms, power is understood to be productive and because discourses are located institutionally, they also become sites of contestation, resistance and/or challenge (Foucault 1988; Weedon 1997). Therefore, at different points in time, alternative framings to the discourse on population growth, development and reproductive health exist to shape the way people think about contraceptive technology.

*Narrative* in this chapter focuses on the modes of knowledge production through which women's bodies are framed in the discourse on population growth, development and reproductive health (Tamboukou 2008). Narratives connect different events over time. These connections are enabled and constrained by many social influences (Bruner 1986) and show how women's bodies in developing countries are disciplined and ordered at different points in time. *Narrative* is used in this thesis to thematically situate contraceptive use within time-bound events, particular happenings and actions that were central to the patriarchal subjection and construction of women's reproductive lives in Nigeria and indeed, other developing countries (Bruner 1991; Gergen & Gergen 1988; Weedon 1997).

Foucault's works on governmentality, biopolitics and biopower provide a framework to critically examine the ways in which multidimensional structures and institutions shape both the discourses around the links between development, population growth and reproductive health, and how women construct their reproductive identities within these discourses. These concepts are extremely helpful for interrogating the manner by which the international community, donor

agencies, state governments, religious and political elites operate at global and local levels to construct and control women's bodies.

Foucault's notion of governmentality concentrates on particular mentalities, arts, and regimes of government and administration (Dean 2004 p.2; Gordon 1991). Understanding reproduction through governmentality allows for a critical engagement focused on the interconnection between micro and macro (local and global) strategies of power (Macleod & Durrheim 2002). Governance occurs and intersects at different levels and concerns itself with individual relations, relations with and within social institutions, and relations with the state (Gordon 1991). Governmentality is thus both individualizing and totalizing (Foucault 1991). Relations with the state exist at a macro level where nation states have relationships with hegemonic structures, institutions and organizations. The totalizing effect of governmentality, therefore, operates at a level where the State and the international community collectively control the population. Here, the international community is indispensable in convincing developing countries to create and adopt population policies that include the implementation of nationwide family planning programs. They do so through narratives of, for example, the negative impact of population growth on economic growth and development. On the individual, governmentality uses biopower to create docile bodies and keep the body under surveillance. Technologies of power thus provide access to the body as a subject and the population as objects of control. The concept of biopower is then useful in locating contraceptive use within the control of populations and women's bodies (Foucault 1984; Foucault 1991; Foucault 1997a; Rabinow & Rose 2006; Takeshita 2011).

The disciplinary and regulatory power of contraception must also be understood through the lens of technology and medicine. Located between the interconnections of power and knowledge is contraceptive research and design, the result of which is a disciplinary apparatus that controls reproductive behaviours in different ways (Clarke 1998 p.205). There are a number of contraceptive technologies available today. These technologies can be grouped into two: reversible and permanent methods. While permanent methods involve sterilization



of the male or female reproductive organ, the reversible methods include intrauterine methods (IUCD and IUS), hormonal methods (injections, implants, pills and the patch), barrier methods (condoms, cervical caps, diaphragms and spermicides), fertility awareness methods, coitus Interruptus (withdrawal) and Lactational Amenorrhea Method (LAM) (Bartz & Goldberg 2011; Nanda 2011; Raymond 2011; McFarlane & Grossman 2015). The hormonal methods, barrier methods and the intrauterine methods can be classified as modern while fertility awareness methods, withdrawal method and LAM are grouped as traditional (Bandarage 1997; McFarlane & Grossman 2015).

Modern methods offer more regulatory and disciplinary control than the more traditional methods of contraception. Apart from the male condom, these methods are designed principally for women (Bandarage 1997). Variety within these methods means that women have the option to space or limit their children with a plethora of methods that engage with their sexuality and knowledge of the body in different ways (Mantell *et al.* 2001; Izugbara & Undie 2008). However, despite their availability, access is mediated and control is exerted by service providers who form part of, or constitute the institutions that seek to collectively manage a population. Hormonal forms of contraception are provider controlled, meaning that potential users of these methods require regular engagement with service providers. These methods are designed to police and monitor women's bodies through repeat doses, post-insertion care (for the implants and the intrauterine methods) and any potential side effects. Delayed return to fertility is one of the side effects of injections such as Depo-Provera. This potential side effect has proved to be important historically for surveillance and control purposes as this injection was used on women in developing countries, women of colour, women with disabilities and women with a history of drug use because once injected, the effects cannot be reversed until the hormones have worn out (Duggan 1986; Bandarage 1997) User controlled methods (for example condoms) give individuals greater control of their reproductive lives. However, they may require an intimate exploration of the reproductive parts, parts of which for many women in developing countries find

difficult to explore for cultural and/or religious reasons (Bandarage 1997; Mantell *et al.* 2001).

Although Foucault's work is useful in exploring the interconnections of governmentality, population/community and the family (Macleod & Durrheim 2002), feminists have criticised much of his work (McNay 1992; Ramazanoğlu & Holland 1993; Soper 1993) for its lack of emphasis on the gendered nature of exercising power at all levels and for its '*covert androcentricity*' (Soper 1993, p.29). This thesis acknowledges these criticisms to the extent that they provide the basis for a gendered critique for understanding fertility and contraceptive behaviour. Contraception is an important health promotion strategy for improving the reproductive lives of women (Bongaarts & Sinding 2009). However, women's bodies are also sites for advancing the research and design of contraception and as exemplified through the continued use of Depo-Provera in spite of other common side effects like weight gain and loss of libido. Depo-Provera is also a feasible and effective means of contraception for men but has not been marketed due to its effect on male sexual activity and a lack of investment in large scale clinical trials aimed at developing and expanding suitable productions for men (Duggan 1986; Meriggiola *et al.* 2003). Women's sexual needs are evidently not important (Duggan 1986; Bandarage 1997). Women's bodies are embedded within relations of power that permeates through knowledge production. Thus they are constructed medically and within demography as a discipline as the solution to the population 'problem'. Consequently, academic foundations for policy implementation view women as targets in family planning programme design, implementation and evaluation (Hartmann 1995; Bandarage 1997; Takeshita 2011).

Governmentality is very useful in exploring how state and international community biopolitics (macro-level) create and implement population policies that serve as a precondition for contraceptive discussions at a micro-level (Macleod & Durrheim 2002). Foucault's view of power allows for resistance (Foucault 1988; McNay 1992; Oudshoorn 1994). Resistance provides opportunities for changes in power. While contraceptive technology acts as a technique of dominance that embodies productivity, women use different strategies to resist the use of contraception.

They often do so by using different narratives within structural institutions. These institutions are sometimes in conflict or alliance with one another and women draw on a number of influences to reject the use of contraception, which also includes the use state biopolitics to negotiate the outcome of their reproductive lives (Oudshoorn 1994; Takeshita 2010).

The following section provides an analysis of discourse linking population growth, development and reproductive health that locates contraceptive use at the centre of these three global issues. By examining the global biopolitics of contraceptive use, the following section illuminates the paradigm shifts and changing biopolitical interests in women's bodies with a focus on contraceptive use in Nigeria.

### **2.3 Global narratives on population growth, development and reproductive health**

Global debates on population have fostered the creation of population policies and, consequently, the implementation of top-down family planning programmes by governments as part of their development strategy (Seltzer 2002). These debates and tactics employed by the international community have discursively influenced the biopolitical construction of women's bodies at different levels. Because of this, contraceptive decision-making at a micro-level cannot be understood in isolation. It must be examined in relation to the structures (global and local) that influence individual reproductive agency.

The debate on population growth can be historically linked to the *Essay on the Principle of Population* made influential by Malthus in 1798. He argued that if left unchecked, overpopulation would lead to the depletion of natural resources, social instability, famine and poverty, calling for the use of positive checks that relied on women marrying late and self-control (Malthus 1976; Bandarage 1997; Weeks 2015). Since then, Malthusianism has provided a philosophical framework for understanding the population problem, particularly during periods of socioeconomic crises. Contemporary supporters of this ideology situate the effects of overpopulation within adverse economic conditions. Neo-Malthusians argue that rapid population growth impedes economic development whilst ignoring class and

global capitalist mode of production and differ from Malthus by encouraging the use of birth control (Bandarage 1997; Weeks 2015). A Marxist perspective provides a different analysis, arguing that changes in the mode of production can address social issues including the effects of population growth (Marx 1890; Menard & Moen 1987; Bandarage 1997).

Both perspectives have framed the population and development debate since the 1950s and have been foregrounded in United Nations (UN) sponsored conferences on population. Whether population growth is a burden on development or development is the cure for high fertility rates (Menard & Moen 1987; Birdsall *et al.* 2001; Merrick 2002), these conferences formed the macro-level basis of power and knowledge production that frames the discourse around the population ‘problem’. Women’s bodies are the main targets of plans of action and policies that have been used to create new kinds of individuals to be governed in response to the population ‘problem’ (Foucault 1991). The discourse focused on the links between population size and economic development until 1994 when there was a paradigm shift change in the language from controlling populations to one that emphasised the individual in relation to reproductive rights (Hartmann 1995; Bandarage 1997). Table 2.1 shows the narratives and policy outcomes that informed the discourse on the links between population growth, development and reproductive health. It illustrates how the concern for population growth has defined the nature of family planning programs and how women’s bodies have been treated as a site of contest between population enthusiasts and advocates for reproductive health in the name of development.

**Table 2.1: Timeline of the shifting narratives of the discourse on population growth, development and reproductive health.**

Time line	Policy focus and key outcomes
1950s-1970s	<ul style="list-style-type: none"> <li data-bbox="571 1731 1407 1832">• Growing concern from developed countries, donor organizations and the scientific community about overpopulation and economic development in developing countries.</li> <li data-bbox="571 1877 1407 1977">• Policy documents called for the creation of population policies with objectives that included the nationwide distribution and use of contraception in developing nations including Nigeria.</li> </ul>

	<ul style="list-style-type: none"> <li>• Developing countries rejected global policy prescriptions</li> </ul>
<b>1980s</b>	<ul style="list-style-type: none"> <li>• Changing stance within the debate and adoption of Neo-Malthusian ideologies by developing countries.</li> <li>• Growing concern among women’s health advocates and feminists on the reproductive health status of women, particularly in developing countries.</li> <li>• Reiterates and expanded on the Plan of Action set out at the 1974 UN population conference in Bucharest.</li> <li>• Developing countries including Nigeria created and implemented its first explicit Population Policy.</li> </ul>
<b>1990s-2015</b>	<ul style="list-style-type: none"> <li>• Paradigm shift from overpopulation to global reproductive health rights.</li> <li>• Links population with sustainable development.</li> <li>• Member states of the United Nations including Nigeria adopted the Plan of Action (PoA) that focused on reproductive health rights.</li> <li>• Omission of targets for reproductive health in the initial draft of the MDGs in 2000.</li> <li>• Links between sexual and reproductive health issues and sustainable development were emphasised. Goal 5 of the MDGs was expanded to include targets for the universal access to reproductive health.</li> <li>• Goal 3 and 5 of the post 2015 agenda for sustainable development includes targets for sexual and reproductive health issues.</li> </ul>

Data for this table was pooled from the following sources: (Hartmann 1995; Bandarage 1997; Seltzer 2002; Federal Republic of Nigeria 1988; May 2013; UN 2015; Sonifield 2006; Hulme 2010; Petchesky 1995; Petchesky & Judd 1998).

### **2.3.1 Overpopulation: The rationale for contraceptive use**

The population conferences in Rome (1954) and Belgrade (1964) were dominated by experts in the field of Demography. Here academic foundations for global policy interventions particularly for developing countries relied on the assumptions made in the classic demographic transition theory developed through a synthesis of works by Thompson (1929), Davis (1945) and Notestein (1953). They highlighted the relationship between economic development and lower fertility and mortality rates and suggested that the increase in economic development would, in the long term,

bring about changes in fertility behaviour due to a decline in infant mortality (Weeks 2015). Theoretically, the idea relied on the impact of modernization on social institutions that had encouraged the desire for large families (Demeny 1968; Hohm 1975; Teitelbaum 1975). Arguably the most influential theory is the Coale & Hoover (1958) analysis of the macro-level consequences of population growth in developing countries. Coale's later work queried the notion that modernization alone can adequately explain fertility behaviour and presented evidence through the European Fertility project that fertility decline was related to meeting three following preconditions: conscious individual agency in making fertility choices, availability of contraceptive services, and the acceptability of the idea of small family size (Coale 1973). Coale & Hoover's work provided the academic framework for policy and program support for family planning programs by the international community (Seltzer 2002).

The 1974 conference in Bucharest was the first UN population conference where governments from UN member states were represented, along with major donor agencies, population specialists and technical experts (McIntosh & Finkle 1995). At Bucharest, the relationship between population growth and development was addressed and considerations for population policies aimed at achieving lower birth rates, and, consequently, a reduction in population growth rates were promoted to the governments of member states (Finkle & Crane 1975). This was also the first conference where conflicting views on the impact population growth had on economic development were expressed publicly by both developed and developing countries (Seltzer 2002). Developed countries encouraged the use of family planning in developing countries under the premise that rapid population growth was bad for development. Contraception provided a cost-effective solution to population growth without necessarily addressing the underlying inequalities that perpetuated poverty and slow socio-economic development. Developing countries, including Nigeria, argued for a more inclusive and equitable international economic order that favoured socio-economic development (Finkle & Crane 1975; Cassen 1994; Hartmann 1995). The notion that promoting smaller families can be viewed

as beneficial is problematic because of the socio-religious context of people's lives in Nigeria.

The socio-religious context in Nigeria favours high fertility and the kinship family system, which encourages the re-distribution of the cost of childbearing, also has an impact on fertility behaviours (Caldwell 1982; Goody 1982; Oni 1995). Oni (1995) describes this re-distribution among the Yoruba people in Nigeria as a societal process. Here, childrearing is collective, undertaken by both the parents, immediate kin and extended family members. Nigerians also have a pronatalist belief in the wealth in people. Thus, proverbs such as 'onye were madu were ike' and 'onye were madu were aku' which literally translate to 'somebody who has people has power' and 'somebody who has people has wealth' (Smith 2005 p.39) are commonly used among the Ibo people to relate the idea of 'having people'. 'Having people' through kinship networks plays a huge role in negotiating Nigeria's patron-client political economy and in accessing public services, education and prospects for rural-urban migration (Smith 2001; 2004; 2005). In addition to this, the idea of smaller families appeals to men and women differently because of their social positioning in society. Marriage and having children are important aspects of women's lives in developing countries and add to the multidimensional nature of women's status in the household and in their communities (Fortes 1987; Gipson & Hindin 2007; Dodoo & Frost 2008). This reinforces the fact that gender inequalities have a significant bearing on people's desire for children (Mason 1984; Dodoo & Frost 2008). Men are more concerned with continuing their lineage and community members commiserate with men without children (Bawah *et al.* 1999).

At the following conference in Mexico in 1984, representatives from developing countries demonstrated a transition from a pro-natalist stance to one that regarded rapid population growth as detrimental to development (Hartmann 1995). Developing countries that had yet to develop population policies containing a strong commitment to population control were encouraged to do so as part of the conference resolution (Shofoyeke 2014). Policy creation and implementation operated under the assumptions of a universally linear path to demographic changes irrespective of the society (Bandarage 1997). For countries like Nigeria, this

change and the subsequent creation of population policy (see Chapter Three), was triggered by a global drop in oil prices in the 1980s and rapid population growth (UN 1988; DuBois 1991; Gordon 2003). The evolution of this change within national politics began around 1980 when there was growing evidence that supported the negative effect of rapid population growth on economic development. Per capita income and agricultural output were decreasing to a point where Nigeria became a net importer of food in order to meet the growing demands of the population (UN 1988). The situation was exacerbated further by the imposition of austerity measures and development strategies that compounded the difficult economic situation in the country and indeed, throughout the African continent (Dixon-Mueller & Germain 1994; Wright 1998; Ebigbola 2000; Adegbola 2008). These changes in the economy led to the adoption of Structural Adjustment Programmes (SAPs) and their accompanying austerity measures, which can be argued to have had a negative impact on the standard of living in the country (Ebigbola 2000; Robinson 2012).

### **2.3.2 Paradigm Shift: From overpopulation to Reproductive health rights**

The 1994 International Conference on Population and Development (ICPD) represented a critical point within the debate on the links between population and development (Correa 2008). The consensus focus on women and the discursive transformation of the language of women as demographic targets to one that emphasised the sexual and reproductive health rights of women was the outcome of years of concentrated work and advocacy by feminists groups that highlighted the critical role of women in development (Hartmann 1995; Petchesky 1995). Particularly, changes in the language and the objective construction of women's bodies can be attributed to the influence of a feminist critique on Neo-Malthusianism (Bandarage 1997). For a population policy document, the language and framing of the Programme of Action (PoA) contained strategies that emphasised women's rights and empowerment and contained less linkages between demographic factors and population growth (Hodgson & Watkins 2007). The Programme of Action (PoA) demonstrated a move beyond the ideological debates that dominated previous population conferences to a broad global



cooperation among all the stakeholders involved in population, development and reproductive health.

Prior to the conference, the United Nations organized several meetings and technical discussion sessions on the links between population and development that were open to all member states (May 2013). Other key events that contributed to the outcome of the International Conference on Population and Development (ICPD) include the population debates at the World Commission on Environment and Development and the 1992 UN Conference on the Environment and Development in Rio de Janeiro. These conferences expressed concerns about the effect of population growth on environmental and natural resource degradation and provided a platform for emerging women's coalitions such as the Women's Environment and Development Organization (WEDO) in linking the status of women particularly in developing countries to achieving sustainable development (WCED 1987; UNCED 1992; McIntosh & Finkle 1995; Petchesky 1995). Such concerns were first acknowledged by Paul Ehrlich in the 1960s in his book *The Population Bomb* where he linked population growth with environmental degradation (Ehrlich 1968). In *The Population Explosion (1990)*, he and his wife Anne highlighted two strands of the effects of population growth on the environment with emphasis on the problematic position of poor people. Poor people die of hunger and also, with rich people, die from the by-products of affluence (Ehrlich & Ehrlich 1990; Weeks 2015).

The consensus also incorporated the latest research within demography and population studies and acknowledged the increased attention on the impact of women's education and political and economic empowerment on fertility decline (Hartmann 1995). Academic attention on the role of gender and men's influence on demographic outcomes in Africa has increased in the past few decades (Dodoo 1993; 1998; Isiugo-Abanihe 1994a; Bankole 1995; Ngom 1997). There were also some ongoing changes taking place among development practitioners who fought to include women's issues at the forefront of development. Programs for women operated by Women in Development (WID) that merged with UNFPA and World Bank (WB) sponsored family planning programs did not result in the social transformations needed to empower women socially and economically. A newer

Gender and Development (GAD) approach that replaced Women in Development (WID) sought to improve, among other issues, women's sexual and reproductive lives. This was particularly important because of the failure of existing family planning and maternal-child health programmes to address complex issues such as sexuality and the use of population control as a motivation for contraceptive technology research and design (Dixon-Mueller 1993; Bandarage 1997). However, there were also concerns and critiques from women activists, scholars and researchers from the Global South and organizations such as Development Alternatives for Women with a New Era (DAWN) about the inadequacies in previous development processes in addressing the needs of women in the developing world (Petchesky 1995; Rao & Sexton 2010).

The combined result was an internationally binding Programme of Action (PoA) at the 1994 International Conference on Population and Development (ICPD) in Cairo, and the 1995 Beijing Platform for Action that reconceptualised population and reproductive health (Petchesky 1995; Haberland & Measham 2002). By placing women's empowerment and reproductive health firmly at its core, the PoA indicated a move away from population policies that feminized poverty and environmental degradation. Further, it challenged religious and fundamentalist efforts to curtail women's rights and promote a universal patriarchal view of the family, and redefined the population field that had neglected sexuality and gender roles (Dixon-Mueller 1993; Petchesky 1995; Petchesky & Judd 1998; Rao & Sexton 2010). Promoting a rights-based approach signalled a change in the discourse on the way women's bodies are governed politically on a global scale, and locally through individual and group claims on governments and intergovernmental organisations (Petchesky 1995).

Reproductive health as defined in the Plan of Action is *'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes'* (UN 2014b p.59). The Programme of Action (PoA) contains two chapters that are of particular significance to this thesis because they recognise gender equity and the empowerment of women as critical to achieving sustainable development and

provide a universally recognised definition of reproductive rights. Chapter 4 of the Programme of Action (PoA) stressed the importance of men in domains traditionally ascribed as women's responsibility, as well as in the economic support and maintenance of families. In addition, it highlighted the role of men in the ability of women to access contraception and other aspects of reproductive health care. In defining reproductive health rights, Chapter 7 of the Programme of Action (PoA) recognised individual and collective (i.e. couple) agency by stating that all couples and individuals should decide freely and responsibly the number, spacing and timing of their children and should have the information and means to do so (UN 1994). This definition also includes the right to attain the highest standard of sexual and reproductive health and the right to make decisions regarding the ability to reproduce free from discrimination, coercion and violence (UN 1994; Petchesky 1995).

An informed and autonomous choice is critical within this definition. It therefore recognises the importance of quality of care in family planning service provision. The quality of care received when accessing contraceptive services became an important focal point in advocacy for reproductive rights when evidence suggested the existence of abuse and neglect, particularly of poor women and men (Smyth 1996; Bandarage 1997). Many poor women lack the freedom to choose their form of contraception, lack follow-up medical care regarding any side effects experienced using such methods and, in some cases, lack access to family planning or health services.

The absence of the freedom to choose is a reflection of the kind of methods provided and made available by the State. Most non-barrier forms of contraception are provider-controlled where individuals are required to have continuous interactions with the providers in terms of post-operative care, repeat doses and monitoring of any potential side effects. This is in contrast to the provision of user-controlled methods (e.g. condoms and diaphragms) that give individuals greater control of their reproductive lives (Smyth 1991; Bandarage 1997). 'Choice' for user-controlled methods is influenced by culture, sexuality and how women can introduce and negotiate the use of these methods in their relationships. Hartmann

(1995) adds that the definition of the effectiveness of family planning programmes has been reduced to measures of the number of acceptors and births averted, as opposed to improving the reproductive lives of individuals. Many of these acts, such as forced sterilizations and insertion of the IUD violate the reproductive rights of women and signal a disconnection between family planning and the concern for women's health that was championed by the feminist movement for birth control. The drafting of the policy resolutions of the International Conference on Population and Development (ICPD) was, therefore, a crucial milestone in the integration of debates on population, reproductive health and development.

Despite the good intentions proposed by the adoption of the PoA, the years following the ICPD did not see it translated into improvements in women's health and reproductive rights. The Cairo document has, firstly, been criticised for offering a value-free notion of sexual and reproductive health rights (Petchesky 1995). This thesis understands the universality of rights and the notion that they should be exercised regardless of race, ethnicity or creed. However, this thesis draws attention to the problematic nature of maintaining a universal framework of sexual and reproductive health rights. The idea of rights and the ability to choose is in juxtaposition with global struggles to control women's bodies and the local pre-existing socio-economic, political, gender, and religious constructions of women's bodies (Rabinow & Rose 2006).

Inherent in this framework is the notion of individual control over the body. The totalizing effect of rights is operationalised through the normalization of the idea of freedom, responsibility and control of women's reproductive lives in their society (Patrick 2003). The implementation of this framework, particularly for women in Sub-Saharan Africa (SSA), is problematic because of the disconnection between global and local narratives on notions of the female body that exists across communities within this region (Nyamu-Musembi 2002; Bowman 2003; Tamale 2008; Izugbara & Undie 2008). For example, bridal wealth payments and marriage processes in many parts of Nigeria confer rights over the female body and the outcome of reproduction to the husband and that of his family (Isiugo-Abanihe 1994b; Ogunjuyigbe *et al.* 2005; Dodoo & Frost 2008). Thus, internationally

sanctioned rights have little bearing for married women in these societies and are resisted by the social structures and institutions that govern marriage and subsequently, the household.

For women in Sub-Saharan Africa (SSA), the global construction and operationalization of rights and their use in the implementation of sexual and reproductive health programmes, including the use of family planning, often conflict with community (religious and cultural) notions of the body and its ownership (Izugbara & Undie 2008; Undie & Izugbara 2011). In some Nigerian communities, rights over a woman's body are transferred after marriage to the community of her in-laws with the reproductive outcome of the union belonging to the community, rather than the husband (Izugbara & Undie 2008). Institutions that discipline regulate and administer hegemonic social control over sexuality and reproductive outcomes govern the bodies of women in Sub-Saharan Africa (SSA) (Izugbara 2004). Through hierarchies of governance, women's bodies are disciplined in ways that remove individual agency and shape ideas on reproductive health practices through group or community surveillance and/or expectations (McNay 1992; Danaher *et al.* 2010).

As far as individual agency is concerned, fertility decision-making is hardly within the locus of conscious choice for women in Africa because they have to negotiate hierarchies of governance when articulating their fertility intentions. Firstly, as Bledsoe *et al.* (1998 p.17) pointed out, women often relate their desire for children through expressions of religious destiny with the use of phrases like 'whatever God gives me'. Secondly, women are highly likely to give similar or identical responses to those of their husbands when asked questions regarding their desired number of children (Ibisomi 2008). Thus choices about fertility and the potential use of contraception need to be contextualized within the social processes that influence women's decision making about their fertility. Access to, and subsequently, use of contraception in countries like Nigeria is influenced by social and political resistance and also by the quality of contraceptive information circulating in the region (Cleland *et al.* 2014). Access to family planning services is also influenced by men and, despite the growing acknowledgement and research that emphasises the role

of men in women's reproductive health outcomes (Isiugo-Abanihe 1994b; Wusu & Isiugo-Abanihe 2003; Bankole 1995; Ngom 1997; Dudgeon & Inhorn 2004), family planning programmes are still women-centric and fail to fully incorporate gender relations in understanding contraceptive use and in planning the provision of family planning services (Dodoo & Frost 2008; Frost & Dodoo 2009). The collusion of global (individual notions of the body) and local (community) views of the body as a corporeal entity and, thus, the creation of policies that treat the body as such will be explored in the analysis of Nigeria's population policies (in Chapter Three). It will demonstrate some of the difficulties in adopting policies and implementing programmes that emphasise the individual (woman) over the family and community.

The Programme of Action (PoA) has also been criticised for its failure to critically address issues of sustainable human development especially the implications of privatizations, debt servicing and SAPs on women's empowerment and sexual and reproductive health rights beyond the level of rhetoric (Petchesky 1995). Many structurally adjusted nations showed a huge decrease in life expectancy, a rise or stagnation in maternal mortality, reductions in public sector expenditure on health and other social amenities, and a rise in the number of preventable and treatable communicable diseases in the years following the International Conference on Population and Development (ICPD) in Cairo (Turshen 2007; Rao & Sexton 2010). These factors work in addition to the criticism put forward by the demographic community on the lack of concern about the impact of rapid population growth in the Programme of Action (PoA) to reduce donor and government funding for family planning programs. Declining political will and financial interest in reproductive health in the international development agenda (especially from some members of the Muslim community, the Vatican and the Bush administration in the US) might explain why reproductive health was ignored in the initial draft of the Millennium Development Goals (MDGs) (Kantner & Kantner 2006; Cleland *et al.* 2006; Speidel 2006; Bongaarts & Sinding 2009). Girard (2001) and White *et al.* (2006) further suggest that this exclusion was political because any prioritization of reproductive health echoed the battles for the Programme of Action (PoA) in 1994 where issues

around abortion and adolescent sexual education were deemed to be promoting immorality and weakening existing family values. Unlike the 1994 conference, opponents of reproductive health threatened to boycott agreements on all other development issues if reproductive health goals were included in the final draft of the MDGs. To compound the situation, this exclusion from the list of development goals also meant a decline in funding, presenting a major challenge for proponents of sexual and reproductive health rights.

Sonifield (2006) and Hulme (2010) question the wisdom of the omission of reproductive health priorities from the MDGs when there was, and still is, overwhelming evidence to show the effects of sustained rapid population growth on sustainable development and the links between reproductive health and progress towards achieving MDGs 1 to 7. Five years on, at the UN's World Summit in 2005, targets for the universal access to reproductive health by 2015 and reductions in the unmet need for family planning were incorporated into the MDGs (Haselgrave & Bernstein 2005; Sonifield 2006; Hulme 2010). However, this inclusion involved targets for pregnancy and family planning for women (UN 2011) and again ignored men's role in reproductive health, brushing aside the gains of several years of struggle to bring plurality of reproductive health practices. By the late 2000s, support and funding for family planning began to regain momentum with the Gates Foundation and the US, UK and Australian governments at the forefront of funding programmes with a primary goal of reducing the unmet need for family planning for 100 million women (USAID 2010; Shiffman & Quissell 2012). In 2012, renewed commitment by the Gates Foundation and the UK government was critical to the success of the London Summit (Shiffman & Quissell 2012). This acknowledged the slow progress in women and couples' reproductive health and built on the work of organizations like Reproductive Health Supplies Coalition and the UN Secretary General's Global Strategy for Women and Children's Health in 2010 by pledging an additional US\$2.6 billion in funding for family planning programmes. In collaboration with the United Nations Population Fund (UNFPA), other international donors, national governments, the private sector, civil society and the research community, the London Summit pledged the provision of affordable, lifesaving

contraceptive information, supplies and services to an additional 120 million women and girls in the world's poorest countries by 2020 (Family Planning 2020 2012; Brown *et al.* 2014).

As the world debates its development agenda post 2015 (the original target of the MDGs), stakeholders in sexual and reproductive health anticipate the role Sexual and Reproductive Health Rights (SRHR) will play beyond 2014 and in the final Post-2015 agenda (Haslegrave 2013). Proponents within this group fought hard to include sexual and reproductive health within the proposed goals for health (Goal 3) and gender equality (Goal 5) and position sexual and reproductive health as a critical element of human rights and development (Germain *et al.* 2015). This position is important in improving the progress made in some aspects of SRHR in low and middle-income countries. Inequalities in access to Sexual and Reproductive Health (SRH) services (Santhya & Jejeebhoy 2015; Snow *et al.* 2015), the quality of those services (Kismödi *et al.* 2014; Sen & Govender 2014) and mechanisms of accountability (Kismödi *et al.* 2014) have been identified as some of the major gaps/issues in understanding and implementing the human rights foundation of the ICPD's Programme of Action. These gaps, identified as a reflection of failures by governments and development partners, require attention in order to effectively incorporate sexual and reproductive health issues into the post-2015 development agenda (Sen 2014; Germain *et al.* 2015). Advocates for these issues are cautious of the narratives of population growth and development. Integrating sexual and reproductive health into the Sustainable Development Goals (SDGs) beyond the level of rhetoric and proposals therefore, will require engagement with the links between global fertility decline and increased access to sexual and reproductive health programmes, including the use of family planning.

The outcome of the UN Summit for the post 2015 development agenda contains targets in Goals 3 and 5 for sexual and reproductive health including the use of family planning, reducing maternal mortality and eliminating harmful practices that have a bearing on the reproductive lives of women and young girls (UN 2015). The implementation of these goals particularly family planning programmes will, therefore, need to pay attention to, and have respect for, human rights (Newman



*et al.* 2014). By 2014, the world's population was estimated at 7.2 billion people (UN 2014a). Based on that number, the world's population is projected to grow on its current trajectory of approximately 82 million every year. A quarter of this growth occurred in developing countries of the world like Nigeria (UN 2014a). This means that women in Nigeria still have high fertility rates and based on the DHS data for 2014 presented in Chapter One, Nigeria still has high maternal and infant mortality rates and low reproductive health indicators (NPC & ICF Macro 2014). Addressing sexual and reproductive health issues in Nigeria is critical now more than ever because it affects every facet of achieving sustainable development in the country.

Sexual and reproductive health issues, including the use of family planning in Nigeria need to be situated within the global and local structures that influence women's ability to control their sexual and reproductive lives. This section examined the global actors, narratives and institutions that frame the construction of women's bodies within the discourse on population growth, development and reproductive health. Global debates on this issue influence policy at a national level. This thesis acknowledges that these policies serve as a precondition for nationwide discussions on the use of contraception at the community and household level thus, making them sites for the implementation of these policies. However, institutions such as religion and culture operate at global and local levels to frame the life course of women thus, making the community and the household also sites of resistance.

The following sections examine the construction of women's bodies and their ability to make decisions regarding their reproductive lives in the household. The household presented here is within the context of Nigeria and is theorised in relation to structure and agency. Structures, defined as a set of schemas and resources that enhance or constrain the reproduction of social systems, are inherently gendered. Here, structures not only shape people's behaviour, but it is also these behaviours that reproduce these structures (Giddens 1984; Sewell 1992; Dadoo & Frost 2008). Here, power is operationalized through the structuring of identities within the household and guiding what women can lay claims to. Thus,

assuming women's dominance in issues surrounding their fertility based on biology and reproductive outcomes ignores gender and the inequalities present in the structures that guide their life choices (Greene & Biddlecom 2000; Dodoo & Frost 2008).

#### **2.4 Fertility decision-making in the household**

Many researchers have attempted to examine the link between household structures and the decision-making process (Agarwal 1997; Becker 1981). Understanding this link first requires the conceptualization of the term *household*. According to Netting *et al.* (1984), this has been problematic particularly because of its intersection with family and kinship ties that extend beyond physical and temporal boundaries.

Household definitions differ between surveys and have several implications for data generated for units that have been classified as a household (Randall *et al.* 2011; Beaman & Dillon 2012). Beaman & Dillon (2012) suggest that household definitions usually include a mix of keywords or phrases that show people's living arrangements, food and cooking arrangements, the pooling of economic resources, and in some situations, reporting to a common head of the household. Demographic surveys like the Nigerian Demographic and Health Survey (NDHS) or census data usually focus on definitions centred on common feeding arrangements or other essentials for living together (UN 1998). Here, 'other essentials' include the pooling of economic resources, feeding from a common pot and having a common household budget. However, Beaman & Dillon (2012) highlight the problematic nature of these criteria in defining households because they cannot adequately distinguish which of the criteria have the potential to bias household economic statistics (including assets and production) and/or reveal differences in the composition or size of the household.

This thesis acknowledges this critique but argues that using the household as the unit of analysis generates a sampling frame that allows the exploration of the fertility practices and contraceptive behavioural patterns of couples where the wife is of reproductive age. As a unit of analysis, the household allows the measurement

of some proximate determinants of fertility that show fertility variation within populations. These are; the proportion of women who are in a sexual union and thus, run the risk of pregnancy; the proportion of women using contraception and; the proportion of women with the physiological capacity to reproduce (Bongaarts 1978; Yeatman 2015).

The NDHS defined *'the household as a person or a group of persons, related or unrelated, who live together and share common cooking and eating arrangements, and acknowledge one adult member as the head of the household'* (NPC and ICF Macro 2014 p.11). This definition echoes the idea of the household as a unit with common interests and pooled resources with an altruistic head of household who makes decisions on the behalf of others belonging to the same household (Becker 1981). Also, this can be argued to be less applicable to households in much of Sub-Saharan Africa where spouses have personal financial autonomy and expenditure priorities (Hill 1972 p. 147; Fapohunda 1988).

Nigerian women have varying degrees of financial autonomy and engage in different forms of income-generating activities in the household. Kritz & Makinwa-Adebusoye (1999) report the income-generating activities of five ethnic groups (Hausa, Kanuri, Yoruba, Ibo and Ijaw) in Nigeria and suggest that all five groups encourage women to have some financial independence for themselves and their children. There are spatial aspects of these activities as Hausa and Kanuri (these tribes are located in the northern regions of Nigeria) women work within the confines of the household and engage in agricultural food processing and animal husbandry (Callaway 1987). These agricultural activities are typical for most women in northern Nigeria, particularly because it can be practised in seclusion (*purdah*) and reinforce the Islamic system of marriage and exclusion of Muslim women from open socioeconomic life (VerEecke 1993; Thomas & Price 1999). Typically, women in the north are housewives and these economic activities occur within this role. Seclusion is usually practiced among poorer Muslim women with children acting as intermediaries between their mothers, who are confined to the household and economic activities outside the household (Robson 2000). Any associated earnings are usually a fraction of a man's income. In this respect children therefore make

highly valuable economic contributions to household and society (Valente *et al.*, 1997; Robson, 2004). However, because of their limited earning abilities, women in seclusion are often in subservient positions within the household. Women who occupy the southern (Yoruba, Ibo and Ijaw) and parts of the North-central (Yoruba) regions of Nigeria, on the other hand, engage in formal and informal economies often in which they often work as traders and farmers. However, while Yoruba women typically have greater control over their income, Ibo women often pool their resources with their husbands (Kritz & Makinwa-Adebusoye 1999; Cornwall 2007). Cornwall (2007) further maintains that most Yoruba women are financially independent and are capable of supporting their families without the help of their spouses, but have on occasion maintained the outward appearance of their husbands as breadwinners in order to protect the public status of their families.

This thesis has adopted the NDHS definition of the household for the following reasons. Firstly, the definition pays attention to external relationships by acknowledging the presence of other related or unrelated individuals in the household. These relationships are important in understanding fertility in the Nigerian context because they often help with the cost of childrearing as discussed in Section 2.3.1. The presence of these relationships suggests the movement of people, resources and, more importantly information, which is important in the diffusion of innovations such as contraception. The underlying premise here is that couples assess the acceptance of behaviours within the community through social networks that are formed via members of the household. This forms a meso-level of analysis that frames the examination of decision-making within the household. This points in turn to the fluid and semi-permeable nature of household boundaries (Scrimshaw 1990), especially among the urban poor and people in rural areas where the role of physical household structures have a role to play in the permeability of people's behaviours.

Over time, urban poverty and housing shortages in Nigeria have led to the creation of cheap easy-to-build housing structures called '*face-me-I-face-you*' or central corridor housing (Ekhaese & Omonhinmin 2014). This type of housing accommodates many families who are households in their own right but share the

same living arrangements with many other households in a single physical housing structure that can also be classified as a household because of the shared living and cooking arrangements within. This kind of housing may also be a multigenerational household or family house, usually called a compound, where members of an extended family live in proximity to one another (see Beaman & Dillon 2012). In Nigeria, occupants of this type of housing pool resources together for the maintenance of the building but do not conduct any other pooling of resources e.g. for food or other expenditure.

Secondly, by identifying a single head of household, which is typically the husband, the NDHS definition allows for the interrogation of gender relations present in the household. Agarwal (1997) and Mabsout & van Staveren (2010) suggest that the gendered social norms, beliefs and practices that shape institutional structures serve as a pre-condition for individual and household power. Gender roles, although diverse and culture-specific, play out at different levels of society in ways that foster male dominance over women (Connell 1987; 2013; Momsen 2010). To Barker & Feiner (2004) the household is a site for support and exploitation. McDaniel (1996) further explains that while marriage helps women achieve their economic and social goals, it often conflicts with their personal interests especially in situations where they have an unmet need for family planning. On the basis of the household definition, particularly in relation to acknowledging a head of the household and the cultural and religious meanings attached to it, it can be argued that the head of the household has relative control over the outcome of women's fertility. The household can, therefore, be viewed as a site for bargaining and negotiating conflicting interests, rights, resources and benefits among its members with the most bargaining power which in most cases are predominantly men (Sen 1990; Agarwal 1997). On a micro level, the household is the site where global notions of rights are contested. Here, people have to negotiate different structural forces, especially gender, in order to claim and perform what have been institutionalised as the rights and roles of different members of the household (Kandiyoti 1988; West & Zimmerman 1987).

These structural forces inform and govern the relationship and interactions between the husband and wife. Conjugal power defines the relative power of the husband and the wife within the conjugal unit (Skinner 1993). Regardless of the type of marriage, decision-making power within the conjugal unit overwhelmingly lies with the husband and is reinforced through social and institutional structures in Nigeria that legitimize their dominance in the household (Isiugo-Abanihe 1994b; Bankole 1995; Feyisetan 2000; Duze & Mohammed 2006). In Nigeria, 33% of currently married women of reproductive age are in polygynous unions (Bove & Vallengia 2009; NPC & ICF Macro 2014). Within this marital system, social relationships are structured among co-wives, such that co-operation is required in both the productive and reproductive functions of the household, all the while placing them in direct competition for reproduction, resources and attention from their husband (Bledsoe 1993; Blanc & Gage 2000; Madhavan 2002). There is a tension between the continuously expressed desire for reduced fertility on the one hand, and the strategic use of child bearing particularly by women in northern Nigeria as a means to secure their economic survival and preserve their marriage on the other (Izugbara & Ezeh 2010; Izugbara *et al.* 2010). This type of marriage is more common in the northern parts of Nigeria, and NDHS survey data suggests that there is a relationship between women's education, their relative wealth and polygyny. Women with no education and in the lowest wealth quintile were more likely to be in polygynous unions than women with at least secondary school education or women who belonged within the highest wealth quintile (NPC & ICF Macro 2014).

Male dominance is fostered by early female marriage and the subsequent lack of communication between couples due to the wide age gaps between them (Nyblade & Menken 1993; Ezeh 1997; Blanc & Gage 2000). As a result, bargaining for individual reproductive preferences is limited. Poor spousal communication, which affects the utilization of contraceptive technology, is related to wider gendered social inequalities and the micro-politics of marital relationships (Adongo *et al.* 1997; Izugbara *et al.* 2010). The marriage process itself, through the payment of bridal wealth, as discussed in Section 2.3, further reinforces this situation. Since

women's primary role is regarded as biological reproduction, gendered power relations in marriage affect their reproductive freedom initially through their inability to discuss contraception (see Chapter Three), and then, their inability to access contraceptive services (Adongo *et al.* 1997).

Household decision-making patterns (e.g. wife-led, husband-led, joint decision making and others) also influence reproductive health outcomes. A frequently used method to examine the effect of decision-making patterns on fertility outcomes is to quantitatively compare participatory levels in the decision-making process (Biddlecom *et al.* 1997; Speizer *et al.* 2005; DeRose & Ezeh 2010). Based on survey results from the NDHS in 2008, there is a strong pattern of husband-dominated (42.5%) and joint (47.3%) decision-making indicating that women have less primary control over their reproduction (NPC and ICF Macro, 2008). The current NDHS shows that while 32.6% of married women in Nigeria reported joint decision-making with their husband, just 6.2% participate in decisions concerning their health care, which includes the use of contraceptive services; 60.8% reported that their husbands made decisions about their health care on their behalf. Furthermore, across the three markers used as a measure of participation in decision-making processes (own health care, major household purchase and the ability to visit family and friends), the survey showed that 48% of women did not participate in any of these decisions in the household. Women's ability to participate in these decisions however, increased with age, urban residence and the number of living children (NPC & ICF Macro 2014).

The idea of joint decision-making suggests that women are involved in the decision-making process but the classification and the research method used becomes problematic because it hides who initiates and dominates the decision-making process. Joint decision-making, therefore, makes gender invisible. Several studies have documented the effect of women's participation in household decision making and the use of contraception (Chapagain 2006; Mbweza *et al.* 2008; DeRose & Ezeh 2010; Binyam *et al.* 2011). Further research has sought to explore how decision-making patterns might predict contraceptive behaviour and highlighted the importance of women as primary decision makers and the role of men in

promoting better contraceptive outcomes (Bankole & Singh 1998; Mullany *et al.* 2007; DeRose & Ezeh 2010). These studies are, again, quantitative and apart from the research conducted in Nigeria by Bankole & Singh (1998), were conducted elsewhere, in Nepal (Mullany *et al.* 2007) and Uganda (DeRose & Ezeh 2010), calling for the need to qualitatively examine the complexity of contraceptive decision-making.

The ability to participate in or make decisions in the household has been related to women's status and autonomy and is used quantitatively as an indicator of women's empowerment. Indeed, demographic and fertility research has used concepts of women's status and autonomy to explore women's fertility decision-making ability within the household in relation to fertility. This is based on the assumption that such measurements of status or autonomy show how women access power in the household (Mason 1984; Basu 1992; Weigl 2010; NPC & ICF Macro 2014). Mason (1986) suggests that the concept of women's status is complex and measuring the status of women distorts the reality of their lived experiences. Greenhalgh (1995), Patel (2006) and Weigl (2010) add to this critique by arguing that the use of concepts such as status provide a reductionist measure of women's position through the use of quantifiable socio-economic and demographic indicators, thereby ignoring the life worlds of those being studied and the structural influences that mediate their actions. Fertility is personal, social and political and as such, women's status should be understood such that it reflects all three of these aspects of their lives.

In Nigeria, marriage and having children confers a higher status on women than being of marriageable age with education and access to resources. Childlessness creates anxiety for women, and indeed couples, because of the shame and social exclusion associated with it, especially in communities where high fertility brings a premium. For women, infertility can render them invisible, and women in such situations have been subjected to gender-based violence as a consequence (Koster-Oyekan 1999; Orji & Onwudiegwu 2002; Araoye 2003; Ibisomi & Mudege 2013). Thus, the use of status then becomes less significant for married women who are reproductively challenged. While the overall importance of these variables cannot



be denied, the social aspects of fertility or rather infertility can confound the value of using measures like status to understand decision-making. Patel (2006) adds that there is a cultural specificity to what constitutes high or low status for women. Greenhalgh (1995) further posits that using status as a variable is a misleading concept because it homogenizes women and fails to appreciate difference and gender relations.

Autonomy, on the other hand, has been used by some demographers to overcome some of the challenges present in the use of status as a concept in understanding women's position in the household. Dyson & Moore (1983) developed the most widely used definition of autonomy within the discipline, which included women's relationships with men and intra-household relationships. It included a gendered perspective in relation to fertility through the use of specific quantifiable demographic variables that measure women's decision-making ability and freedom of movement. As mentioned above, many women in Nigeria lack the opportunity to make autonomous decisions in the household. The percentage of women who make independent decisions on how to spend their income varies regionally, with women in the southern parts of the country more likely to make joint decisions with their husbands on how to spend their income than women in the North (NPC & ICF Macro 2009; NPC & ICF Macro 2014). Again, this percentage increases as levels of education and wealth rise. In the North-Central region, 26% of husbands made decisions on the use of their wives' earnings (NPC & ICF Macro 2014). Autonomy then becomes problematic as an indicator too, because it equates the meanings attached to decision making in many cultures to those characteristic of European and North American societies (Jeffery & Jeffery 1997 p.118).

Madhok (2006 p.230-231) argues that the use of autonomy in the demographic literature promotes individualism and rational thinking. This takes the community out of the individual and can be considered as ethnocentric (Greenhalgh 1995 p. 24; Weigl 2010), particularly because, for most women in Nigeria, the community has rights of ownership over the body and, by extension, reproductive outcomes (Izugbara & Undie 2008). Fertility is far from rational. Considering people as a unit that makes rational decisions portrays a failure to understand women's agency or

lack thereof within the household. The concept of autonomy is narrow because it portrays women based on quantifiable indicators, as '*passive victims of patriarchy*' (Greenhalgh 1995 p.25) and lacks an understanding of how women negotiate and deal with emerging intra-and extra-household relationships (Jeffery & Jeffery 1994 p.24). Acknowledging the limitations of status and autonomy as demographic concepts, and the little attention research has paid to women's agency in the construction of fertility outcomes in Africa, this study will employ the concept of women's agency to understand how contraceptive decisions are negotiated within and outside the household.

## **2.5 Agency, structure and contraceptive decision-making**

The concept of agency focuses on the meaning, motivation and purpose that individuals attach to their goals and the ability/ freedom to act on them (Sen 1990; Kabeer 1999 p.438). Agency takes many forms, ranging from bargaining and negotiation to subversion and resistance. Traditionally, agency has been linked with structure to show the way people navigate their individual interests amid structural forces in any given society (Weigl 2010). Therefore, to understand the ability to make choices and exercise *the power within* (Kabeer 1999), one must understand the structures in which these choices are embedded. Structures are sets of schemas and resources that enhance or constrain the reproduction of social systems and tend to be reproduced by those same social systems (Giddens 1984; Sewell 1992). Sewell (1992) highlights that being an agent means being capable of exerting some degree of control over the social relations in which one is embedded. Thus, agency is affected by the permeability of structures i.e. the agency attached to fertility behaviour is influenced by the nature of the norms, rules and customs that govern everyday life, ranging from household/familial rules and norms to the state, service provider and societal norms that govern fertility behaviour.

More importantly, this thesis echoes Risman's (2004) call for the application of gender as a structure because it is deeply embedded in society and, for this research, it intersects with and is embedded in religious, political, cultural and socio-economic institutions that affect women's agency in the use of contraceptive technology. Structuration theory put forward by Giddens (1984) provides a more

nanced analysis of gender as a social structure because of its emphasis on reflexivity and personal interpretations of agency. Risman (2004) argues that people perform what is expected of them within different structures and therefore research must be concerned with why people choose to act the way they do. She stresses Giddens' call for analysis to move beyond verbal affirmations to include taken-for-granted aspects of performed actions. Gender is embedded in our individual personalities, culture and institutions, and all three intersect in complicated ways to influence agency (Connell 1987). Adding gender into the structures under analysis explains how women and men engage with each other in the household and how they re-create socially approved ways of being in the household that include how and whether fertility discussions can occur in the household. It highlights how men and women attempt to do things differently, thus providing different narratives of how men and women instantiate gender in the household and their communities. Agency also allows for an analysis of the relationships between households and community members as both members of the community and/or representatives of the state.

Agency allows people to define their choices and pursue their goals even in the face of structural forces for example religion (Kabeer 1999). Feminists have juxtaposed agency with resistance (Sax 2009 p.93). Foucault (1984) elaborates on the notion of resistance as present in every form and site of oppression. For him, power is ubiquitous, and people have the ability to draw on different practices within different techniques of power, use them and reflect on them. Thus, people are in constant negotiation with regimes of truth that determines acceptable knowledge and discourse (Foucault 1984; Foucault 1988). His work on power provides a useful analytical framework for understanding how individual experiences are controlled by certain techniques of power and how knowledge of women's bodies are constructed within these structures. By so doing, it highlights individual struggles with being masculine and feminine based on the effects of power produced in discourses (Smith 1988). This is by no means a Foucauldian thesis however; this thesis is interested in looking at power as structural because of the context in which women in Nigeria live their everyday life.

Drawing on Scott's (1985) analysis of the ways subordinated people resist structures and avoid confrontation with authorities, resistance in the context of this study involves conceiving contraceptive desires in a largely pro-natalist society, discussing such desires with one's spouse and confronting norms and rules surrounding social behaviour that perpetuates reproduction of certain outcomes. More so still, it involves the clandestine use of contraception. By avoiding confrontation, women manipulate power within the system while maintaining the status quo. This highlights women's behaviour as being more than simply passive and obedient in the decision-making process (Weigl, 2010) which challenges the notion that women who secretly use contraception lack relative power in the decision-making process (Biddlecom and Fapohunda, 1998). Resistance may also mean deciding not to use contraception as using contraception goes against the norms that stem from naturalised power relations embedded in everyday life.

Agency is also critical in understanding how people act on their decisions. Making the decision to manage fertility outcomes or have a particular family size is not enough to guarantee the actual access to, and use of contraception. These decisions have the potential to remain in the household. Thus, understanding people's actions and the motivations for performing these actions is important in ensuring that people's desired family size mirrors their actual family size at all stages of their reproductive life, particularly for countries with high population growth rates and poor reproductive health outcomes including maternal mortality. There is a need to understand how the decision-making moves from intention to action or inaction i.e. if the decision to use contraception remains in the household or why these decisions are implemented in the public sphere of service provision. In summary, contraceptive decision making must be understood within its social contexts as it forms an aspect of the wider social division of labour which in turn, is reinforced by the cultural, religious and ideological systems prevailing in that society (Caldwell *et al.* 1992; McDonald 1996; Obono 2001; Dudgeon & Inhorn 2004; Duze & Mohammed 2006; Momsen 2010).

## 2.6 Conclusion

This chapter provided the main theoretical and conceptual frameworks that informed this research. Drawing upon Foucauldian concepts of Biopower and governmentality, this chapter reviewed the three interconnecting issues that are critical to understanding contraceptive decision-making: population growth, development and reproductive health. Focus was placed on the global and local construction of women's bodies as solutions to development issues such as rapid population growth and sustainable development. Regarding contraceptive use, women's bodies were located between the personal and the political that therefore, situated their reproductive lives with competing structural interests over their bodies and shifting power relations that have a bearing on contraceptive agency.

The multiplicity of these structures allowed the exploration of the mutually sustaining institutions that operate at a macro level to construct women's bodies first within medicine and contraceptive research and design and secondly, through the creation of global policies that support the use of family planning. It has been argued that contraceptive technologies are designed to discipline and regulate women's bodies. These methods are gendered and promoted to allow collective and individual control over the body by the international community and nation states through the implementation of population policies. Women's bodies are also sites of resistance, illustrations of which were found at the point of policy rejection by nation-states due to conflicting narratives on the effects of overpopulation on economic development and through the manifestation of side effects.

Paradigm shifts within the links between population growth, development and reproductive health changed the way women's bodies were policed globally and locally. While sexual and reproductive health rights are important in improving women's lives generally, this chapter demonstrated that reproductive rights present a universal framework for constructing the idea of the freedom to choose. These freedoms are in direct conflict with the local realities of women in Nigeria at the household and community levels. Familial and community rights over the body were argued to have greater control over the reproductive outcomes and the use of

contraception than the idea of personalized rights over the body. These familial and community rights were provided by structures that govern the household, are also subject to resistance and as such, theorised the household as sites of bargaining and negation where agency attached to the use of contraception will be examined.

The following chapter situates fertility and contraceptive use in relation to development in Nigeria. It provides a review of the existing literature on population policies and the challenges in creating a demand for contraception and supply of contraceptive service provision in Nigeria.

## **CHAPTER 3: HISTORICAL OVERVIEW AND ANALYSIS OF CONTRACEPTIVE USE IN NIGERIA**

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### **3.1 Introduction**

Recognising the links between population and reproductive health, this chapter acknowledges that sexual and reproductive health is a critical human rights issue regardless of global and /or local concerns for rapid population growth. However, this chapter draws on the global perspectives on population growth, development and reproductive health established in Chapter Two and situates these debates locally within Nigeria. Focus is placed on providing a better understanding of the relationship between global and local discourses surrounding population growth and reproductive health and the lives of women in Nigeria. This is because reproduction is a global process that brings together the individual, the state and the global as interrelated forces that work simultaneously in relation to each other (Browner & Sargent 2011).

This chapter begins by discussing the trends in fertility and population growth in Nigeria. Section 3.3 situates Nigeria's high fertility within the socio-economic and political landscape of the country through an analysis of its population policies. As revealed in this section, the international community influenced the policy environment. Global influence was not limited to policy as contraceptive service provision in Nigeria is largely donor driven. Thus, this section discusses the supply of contraception within this relationship and highlights the supply-related barriers to contraceptive use in Nigeria. Section 3.4 draws on existing literature that identified the significant demand-related barriers to the use of family planning.

### **3.2 Fertility trends and population growth in Nigeria**

Over the past several decades, marked decreases in fertility and maternal and infant mortality rates have been observed globally (Bongaarts 2015; Weeks 2015). However, these decreases mask important regional differences as most Sub-Saharan African (SSA) countries have maintained high fertility rates despite a steady decline in maternal and infant mortality rates (McFarlane 2015). Unlike most developing countries that began their onset of fertility decline from the 1960s to

the 1980s (Lesthaeghe 1989), Sub-Saharan Africa sustained its fertility rates until the 1990s where evidence suggested decreasing fertility rates (Shapiro & Tambashe 2002; 2003; Bongaarts 2008; Shapiro & Gebreselassie 2008). However, by the 2000s, situations of stalling fertility rate declines had been described in many African countries, with Kenya and Ghana as the first countries to experience such stalls (Bongaarts 2006; Shapiro & Gebreselassie 2008). Some authors have linked the stall to changes in the proximate determinants of fertility particularly in the access to, and use of, contraceptive services (Westoff & Cross 2006; Bongaarts 2006; 2008). Others have linked the stall to changes in socio-economic determinants and the impact of HIV/AIDS on infant mortality (Westoff & Cross 2006; Shapiro & Gebreselassie 2008). Also, poor socio-economic development and the lack of commitment to family planning service provision in many African countries may be another cause of stalling declines in fertility rates.

Nigeria has maintained its high fertility rate. A stall in fertility decline cannot be applied to Nigeria since the fertility rate has declined by 1.5 in 2013 from its TFR of 6.0 in 1990 (NPC & ORC Macro 2004; NPC & ICF Macro 2014). Nigeria's per capita income, although growing, was estimated at 3,203.3 (current US\$) in 2014 (World Bank 2014). According to Bongaarts (2015), countries with per capita incomes lower than 1000 usually have fertility rates higher than five births per woman. Disaggregating the national figure to show the fertility rates across the geopolitical regions of Nigeria, however, reveals what can be assumed to be a stall in fertility rates in the southern regions, where they have remained below 5 births since 1999. Currently, the average woman in Nigeria has approximately six children over the course of her reproductive life (NPC & ICF Macro 2014). High birth rates have several implications for rapid population growth rate and high maternal mortality particularly in the presence of low contraceptive use as discussed in Chapter One. Such rapid population growth, when accompanied by low contraceptive use, has several implications for the reproductive lives of women and, indeed, Nigeria's overall sustainable development.

The age structure and sex ratio of the population are critical factors in understanding the social and economic consequences of population growth. These



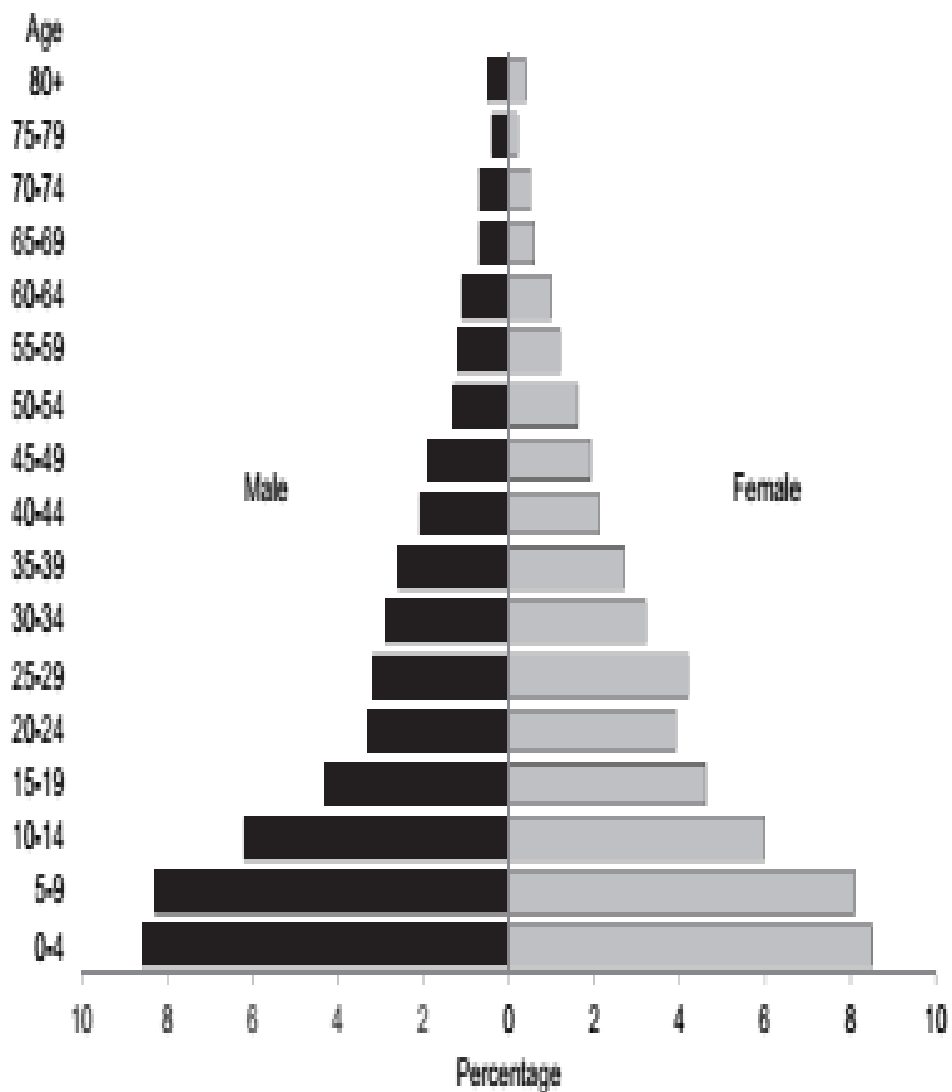
factors are intrinsically linked to fertility, mortality and migration (Hamilton 2015). Although fertility, mortality and migration are components of population change, this thesis draws particular attention to the subject of fertility and juxtaposes population issues with reproductive health because these practices are directly linked to population growth. The age structure and sex ratio of the Nigerian population are shown in the population pyramid in Figure 3.1. The figures presented in the pyramid suggest a predominantly young population, which is to be expected for countries with high fertility rates and declining mortality rates (Hamilton 2015). The percentage of the population under 15 years of age is around 46% while the percentage over 65 years of age is just 4% (NPC & ICF Macro 2014).

The increasing percentage of Nigeria's population which is of working age has the potential to increase its economic growth and influence in the global economy particularly when the concern of most developed countries is aging population (Bloom *et al.* 2003; Reed & Mberu 2014; McFarlane 2015). When utilised properly, the productivity of young populations can produce a demographic dividend, dividends of which has helped define the nature of the economic growth in many Asian countries (Bloom *et al.* 2003). Nigeria's ability, and indeed, the ability of most countries in Africa to replicate the economic growth experienced on the Asian continent is now subject to debate (Reed & Mberu 2014). For this to happen, the life expectancy of people in Nigeria must increase along with increased female labour force participation and a decline in fertility rates and infant mortality (Galor & Weil 2000; Bloom *et al.* 2009). Also, children must be seen as consumers of resources especially in relation to providing quality education and health services in order to increase productivity (Soares 2005).

The magnitude of this economic growth however, depends on the kinds of policies that are implemented to take advantage of this opportunity (Bloom *et al.* 2003; Reed & Mberu 2014). Young populations have been identified as a potential indicator for national risks of higher unemployment, greater likelihood of violence and national security issues, and increased pressure for rural-urban and international migration (Bloom *et al.* 2003; Sachs 2008). Without effective policies, the potential for a demographic dividend would pass by without any significant

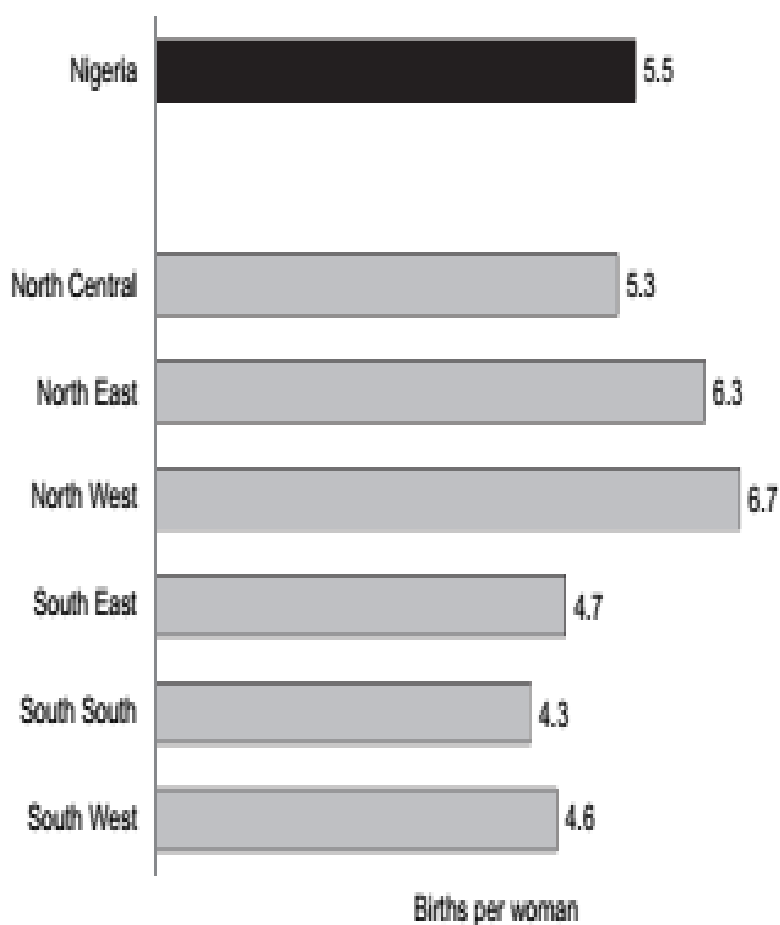
contributions to the lives of people in Nigeria. These policies are important now more than ever before because of the unique position of the working age population in Nigeria (Reed & Mberu 2014). While this working age group has the greatest potential for changing the economic situation of Nigeria, this group is also characterised by poor health indicators. The life expectancy of men and women in Nigeria is 54 and 55 years of age respectively. The HIV/AIDS prevalence rate is 3.2 % for people within the age of 15 and 49 and the probability of death between 15 and 60 years of age is 357 for men and 325 for women per 1000 population (WHO 2015).

**Figure 3.1: Nigeria’s population pyramid**



Source: NPC and ICF Macro 2014

**Figure 3.2: Nigeria's fertility differentials by geopolitical zone**



Source: NPC and ICF Macro 2014

Young populations also eventually produce larger cohorts of women of reproductive age as suggested in Figure 3.1 where the sex ratios for individuals between the ages of 15 and 49 in Nigeria show a marked increase in the proportion of women. Rapid population growth is fostered by high fertility rates within large cohorts of reproductively active women. Figure 3.2 shows Nigeria's fertility differentials by geopolitical zone. The current Total Fertility Rate (TFR) represents a slow decline from its estimated value of 6.0 in 1990. However, there are differences between regions as the southern parts of the country report fertility rates as low as 4.3, while the northern regions are considerably higher, particularly the North-Western region which has a fertility rate of 6.7 (NPC & ORC Macro 2004; NPC & ICF Macro 2014). High fertility rates are usually a reflection of the scarcity or absence of quality reproductive health services including contraception, which sadly is the case in Nigeria (Leahy 2006; McFarlane 2015). More so, even if contraceptive services

are provided, and the fertility rates of women reduce, Nigeria's population would continue to grow because of the population momentum built with the presence of large cohorts of young women (McFarlane 2015).

The challenges presented by high fertility rates have been influential in the creation and adoption of population policies with programme targets aimed at increasing access to family planning and reproductive health services (Leahy 2006). These programmes and, indeed, most reproductive health services are women-centred. This is to the extent that contraceptive technology research and design is largely focused on women (McFarlane 2015). In Nigeria, women of all ages have inadequate access to modern contraception and other reproductive health services, even more so in northern Nigeria (Izugbara & Ezeh 2010). While the unmet need for family planning for all women of reproductive age is 16%, married women of reproductive age in Nigeria report low use of contraception at 15% (NPC & ICF Macro 2014). Unintended pregnancies maintain population growth and have far-reaching consequences on the reproductive health status of women and the overall health of their children. One of these consequences is induced abortion, which in Nigeria is most often performed in septic and unsafe conditions (Otoide *et al.* 2001; Oye-Adeniran *et al.* 2002; Omideyi *et al.* 2011; McFarlane 2015).

The global response to the interconnecting challenges of population growth, development and reproductive health has been detailed in Chapter Two. What follows in this Chapter are the ways in which these global debates influence national policy in Nigeria. This thesis argues that development prescriptions in the form of population policies and family planning programs influence the decision-making process through the demand for contraception at the level of the household and the supply of contraceptives at the level of service provision. The following section situates population and development issues within the socio-economic and political landscape of Nigeria and discusses the two population policies that are relevant to providing a macro-level analysis of contraceptive decision-making.

### **3.3 Local realities: population policies and family planning in Nigeria**

#### **3.3.1 National Population Policy, 1988**

The 1988 *National Policy on Population for Development, Unity, Progress and Self-Reliance* was Nigeria's first policy that explicitly sought to address the nation's increasing population growth rate (Obono 2003). The creation of this policy was a reflection of a number of political and economic influences and global disciplinary measures that sought to cultivate and condition the conduct of global citizens to the population problem in the hope that nation states would form self-regulatory mechanisms with effects around the globe (Dean 2004). An analysis of this policy is essential for this thesis because it unpacks some of the critical factors and issues that influence the use of family planning and fertility in Nigeria.

Nigeria experienced economic and population growth pre-1988. As suggested in Chapter Two, the economic and population growth experienced during that period has been the subject of debate, particularly because of the drop in the economy in the presence of a rapidly growing population (UN 1988; DuBois 1991; Gordon 2003). The situation, made worse by the introduction of SAPs in 1986, prompted a shift away from Nigeria's pro-natalist stance of previous national development plans and an acknowledgement of the necessity of reducing its fertility rates in the Fourth National Development Plan (Obono 2003). This shift was particularly significant because the Nigerian delegates at Bucharest in 1974, along with many other delegates from developing countries, had expressed confidence in their respective nation's ability to accommodate changes in population growth and thus did not adopt resolutions from the Plan of Action that encouraged the adoption of population policies (Orubuloye 1983; Dixon-Mueller & Germain 1994).

A number of international conferences specific to the African continent held before the 1984 World Population Conference in Mexico provided a platform for many African countries including Nigeria to discuss the problem of rapid population growth. From the Lagos Plan of Action in 1980 to the Kilimanjaro Programme of Action in 1984, Nigeria recognised the challenges associated with sustained population growth and slow economic development (Obono 2003; Adegbola 2008; Shofoyeke 2014). Consequently, the National Policy on Population was created

after four years (1984-88) of coordinated meetings, activities and drafting by the Federal Ministry of Health, UNFPA, the World Bank, the donor community, family planning organizations and other stakeholders (Adegbola 2008). Robinson (2015) argues that Nigeria and other Sub-Saharan African countries adopted population policies as a result of coercive and normative pressure by the international community. The adoption of this population policy tied to the influence of the links between population and development, coercive pressure from the international community and donor organizations and Nigeria's desire to address its development issues (Connelly 2006; Barrett *et al.* 2010; Robinson 2012; Robinson 2015). Although direct pressure has not been documented, several researchers have linked the use of development aid to the adoption of population policies in many African countries (Hartmann 1995; Connelly 2006). In Nigeria's case, the World Bank and International Monetary Fund (IMF) were particularly influential because of Structural Adjustment Programs (SAPs) (Gibbon 1992; Mosley 1992; Adegbola 2008).

Policy recommendations included targets that sought to improve the standards of living, promote health and welfare, lower the population growth rate and achieve an even distribution of the Nigerian population (Federal Republic of Nigeria 1988 p.12). Many of the targets, including those aimed at population growth, had quantifiable objectives for the years 1995 and 2000. The policy aimed to reduce the existing 3.1% population growth rate to 2.5% by 1995 and 2.0% by 2000. Regarding fertility, the policy had targets that sought to reduce both the proportion of women marrying before the age of 18 and the percentage of women having more than four children by 50% by 1995 and 80% by 2000. It also called for a reduction in infant mortality (then 100 per 1000 live births) by 50% by 1995 and 70% by 2000.

The policy was implemented through the National Population Program (NPP) and this included targets for the increased provision of family planning services to women of reproductive age by 50% 1995 and 80% by the year 2000. The targets for reducing population growth proposed a reduction in the TFR from six to four births by the year 2000 through the provision and marketing of contraception (Federal Republic of Nigeria 1988). Here, women's bodies were constructed as the solutions

to overpopulation and contraception acted as the disciplinary mechanism that represented state and non-state investments in controlling life both collectively as Third World populations and, individually as discrete bodies (Foucault 1997b; Takeshita 2011).

### *Critiques of the population policy*

The 1988 population policy has been criticised on some accounts (Dixon-Mueller & Germain 1994; Adegbola 1995; Renne 1996; Obono 2003; Adegbola 2008). The first of these relates to a lack of understanding of reproductive behaviour and fertility practices in Nigeria as evidenced in the policy's targets for women's fertility, which showed little regard for the socio-cultural landscape of their fertility practices (Isiugo-Abanihe 1994b; Obono 2003). Family planning service provision emphasized the notion of 'free choice' regarding the use of contraception yet at the same time encouraged women not to have more than four children (Federal Republic of Nigeria 1988; Avong 2000). From a demographic standpoint, Frost & Dadoo (2009) suggest that excluding provisions for men in family planning programmes in Africa has cost the continent its chance to reduce high fertility rates. The lack of engagement with the socio-cultural contexts of women's reproduction has several implications for the acceptance and implementation of the policy. The policy refused to engage with patriarchy and hierarchies of governance within society and by extension, within the household, which support reproductive practices that favoured of high fertility. In Nigeria, these reproductive practices are profoundly embedded in culture and religion, both of which influence the demand for and supply of, contraceptives in the country. By ignoring patriarchy and societal governance, the Nigerian government failed to acknowledge the women's bodies as sites of control by the conflicting interests of culture and religion.

Culture, defined as a set of prescribed norms that guide social attitudes and behaviour (Freedman 1987), operates at the macro-level of society and also at the micro-level of the household. Here, culture renders women docile in relation to their reproductive health decision-making, including the use of family planning, by establishing norms and beliefs that govern their identity as women. These norms

and beliefs are enforced by men who act as custodians of culture and their lineage on the one hand, and by older women who internalize these practices on the other (Kandiyoti 1988; Isiugo-Abanihe 1994b; Campbell et al. 2006; Price & Hawkins 2007). In Africa, women's lack of reproductive health decision-making autonomy is reinforced further by the marriage process and the payment of bridal wealth (Dodoo & Frost 2008). Bridal wealth payment is at the core of the marriage contract and so it perpetuates gender inequality within marriage and marginalises women's decision-making power (Goody 1973; Caldwell & Caldwell 1990; Davies 1999). Research on bridal wealth payment in West Africa suggests that it confers women's bodily ownership and the outcome of reproduction on the husband and/or his family to such an extent that women come under the authority of men and take instructions from them as the altruistic head of the family (Isiugo-Abanihe 1994a; Bawah *et al.* 1999; Ogunjuyigbe *et al.* 2005).

Religion works alongside culture to influence all levels of contraceptive decision-making. Polygyny, an institution supported in Nigeria by both culture and religion, protects the interests of patriarchy. Representatives from women's groups such as the Nigerian Council of Women's Societies (NCWS) and the Federation of Muslim Women's Association (FOMWAN) argued that polygyny was ignored in terms of its consequences for fertility within the targets set in the policy (Dixon-Mueller & Germain 1994). They protested that the four births per woman target was discriminatory because men, by contrast, have been allowed by customary and religious laws to have as many children by each of their wives, subject to the availability of resources (Federal Republic of Nigeria 1988; Dixon-Mueller & Germain 1994; Obono 2003). Religion, culture, social institutions and medicine (contraceptive design and research) converge to produce knowledge on how contraception is constructed and how it is viewed and accepted individually and collectively as a population. Religion also operates politically on a macro level to influence the adoption of global recommendations on population growth, the acceptance and implementation of a national population policy and, finally, the actual use of contraception on a household level.



In northern Nigeria where the fertility rate is high, opposition to population programmes was based on the premise that such programmes undermined some of the principles of Islam (Renne 1996; Adegbola 2008). The argument presented against the policy by Muslims, mainly in the North, was based on the following Quranic verse: *'and do not kill your children for fear of poverty. We provide for them and for you. Indeed, their killing is ever a great sin'* (see Quran 17:31). Thus the use of contraception for fear of economic difficulty was *haram* (forbidden) and implied a weakness of faith and trust in Allah for provision and sustenance; any attempt to interfere with destiny is interpreted as acting against religion and the will of God (Adegbola 2008). There is also an issue of regionalism. The population size of subgroups in Nigeria has political significance in terms of resource allocation. This, in addition to security, identity and wealth in numbers as ordained by Islam (see Quran 2.223 and 6.151) was a fundamental point of criticism of the population policy as far as Muslims in the north were concerned (Gordon 2003; Yin 2007; Adegbola 2008). The use of the withdrawal method (*AzI*) had also been subject to debate within the Muslim community where opponents against its use argue that practicing withdrawal was infanticide, an act that is condemned in the Quran and Hadith (Adegbola 2008).

Within the Christian community that is predominantly located in the southern parts of Nigeria, the Church, similarly played a crucial role in the non- acceptance of family planning in the eastern region of the country and also in Christian communities in the north. The Church's influence is evidenced in the low uptake of family planning services in these communities who, along with the Muslim community, represented an integral part of the failure of the policy to reduce fertility rates to four births by the year 2000 (Renne 1996; Avong 2000; Adegbola 2008). Islamic opinion on population matters was very influential in Nigeria's role and participation at the 1994 International Conference on Population and Development in Cairo. Although the government made adequate preparations, prominent Islamic leaders and other elites in northern Nigeria influenced public and political interest in the conference based on the assertion that the conference focused on issues of family planning and abortion, practices that they said were

condemned in Islam. The result was a decline in political interest in the conference as evidenced in the small delegation sent to represent Nigeria. This waning political interest caused a lack of motivation to adopt resolutions set in the Plan of Action of the International Conference on Population and Development beyond the level of rhetoric. Ensuring sexual and reproductive health rights at both policy and programme levels became difficult in the midst of conflicting religious and cultural rights and expectations of men and women in the country (Adegbola 1995; Adegbola 2008). Religion and culture thus provided a framework for male resistance to the use of family planning in Nigeria.

Nevertheless, there was a slow decline in the Total Fertility Rate from its overall estimate of 6.0 in 1990 to 5.7 in 2003, with rates as low as 4.1 in more southern regions (South-West and South-East) and as high as 7.0 in the North-Eastern region of the country (Obono 2003; NPC & ORC Macro 2004). It has been argued that one of the challenges faced by the Nigerian government in the implementation of any population programme is negotiating the North-South divide within the country. Mechanisms that favour low fertility rates such as social advancement, education, modernization and urbanization are evident in the southern regions while the north's political, economic and cultural milieu favour high fertility rates (Caldwell *et al.* 1992; Adegbola 2008). However, it has also been argued that this slow decline in fertility can be attributed to the removal of government subsidies for health and education as part of the conditionality attached to the World Bank and International Monetary Fund (IMF) sponsored Structural Adjustment Programmes (SAPs) (Ekwempu *et al.* 1990; Obono 2003; Harrison 2009). Evans (1995) and Harrison (1996) have pointed out that maternal health was affected most especially in Sub-Saharan Africa. Privatization, public sector cuts and the introduction of user fees are some of the principles of SAPs that may have increased maternal mortality rates and increased the cost of children for many families (Obono 2003; Harrison 2009). Increasing privatization had several implications for the supply of family planning commodities and services in the country. The effect was particularly drastic when combined with the religious and cultural objections to family planning on both micro and macro levels.

Although SAPs were removed from Nigeria in 1994, the reduction in public sector spending, together with the privatization and free market ideologies associated with the programmes, led to the proliferation of the private sector in health care delivery in Nigeria (Moser *et al.* 1997; Adegbola 2008). What this meant for the supply of family planning commodities was an increase in NGO involvement, and a reliance on development assistance from agencies like the UNFPA and USAID to provide commodities as the Federal Government failed to allocate funds for their supply of commodities for the population programme (Adegbola 2008). More importantly, the private sector share in the supply of contraceptive technology grew steadily over the years to the extent that it led to a binary split in the specialization of method delivery. Thus, the private sector largely accounted for the supply of condoms and pills while the public sector accounted for the supply of injectables and IUCDs (Adegbola 2008). This split is also reflected in the coping mechanisms adopted by many Nigerians in dealing with the impact of austerity measures such as the introduction of user fees for accessing health care. Many Nigerians began to self-diagnose and treat themselves with drugs acquired from local pharmacies/Patent Medicine Stores (PMSs)/Patent Medicine Vendors (PMVs) in their localities. People weighed the cost of accessing and the availability of services in the public sector, thereby increasing the need and reliance on the private sector for services (Harrison 1996; Adegbola 2008; Harrison 2009). These specializations in service provision further highlight the state's control over provider-dependent methods and the private sector's control over user/self-controlled methods.

In 1990, the private sector provided services for 47.2% of users of modern forms of contraceptive technology, with 29% of users accessing services from pharmacies/PMSs. The public sector accounted for 36.7% of services, with government hospitals leading the sector with 25.9% of users (Federal Office of Statistics 1992). By 1999, there was a change in distribution patterns as both sectors accounted for an almost equal level supply of commodities throughout the country. This new pattern was a reflection of the government's response to the withdrawal of development assistance to the country (Adegbola 2008). Three years

after the government introduced measures to streamline population programmes in Nigeria, there was a marked decline from the public sector's 1999 share in the supply of commodities. Private sector growth accelerated in 2003 to a 57.7% share of service provision up from 47.2% in 1990 and 42.9% in 1999 and also revealed an increase in the supply of injectable forms of contraception compared to the public sector (NPC & ORC Macro 2004; Adegbola 2008). The public sector has, over the years, maintained its lead in the provision of intrauterine devices. This might be because of the level of medical expertise required for the insertion of the device. Such expertise, along with mechanisms for follow-up, is among the skills lacking in many owners of neighbourhood pharmacies and PMSs (Adegbola 2008).

The growing dominance of the private sector in service provision further serves as a barrier to the use of family planning in two other ways, namely cost and quality of information provided to clients, which Bruce (1990) included as key elements in her framework in examining the quality of care in family planning services. Family planning research in Nigeria has identified the cost of available services as one of the main barriers to the use of contraceptive technology (Orji & Onwudiegwu 2002; Oye-Adeniran *et al.* 2005; Mbizvo & Phillips 2014; Anyebe *et al.* 2014). The type of information obtained in most private sector facilities is mostly inadequate as these facilities are private businesses where members of staff are not trained in delivering quality family planning services. Those that are staffed with qualified personnel are few and often found in urban areas (Monjok *et al.* 2010). Inadequate information, particularly from pharmacies and Patent Medicine Vendors accessible to clients, also helps to fuel some of the myths and misinformation about various forms of contraception within the community, which have also been identified as barriers to the use of family planning services (Oye-Adeniran *et al.* 2005; Campbell *et al.* 2006).

Another barrier within service provision is based on the idea of choice. Making informed choices about family planning is based on an individual's understanding of the benefits and risks associated with all available forms of contraception. Thus, informed choice places the decision-making power with the individual. However, there is a tension associated with this because it also confers power onto the service provider as they serve as the interconnection between global reproductive

health discourses on the one hand and local level reception on the other. Service providers thereby act as translators between global population knowledge and local bodies (Richey 2008). Being members of the community themselves, service providers interpret scientific knowledge for themselves and their clients. Thus, access to knowledge gives them the power to act in ways that reinforce their professional dominance (Richey 2008). Service providers have the power to deny access to family planning services based on their understanding of contraceptive technologies or their delivery systems (Campbell *et al.*, 2006). This often manifests itself in unnecessary medical barriers such as blood tests or confirmation of menstrual flow before contraceptives can be given to women. Stanback *et al.* (1994) argue that these practices are often very difficult to eliminate once firmly rooted in the delivery of contraceptive services. In addition, access to knowledge establishes techniques for monitoring, observing and controlling women's bodies through, for example, the promotion of forms of contraception that meet the programme evaluation needs of service providers and family planning stakeholders.

Research in other African countries has shown that service providers are accustomed to evaluating their clients' needs through, for example, embodied practices, outward appearance of their children, language, vocabulary and existing relationship with someone in the clinic (Richey 2004; 2008). This suggests that the identity discursively constructed on their bodies limits women's access to certain methods, thereby supporting the view that a client's modern goal of limiting family size is threatened by the very services designed to achieve this goal (Schuler *et al.*, 1985, Richey, 2008). Reproductive choice should be operationalized through a choice of methods, as selective promotion of contraceptive technology removes control from women and reinforces the disconnect between family planning and the concern for women's health that first catalysed the feminist movement for birth control (Hartmann 1995; Kabeer 1999). Research has also highlighted inadequacies in the information provided by service providers to their clients (Miller *et al.* 1991; León *et al.* 2001). This suggests a lack of understanding between service providers and clients regarding their roles in contraceptive decision making (Kim *et al.* 2005). Lack of understanding can result in overzealous providers who

think on behalf of their clients (De Irala *et al.* 2011; Merckx *et al.* 2011) or who totally abandon their role in decision making (Kim *et al.* 1999; Rudy *et al.* 2003).

### **3.3.2 National Population Policy, 2004**

By the early 2000s, Nigeria - with other countries in the world particularly those in Sub-Saharan Africa - began to focus on the impact on development of emerging issues such as HIV/AIDS, poverty and gender inequality (Cleland *et al.* 2006; Mandara 2012). These emerging priorities shifted the gaze and funding from fertility-related and reproductive health issues on a global scale to the extent that donor support and funding for family planning had declined from US\$560 million in 1995 to \$460 million by 2003 (Cleland *et al.* 2006). This happened as the world's population grew bigger and more women in developing countries died from pregnancy-related causes (Cleland *et al.* 2006; Cleland 2009). As discussed in Chapter Two, the initial draft of the MDGs in 2000 ignored sexual and reproductive health issues regardless of the fact that their inclusion promised better outcomes in achieving MDGs 1 to 7 (Sonifield 2006; Hulme 2010).

In 2004, the Nigerian government introduced a new national policy on Population for Sustainable Development wherein it stressed the importance of improving the quality of life of its citizens by including goals to address issues around population growth, social and economic development and the environment (National Population Commission 2004). The goals specifically addressing population and reproductive health included the improvement of the reproductive lives of all Nigerians at every stage of their lives, the achievement of a balance between population growth, available resources and socio-economic development, and progress towards a demographic transition characterized by lowered population growth and death rates. The targets set to achieve these goals included:

- To reduce the national population growth rate to 2 percent or lower by 2015;
- Reduction of the Total Fertility Rate (TFR) by at least 0.6 children every five years by encouraging child spacing through the use of family planning;

- An increase in the Contraceptive Prevalence Rate (CPR) for modern methods of at least two percentage points per year through the use of family planning (National Population Commission 2004; NPC & ICF Macro 2009).

Progress towards the targets set by this newest policy has been mixed at best. For example, with regard to reduction of the population growth rate, the 2006 national census estimated that the growth rate was 3.2% per annum (NPC & ICF Macro 2009) while the current average estimate of growth for the years between 2010 and 2015 is 2.8% (UN 2014c). The TFR remained steady at 5.7 births in both the 2003 and 2008 National Demographic and Health Surveys (NDHSs) (NPC & ORC Macro 2004; NPC & ICF Macro 2009), but declined by 0.2 births per woman in 2013 (NPC & ICF Macro 2014). Finally, the CPR initially showed modest progress as the percentage of married women of reproductive age using contraception increased from 13% in 2003 (8% by modern methods) to 15% in 2008 (10% by modern methods). However, in 2013 the figures for both the overall CPR in the country and the percentage use of modern forms of contraception were unchanged on 2008's levels (NPC & ICF Macro 2014).

The data above indicate that Nigeria has not achieved any of the relevant targets set for 2015 by the new population policy. Furthermore, Shofoyeke (2014) suggests that any changes observed can be attributed more to the effects of inflation and the current economic situation in the country than to the implementation of the population policy. This observation echoes those suggested by Obono (2003) regarding the effect of poor economic growth on the fertility changes observed in the previous population policy. Mandara (2012) points to a lack of political and financial will as the key factors that affect the unsuccessful implementation of the population policy in Nigeria. Service delivery is largely donor driven and has fostered an environment of dependency, especially for matters relating to reproductive health, to the extent that the withdrawal or inclusion of reproductive health priorities on a global scale affects the discussions and level of engagement at a national level. The inclusion of reproductive health targets in the second draft of the MDGs in 2005 did not create any momentum at either level. In Nigeria, despite

the fact that many women die needlessly from pregnancy-related causes, allocation of funds for the procurement of life-saving family planning commodities is not a priority.

As already explored in Chapter Two, family planning gained funding and advocacy from the Gates Foundation and, the US, the UK and Australian governments in the late 2000s (USAID 2010; Shiffman & Quissell 2012). Nigeria was one of four countries to receive funding for family planning through the Urban Reproductive Health Initiative (URHI) funded by the Gates Foundation. The country-level initiative known as the Nigerian Urban Reproductive Health Initiative (NURHI) was set up in 2009 to increase the use of family planning services by targeting vulnerable populations in urban areas (Fotso *et al.* 2011; NURHI 2011; Krenn *et al.* 2014). Building cost-effective urban supply, increasing contraceptive use through demand and advocacy interventions and forming partnerships between state and local governments and stakeholders to meet project goals and share best practices are some of the features of the initiative. Their overall goal was to increase the CPR by at least 20% in selected urban sites including Abuja, Kaduna, Benin, Ibadan, Zaria and Ilorin (Krenn *et al.* 2014). The latter is the capital city of the State where this research is situated. Ilorin East Local Government Area (LGAs) is one of three LGAs that make up the capital city.

Nationwide, advocacy efforts by women's groups, civil society organizations and other stakeholders sought commitments from the Nigerian government to bridge the gap between the demand and supply of family planning in the country (Mandara 2012). In 2010, the first National Family Planning Conference was organized in the capital city Abuja and recommendations from the conference included promoting the use of family planning services through procurement and distribution, and the provision of cost-free family planning commodities nationwide (Federal Ministry of Health 2010). The commitment to family planning also included the allocation of funds (\$3million) in the 2011 fiscal budget to address the supply of family planning commodities (Goliber *et al.* 2009; Mandara 2012; NPC & ICF Macro 2014).



Section 3.3 has situated the supply of contraceptive services within national population policies in Nigeria. By so doing, it has highlighted the influence of global policies on the creation and implementation of family planning programs and the reliance on the international community and private health care sector in Nigeria for the provision of family planning services. Also, it located the interconnectedness of religion and culture on both the demand for contraception at the level of the household as discussed in Chapter Two and the supply of contraceptive services at a policy level. Patriarchy works to prevent the state provision of services and collective governing of women's bodies for the greater good of the country. Feyisetan & Ainsworth (1996) call for a greater understanding of the factors that influence the demand for children and the use of family planning because they are critical to achieving lower fertility rates and improving the reproductive lives of women in Nigeria. Building on this, the following section engages with studies based in Nigeria and other developing countries to examine the factors that affect the demand for contraception that are relevant to this thesis.

### **3.4 Barriers to contraceptive use**

There are many barriers to the use of contraception in Nigeria. These barriers operate in both obvious and more sophisticated ways to prevent women from using contraceptive technology (Campbell *et al.* 2006; Campbell & Bedford 2009), and they locate women's bodies within conflicting structures that affect women's reproductive agency.

#### **3.4.1 Demand for children**

Given that the fertility rate in Nigeria is relatively high, it is important to understand the factors that drive the demand for children at the household level. Religion and culture have been identified as primary factors that affect women's reproductive agency within the household. These factors operate by influencing the demand for children, particularly with regards to the preference for male children, and controlling women's identity by ascribing status and rewards for high fertility (Isiugo-Abanihe 1994b; Izugbara & Ezeh 2010; Kodzi *et al.* 2012). Child mortality also plays a role in increasing the demand for children in the household. Many

demographers have argued that a decline in infant/child mortality rates is an important precursor to a decline in fertility rates (Caldwell 1982; Mason 1997; Cleland 2001). Although infant and under-five child mortality rates have reduced since 2000, one in fifteen infants dies before their first birthday and one in eight children die before their fifth birthday (NPC & ICF Macro 2014). Therefore the demand for children in Nigeria remains high. Drawing on research in other countries in Sub-Saharan Africa, LeGrand *et al.* (2003) argue that parents use high fertility as an *'insurance'* strategy in response to the risk of child death and/or having unhealthy children that may, perhaps, be unable to provide economic support for them in their old age. High fertility rates in Nigeria thus reflect the state of infant and child mortality. While people in Nigeria are undeniably pro-natal for religious and cultural reasons, high infant and child mortality contribute to creating the need for women to have more children.

Caldwell's (1982) wealth flows theory is arguably best suited to explain people's demand for children in Africa. Building on Easterlin's (1975) microeconomic theory that postulates that the demand and supply of children and the overall cost (including social and financial considerations) of family planning influences people's fertility choices, Caldwell argues that development, modernization and mass education merge to re-organize prevailing family structures and reverse intergenerational wealth flows. Changes as the market economy moves from an agrarian to an industrial capitalist economy promote individualization and nucleation and break some of the bonds that encourage high fertility. Mass education and societal changes in the mode of production promote smaller families as parents spend more money on children and children contribute less to the household economy (Caldwell 1980).

Caldwell's theory has been applied to regions in southern Nigeria and he has argued, along with others, that the transition to fertility reduction exists in southern Africa and a number of other countries due to changes in educational attainment and marriage ages of women relative to their reproductive age. This transition is displayed in southern Nigeria where the NDHS survey showed an average of 4.5 births per woman in the region (Caldwell *et al.* 1992; Caldwell & Caldwell 2002; NPC

and ICF Macro 2014; Shapiro & Gebreselassie 2008). As described in Section 3.2, Nigeria's overall total fertility rate is 5.5. Smaller regional differences exist within southern Nigeria's TFR average of 4.5, with the highest fertility rate in the South-East region (4.7) and the lowest (4.3) in the South-South region. These average rates in the south have hovered around 4.5 births since 1999 (4.5 in 1999, 4.2 in 2003, 4.6 in 2008 and 4.5 in 2013), with changes in the average births between 2003 and 2008 in part reflecting the impact of HIV/AIDS on the population (NPC & ICF Macro 1999, 2009, 2014; NPC and ORC Macro 2004).

The financial and social cost of education for African children has played a role in decreasing the desire for larger families (Caldwell 1980; Dow *et al.* 1994). Some feminist demographers are critical of Caldwell's theory because it hides the gendered nature of resource expenditure and allocation in the household, and inequalities in the decision-making process (McDaniel 1996; Riley 1999). Research suggests that while the financial obligation attached to providing children's education was a bigger incentive to have smaller families, the change in attitude towards high fertility was mainly among men as they incur the cost of children's education (Dow *et al.* 1994; Dodoo & Frost 2008). In recent years, for Nigerian men living south of the River Niger, this has played a role in them postponing marriage and having fewer children (Casterline 2010; Alonge 2014; Kanayo *et al.* 2014). Here, the pressure to invest in education works in two ways. Firstly, there is the idea that having fewer children increases emotional investment in the parent-child relationship, making it different from the way parents themselves were raised, and thus challenging dominant narratives of how to be a father, wealth in people and patriarchy (Smith 2015). Secondly, with the growing acknowledgement of the importance of formal education in employment, parents in Nigeria have pooled resources to ensure that their children access higher education, especially now that there is a polarization within the educational sector that has fostered the growth of private higher educational institutions in the country. This further intensifies the costs of educational attainment and, thereby, polarizes job prospects between the rich and the poor (Geo-JaJa & Mangum 2003; Geo-Jaja 2004; Bolaji 2004; Akpotu & Akpochafo 2009).

Others within the discipline argue for a non-economic analysis of the demand for children and fertility decline, suggesting that changes in fertility preferences are based on changes in ideology and the diffusion of contraceptive technology (Cleland & Wilson 1987). Changes in attitudes and diffusion of innovation begin within the more exposed communities/settlements of a region. Diffusion is characterized by education, awareness and urbanization, with women in urban areas more likely to adopt the use of contraception than their rural counterparts (Cleland & Wilson 1987; Casterline 2001a). Diffusion is multi-layered, occurring at local, national and global levels (Bongaarts & Watkins 1996). As a theory, the diffusion of innovation offers a less predictable measure of the timing of the onset of fertility decline than conventional economic-based theories (Cleland 2001a).

However, diffusion theory situates the demand for smaller families within the influence of social interactions that occur between individuals, the household and the community. Its strength lies in the permeability of communicating innovations across different levels and allowing for interactions with service providers, not just as health personnel but also as members of the community (Rutenberg & Watkins 1997), to the extent that research has shown the considerable influence of these networks on the acceptance and use of contraception (Behrman *et al.* 2002; Dynes *et al.* 2012; Okanlawon *et al.* 2010). Since communication relies on exchanging information, it is affected by the transmission of individual narratives of the effectiveness of contraception that differ from the dominant medical-based narratives. These narratives have been argued as forming part of the myths and misinformation that also serve as barriers to the use of contraception. Furthermore, Behrman *et al.* (2002) adds that social networks provide information through social learning rather than actually influencing the use of contraception.

### **3.4.2 Male control over reproduction**

Historically, the assumption has been made in the area of reproduction that women have control over their fertility and contraceptive use. This assumption ignored the socio-cultural context in which such decisions are made and downplayed the role of men in the reproductive decision-making (Isiugo-Abanihe 1994b; Greene & Biddlecom 2000). Nigeria is largely a patrilineal society. Because of this, men have

control over the fertility outcomes in the household, which, constrains women's access to and use of family planning services (Duze & Mohammed 2006; Campbell & Bedford 2009). Male control operates at different levels. As discussed in Chapter Two and again in this chapter, male control over reproduction operates at the macro level where the State and the international community create policies and/or frameworks that govern the lives of women. At a household level, male control occurs in internalized ways that prevent women from communicating fertility preferences and their potential use of family planning.

Spousal communication is important in the use of family planning. However, because men and women occupy different gendered spheres within the household, spousal communication is not overly encouraged. The inability of women to discuss fertility preferences with their spouses is caused primarily by socio-cultural ways of being in the household that are enforced by the marriage process itself as discussed in Chapter Two. The extent to which men allow women use contraception thus determines the rate at which maternal mortality and fertility rates decline in Nigeria (Duze & Mohammed 2006; Hamilton 2015; Yeatman 2015). There is a strong body of work that links spousal communication with contraceptive use (Feyisetan 2000; Ogunjuyigbe 2002; Iklaki *et al.* 2005; Meekers & Oladosu 1996; Bawah 2002; Hartmann *et al.* 2012; Sharan & Valente 2002; DeRose & Ezeh 2010). These studies have shown the role men play in women's ability to achieve better reproductive health outcomes. In addition, Duze & Mohammed (2006) argue that men rationalize the use of contraception for spacing purposes only, rather than to limit the overall number of children. This links back to the insurance strategies described in the study by LeGrand *et al.* (2003) and suggests that men prefer the security of the option to have more children in the event of experiencing infant or child mortality.

While these studies suggest male dominance in spousal communication, they do not explicitly discuss the nature of that communication. In this respect, this thesis refers to a lack of engagement with communication in terms of its timing, the events that lead to spousal communication, and whether and how communication moves from the level of the household to that of service provision. Linking spousal

communication to the use of contraception is not sufficient to fully understand how women negotiate intra - and extra - household structures in order to achieve their reproductive goals. Research has shown that men often find it difficult to discuss family planning because they are anxious about female infidelity, religious and cultural opposition, fear of infertility as a perceived side effect of contraception and pro-natal desires (Bawah 2002; Orji *et al.* 2007; Izugbara *et al.* 2010; Asekun-Olarinmoye *et al.* 2013). Women, on the other hand, were afraid to discuss the use of family planning because they feared opposition from, and rejection by their husband and the possibility of gender-based violence as a result from resisting control and secretly using contraception (Ogunjuyigbe *et al.* 2005; McCarraher *et al.* 2006; Stephenson *et al.* 2006; Orji *et al.* 2007; Okwor & Olaseha 2010). However, Izugbara & Ezeh (2010) argue that the inability of women to discuss their fertility intentions should not be interpreted solely as a consequence of male oppression and dominance in the household. They stress the strategic ways that women in Muslim communities avoid fertility discussions and use high fertility to increase the allocation of resources to them and their children, prevent the possibility of divorce, and also prevent their husband from engaging in polygyny.

### **3.4.3 Myths and Misinformation**

Myths and misinformation about the effectiveness of contraceptive technology, including its side effects, are a reflection of the quality of family planning services available in any society (Campbell *et al.* 2006). These myths and misinformation operate at the household and community levels to influence what is known about family planning. They also act at the point of service provision to influence people's choices of available methods based on preconceived knowledge of contraception. Studies have shown that friends and family members serve as the primary source of family planning information in Nigeria (Okpani & Okpani 2000; Oye-Adeniran *et al.* 2005). This often indicates that people have access to inadequate information on contraception. Because service providers, particularly in the public sector, do not serve as the primary source of contraceptive information in Nigeria, Monjok *et al.* (2010) argue that this trend has several implications for maternal and reproductive health indicators.

Understanding the transmission of these myths and misinformation is based on the premise that households are porous. People rely on their social networks, including family and friends, to normalize the acceptance of contraceptive use. Many studies have highlighted the role that social networks play in weighing the pros and cons of high parity (Valente *et al.* 1997; Godley 2001; Kohler *et al.* 2001; Campbell *et al.* 2006; Yee & Simon 2010; Ochako *et al.* 2015). The social learning implied here relies on diffusion theory as discussed in Section 3.4.1. Social learning is also gendered as with research showing distinctions in the types of conversation that men and women have within their various circles. While the conversation among men typically centre on family sizes in general, the conversations among women's networks move beyond family sizes to include methods of contraception, sources, side effects and covert use of family planning (Paz-Soldan 2004). This lends further support to the argument that without proper understanding of gender, fertility and contraceptive use cannot be fully comprehended (Dodoo & Frost 2008). Men discuss their fertility with other men; likewise, women have similar conversations with other women. However, men and women do not fully communicate their fertility preferences to each other because of the very highly gendered nature of marriage and marital relations in Nigeria and, indeed, most African countries, as discussed earlier in this chapter and in Chapter Two. This further highlights the problematic nature of spousal communication because it hides the extra-household communication that has a bearing on people's reproductive decisions inside the household.

### **3.5 Conclusion**

This chapter has provided a broad overview of population growth, fertility and contraceptive use, which helps to situate this research in Nigeria. At the chapter's onset, emphasis was placed on Nigeria's role in shaping nationwide discussions on the use of contraceptive technology at community and household levels. Of particular importance to this thesis are structures such as religion and culture that operate at multiple levels to influence the adoption and implementation of national population policies, the acceptance of family planning programmes and the use of contraception in the household. Contextualizing family planning use revealed the

complexity of contraceptive service provision in Nigeria, highlighting the country's dependence on international donors and the private sector in providing healthcare within Nigeria.

Exploring the existing literature on service provision in Nigeria showed the supply-related barriers to contraceptive use, which include issues of cost, medical bias, access to quality services, and myths and misinformation. Myths and misinformation operate at both supply - and demand - related barriers to family planning. They are present in the role of the family and friends in the weighing up of the benefits of contraception, and are visible in the diffusion of inadequate contraceptive information, thus preventing access to contraceptive use at the household level. Demand-related barriers emphasize the influence of religion and culture in women's ability to negotiate their reproductive interests in the household. The evidence presented in this chapter indicates that women's bodies and women's decision-making abilities must be understood within the structures that govern their everyday lives. Decision-making within couples suggests a conversation or discussion about an issue. However, there is a need to apply a gendered lens in understanding whether, who and how of the decision-making process. This is important because of the role of spousal communication plays in predicting the use of contraceptive technology.

This thesis will begin this exploration by further examining the household and revealing the structures that empower men and women within it. Contraceptive decision-making cannot be understood as a rational one-size-fits-all process because people draw on and access different resources and schemas to negotiate decision-making in the household, and this includes the use of contraception. The following chapter provides a detailed account of the methodological approach adopted in this research to examine such contraceptive decision-making.



## CHAPTER 4: CONTRACEPTIVE DECISION-MAKING: A MIXED METHOD QUALITATIVE APPROACH

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### 4.1 Introduction

The focus of this chapter is to provide an overview of the rationale underlying the use of qualitative research methods to facilitate a nuanced exploration of contraceptive decision making in Kwara State, Nigeria. Taking place across two LGAs, qualitative research methods allowed for the use of a phenomenological, philosophical standpoint that stressed the importance of seeing/understanding social reality through the meanings associated with that reality in order to achieve the aims of the research (Schütz & Natanson 1982).

In order to do this, the methods employed were inductive, interpretivist and constructionist. These methods allow for an identification of the structures that create events and discourses in the social world. Inherent in these methods are the roles social actors play in the use of social phenomena to explain their social reality. More recently, constructivism has included the notion of reflexivity. Here, the researcher's own account of the social world is considered and there is specificity in the version of the social reality presented in the research (Bryman 2008). Thus, this research employed the use of semi-structured interviews, focus group discussions, observations and key informant interviews as data collection tools to understand contraceptive decision-making. Sampling within this method was purposive and data analysis reflected thematic techniques (Teddlie & Tashakkori 2009).

This chapter begins with an overview of the research aims and objectives followed by a justification for the selection of Kwara State in Nigeria as the research location and an examination of my positionality in the field. The following sections within the chapter will discuss the use of each qualitative research method including method-specific issues of positionality. This will be followed by sections that discuss data analysis, ethical considerations and limitations of the research.

## **4.2 Research aim and objectives**

As mentioned in Chapter One, the aim of this research is to explore contraceptive decision-making in Kwara, State. The objectives of this research are reiterated as follows:

- 1) To explore men's and women's experiences of negotiating contraceptive intentions as couples:
- 2) To investigate if and how contraceptive intentions are implemented:
- 3) To examine the role of the State in contraceptive service provision.

## **4.3 Research location**

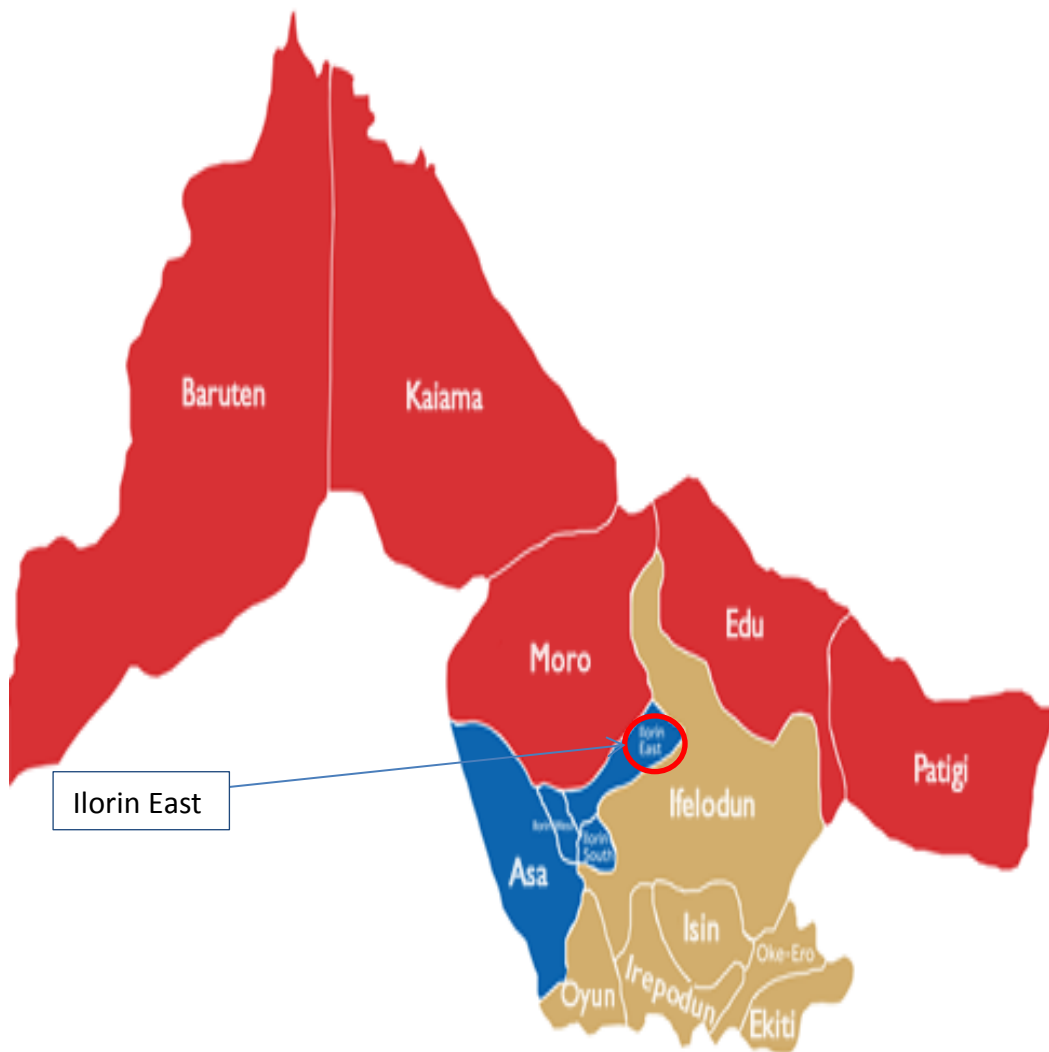
The reproductive health status of women in Nigeria as discussed in Chapter Three suggest marked differences between the reproductive outcomes of women in the Northern and Southern parts of Nigeria. This is such that women in Northern Nigeria report lower use of contraception and account for a higher percentage of maternal mortality in Nigeria. This research was conducted in Kwara State, located in the North-Central region of Nigeria (map in Figure 1.1). It is predominantly a Yoruba-speaking State with large Nupe, Fulani and Bariba tribes as ethnic minority groups residing towards the northern in the State. This is to the extent that the ability to speak the Yoruba language decreases particularly in areas where the Nupe and Bariba peoples reside close to the border with Niger State.

The Nupe and Fulani peoples in the State are predominantly Muslims, while there is an almost-even distribution of Christians and Muslims within the Yoruba-speaking areas of the State. Administratively, Kwara State is divided into 16 LGAs (see map in Fig.4.1) (Kwara State Government 2012). Two of these LGAs, Edu and Ilorin East were selected to reflect the concentration of Nupe, Fulani and Yoruba ethnic groups in the State, and to provide good comparisons and highlight potential differences in the socio-cultural dimensions of contraceptive decision making among these groups. Administratively, Edu is made up of three emirates: Lafiyagi, Tsaragi and Tshonga. Within these LGAs, rural and urban settlements were selected based on population size.

As discussed in Chapter One, Kwara State has a high fertility and maternal mortality rate (Kwara Government 2010; NPC and ICF Macro 2014). Women in Kwara State lack the opportunity to exclusively make decisions on how to spend their income, particularly in situations where the income is less than their husband's earnings. 24.3% of women have control over the use of their income, while 51.3% reported that their husbands controlled how they spent their earnings. Also, 35.5% of women in Kwara State exclusively made decisions regarding their health care, which included the use of family planning (NPC & ICF Macro 2009). With a CPR of 40.2%, 12.2% of currently married women have an unmet need for family planning (NPC and ICF Macro 2014). Ilorin, the state capital, is one of the major cities in Nigeria. Since 2010, the three LGAs (Ilorin East, West and South) that make up the state capital, together with two other major urban areas in Kwara State, have been prioritised for the implementation of a family-planning programme targeted at improving the access and use of contraception among the urban poor in the State (NURHI 2011).

This thesis acknowledges the limitations of defining research locations because doing so artificially separates geographical space and creates time-bound or time-specific data that reinforces power relations between the researcher and the participants. Power relations can be further influenced by the inclusion criteria chosen for the research (Katz 1994). Consequently, the data collected here is not entirely representative of the situation in Kwara State or indeed, the country as a whole, particularly because there are over 250 diverse ethnic groups with different cultures present in Nigeria (NPC & ICF Macro 2014). However, defining the research location and providing context-specific information contraceptive decision-making is important to enhance understanding of contraceptive decision-making in a broader regional context. This is because of some of the effects of social institutions (like gender, culture and religion) on people's lives being similar throughout the region.

**Figure 4.1: Map of Kwara State showing the 16 LGAs**



Source: [http://www.kwarapp.gov.ng/about\\_kwara.html](http://www.kwarapp.gov.ng/about_kwara.html)

#### **4.4 Researching ‘home’: issues of positionality and representation**

Doing ethical development research is challenging especially concerning some of the issues that arise from positionality and representation between the researcher and the researched (Scheyvens & McLennan 2014). These issues have demanded an awareness of the self and how a researcher’s positioning in relation to the research and the participants affects knowledge production and interpretation (Kobayashi 1994; Mullings 1999; Mohammed 2001; Scheyvens *et al.* 2003). Consequently, any knowledge produced in the field must be clearly situated, and the role of the researcher in producing ‘partial truths’ must also be acknowledged (Rose 1993; Mohammed 2001). Acknowledgement is particularly important for researchers

from the global South where they have been tasked with the responsibility of creating new forms of knowledge and speaking *for and about* their communities (see Giwa, 2015). Returning 'home' for fieldwork is, therefore, both professional and personal. Here, researchers have the opportunity to see friends and family and also contribute to academic knowledge about the global South (Sultana 2007; Mandiyanike 2009; Yakushko *et al.* 2011).

Inherent in this position as a researcher from 'home' are a myriad of identities that intersect at different points in the research (Bhopal 2001). For me, this meant a shared nationality, national culture and social ways of interacting with the study population and perhaps, implying that I had unique insights, access to social capital and participants that lent credibility to my research (see Bhopal 2001; Tembo 2003; Oriola & Haggerty 2012). I identified as a young, single, Muslim, Yoruba and middle-class Nigerian. However, there were several degrees of difference between the participants involved in my study that made researching home problematic and me, hence the need to elaborate upon these issues.

Sultana (2007) argues that there is a problematic distinction between the *field* and *home* for researchers from developing countries because of the existence of spatial boundaries between the field and home. In this research, doing fieldwork in Kwara State was by no means home. Although I shared nationality, ethnicity, language and religion with more than half the State's population, I lacked familial ties in these communities. This distance was even greater in Edu LGA where there were multiple degrees of difference in terms of ethnicity, language and, in some cases, religion. Going home in most cases denotes researching from the inside. This position has been questioned because of the degree of closeness to the subject matter researchers experience (Mullings 1999). This thesis acknowledges 'closeness' by looking at decision-making in Edu LGA in order to report behavioral and attitudinal differences between both groups and encourage more reflexivity (see Tembo 2003), in addition to the rationale provided in the previous section.

Regarding the issue of language and communication with participants, the Yoruba language, was used to interact with participants who lacked both English language

and Nigerian Pidgin English speaking skills, as was typically the case in Edu LGA. This was done, in part, to access the original dialogue, foster relationships with the participants and limit some of the effects of translation in the research (Bujra 2006). Another degree of difference is in the privileged position of scholarship especially for researchers attached to Western universities. This position reflects access to resources that is further compounded with variables such as gender, class and age (Rose 1997; Scheyvens *et al.* 2003), and questions the privileges associated with researching home.

Presentation of 'self' is important in research. This is even more pronounced for researchers going back home, as this affects both the process of negotiation to obtain potential respondents, and the actual interview process itself (Mizra 1998 p.83). Presentation of self here may involve an act of performance, especially in situations where religion acts as a source of commonality between the researcher and the researched. Although I identified as a Muslim woman, I had personal opinions on ways of identifying as a young, single Muslim woman. I typically wore Western<sup>3</sup> clothing with a headscarf, but I found that when I was in Kwara State I consciously dressed in more conservative traditional attire, with head scarves similar to the hijab, in order to gain the confidence of my participants and negotiate access within the community (see also Nazneen & Sultan 2014). This attracted less attention to the differences in the way I 'performed' being a Muslim woman, and to the socially expected ways of performing religious inductions and social beliefs around the perceptions of young Muslim women's bodies in these spaces. It also allowed me to lay claims on cultural notions of decency within these communities.

My marital status and age had an effect on collecting contraceptive information and on everyday interactions with most women participating in the study. I observed that being a young unmarried woman and asking women of my age and older about their fertility engendered some credibility concerns about my legitimacy in knowing

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<sup>3</sup> Western clothing is a contested term particularly when negotiating the identity of Muslim women. This thesis acknowledges the debates on the role of dress in the construction and contestation of group identities (see Dwyer 1999; Hansen 2004) and engages with these debates through an exploration of the ways in which I used dress to negotiate and perform my identity as a young Muslim woman.

and asking about issues relating to contraception. In such scenarios, my research assistants (see Section 4.6) were useful not only as gatekeepers but also in balancing out the effects of age and marital status in the study, especially in situations where these assistants were married with young children who accompanied us during fieldwork. This lent some credibility to my presence and dissolved some of the power hierarchies. However, the presence of these research assistants had an unanticipated effect on interactions during some of the interviews, and this will be elaborated upon in later sections (see section 4.5.1).

The following section provides a description and analysis of the methods used in data collection and begins with a discussion of the household survey used in purposively sampling the participants for the semi-structured interviews and Focus Group Discussion (FGD). Subsequent sections explore the qualitative methods used in this study. Within these methods, this thesis used extracts from my research diary to provide illustrations of how I performed (aspects of my identity that were accessible to me) and maintained certain aspects of my identity in the field, as well as cases of 'slipping' from the norm and the negotiation of these identities during data collection.

#### *Household Survey*

A sample survey was used to provide an assessment of the fertility preferences and contraceptives practices of couples in households in both Edu and Ilorin East LGAs. However the results were not analysed in this thesis. As discussed in Chapter Three, household structures in the Nigerian context are complex and may require an analysis of the presence of extended family members within the home. Thus, this survey adopted the household definition provided in the 2008 Nigerian Demographic and Health Survey (NDHS) which states that a '*household is a person or group of persons, related or unrelated, who live together and share common cooking and eating arrangements*' (NPC & ICF Macro 2009). This study has acknowledged some of the tensions in establishing the head of the household in Chapter Three and defines the position of the 'head of the household' firstly, on the authority over the home given by the marriage institution, and secondly, on economic contributions to the home (Randall, Coast & Leone 2011). The sampling

frame for the survey was drawn from couples in which the wife was within the reproductive age group of 15 to 49. This was because marriage, exposure to sexual intercourse and, consequently, the risk of pregnancy are some of the proximate determinants of fertility (Bongaarts 1978). This study however agrees with Yeatman's (2015) suggestion that 44 years of age is now becoming the upper benchmark for fertility statistics because fewer pregnancies occur in perimenopausal women. Because of the age group scale used here, the upper benchmark for this thesis is 45 years of age.

The population of women within the reproductive age group in Kwara State was 574,454 in 2010 and the State reported an estimated annual growth rate of 3.4% (Kwara State Government 2010). Therefore, the 2012 estimate for the number of women within this age group was 593,985. A total of 400 households (with a 95% confidence interval) with a margin of error of +/- 4.9% were sampled in the survey. Kwara State is divided into 16 LGAs (Kwara State Government, 2012). Using a cluster sampling technique, sampling occurred through the following sequence (Bryman 2008):

- Two LGAs (Edu and Ilorin East) were selected based on the distribution of the three ethnic groups to be studied;
- Within each LGA, several rural and urban settlements were selected based on their population size;
- 100 households were then selected within each of these settlements using a randomly chosen number between 1 and 10 as a starting point. Thereafter, every fifth household was sampled in each settlement.

A total number of 480 households were approached to achieve the desired sample size, and the response rate was estimated at 83.33%. The non-response rate (16.67%) covers households that refused to participate in the study and households that lacked the presence of either the husband or the wife/wives in the household due to occupational or social commitments at the time of the survey. The survey provided background information, informed consent and contact information that



served as a basis for purposive sampling for the semi-structured interviews and Focus Group Discussions (FGDs). The participants for the semi-structured interviews and FGDs reflected diverse socio-economic characteristics and contraceptive practices (use/non-use of contraception and forms of contraception used) among couples with wives of reproductive age. The sample drawn reflected each location (Edu and Ilorin East) and settlement (rural and urban) within the case study.

#### **4.5 Qualitative research methods**

The section above reflected on issues around conducting research at 'home' and elaborated upon the complexity of positionality and power relations for researchers from the global south. This section moves on from this by using various qualitative research tools and multiple locations (Edu and Ilorin East LGAs) to provide a description of the decision making process in Kwara State. Also, the use of multiple locations provides a basis for comparison to highlight the uniqueness of each LGA (Geertz 1973; Stake 2000). Interviews (Semi-structured and Key-Informant), Focus Group Discussions (FGDs) and Participant observations were used to address research questions that sought to explore men and women's experiences of negotiating contraceptive decisions in the household, investigate the agency attached to the implementation of contraceptive decisions and examine choice and the role of service of service providers in the decision making process. All the data collected through these different methods were complemented with extracts from the research diary. Fieldwork for this phase of the study was undertaken between October 2012 and August 2013. The participants involved in this study were sampled purposively from a household survey conducted between November 2012 and January 2013. Purposive sampling involved identifying individuals or groups of individuals who were knowledgeable about or had experiences with the subject matter (Patton 2002; Cresswell & Plano Clark 2011; Palinkas *et al.* 2013). In addition to this, Bernard (2002) notes the importance of the availability to take part in the research, and the ability to communicate and reflect on knowledge and/or experiences with the subject matter.

#### 4.5.1 Semi-structured interviews

Burgess (1984, p102) aptly describes interviews as ‘conversations with a purpose’. Interviews differ in their structure, format and formality depending on their ability to address the research questions and methodological position (Willis 2006). This research employed the use of the semi-structured interview because it is flexible yet guided and allows participants to ascribe meanings to phenomena (Kitchin & Tate 2000; Willis 2006; Bryman 2008). It also permitted the use of an interview schedule/guide that provides the interviewer with the freedom to probe and the interviewee with the freedom to articulate their responses (Willis 2006). The use of interview guides determines the structure and agenda of the interview through the kinds of questions asked. However, participants can control the amount of information provided in responses depending on how the questions are asked and the sensitivity of the issues raised (Corbin & Morse 2003). Because this form of interviewing is flexible, the researcher can move from ‘*how?*’, ‘*why?*’ and ‘*can you tell me about?*’ questions to ‘*and what happened then?*’ to further explore an issue (Anderson & Jack 1998).

The semi-structured interviews were used to explore men and women’s experiences of negotiating contraceptive decisions in the household, investigate the agency attached to the implementation of contraceptive decisions and examine men and women’s experiences with their choice of contraception. A total of 27 interviews were conducted in Edu and Ilorin East LGAs. The profile of the participants involved in the interviews can be found in Appendix I. The participants were mostly couples, women whose husbands did not consent to be involved in the study but allowed their wives to take part and women who engaged in the clandestine use of contraceptive services. The interview guide was developed in English and provisions were made for translation into the local language depending on the needs of the participants. However, all of the interviews were conducted in English, Pidgin English or Yoruba apart from one, which required the use of a translator. Apart from the couple recruited from one of the clinics involved in the participant observation, all other participants were purposively sampled from rural and urban settlements in Edu and Ilorin East LGAs.

The questions included in the interview guide explored issues around general decision making in the home, reproductive health decision making with a focus on family size formations, contraceptive use and access to reproductive health services. In addition, the questions dealt specifically with issues around the motivation to discuss and use/not use contraception, experiences with their individual choice of method and issues around accessing contraceptive services in their various communities. Although the same themes were used, differences existed between couples and the flow of the conversation and questioning was altered depending on the responses during the interview.

Prior to each interview, the overarching aim of the study was explained to each participant. The independent nature of this study was emphasised before every interview and each participant was assured of the confidential nature of all data collected during the course of the interview session. Consent forms were read to each participant in their preferred language to ensure that they understood what they were agreeing to do. A digital tape recorder was used to record the interview sessions. This allowed the researcher to concentrate on the interview, take notes on the interview process and provide an accurate record of all the issues discussed during the session. Participants were asked before the device was used and consent was sought again when the device was turned on. Willis (2006) and Longhurst (2010) stress the importance of the location in which the interviews take place as this has an effect on the willingness of participants to engage in discussions around the subject matter. The interviews were mostly conducted in the homes of the participants or at their business establishments and/or offices. Other interviews were conducted at the local health care facilities, especially in Edu LGA. This was done to ensure privacy and confidentiality for the participants because conversations around family planning were not overly encouraged in these communities and health care facilities provided a neutral location that would avoid unwanted attention. The interviews lasted between 45 minutes to one hour.

The question of whether the research assistant should be present during the interviews was a double-edged one. Because of the nature of the study and the fact that most research assistants employed in the study were firstly members of the

community and, secondly, provided some form of health care service within the community, their presence during the interview raised some issues around the politics of access and trust both for the researcher and the research assistant. Their presence was based on the preference of the participants. However, most of the interviews happened in the absence of the research assistant as the participants trusted me enough to take part in the research and rapport was built over time through text messages and occasional visits when passing their communities. In these instances, the role of the research assistant was limited to gatekeeping and they were, therefore, asked to come back at the end of the interview or convene at a suggested meeting point. Other interviews took place in the presence of the research assistant. This was at the participant's request and also if the interview required the use of a translator. Overall, their presence often eased the interview process for the participant but not necessarily for the researcher.

Building rapport and sharing information is an important feature in qualitative research. These features enabled the researcher to engage with the participants, ease the flow of conversations and consequently affect the quality of data produced. Such engagement involves the use of non-demographic characteristics as a point of departure and reinforces the identity of the researcher (Apentiik & Parpart 2006). These characteristics influenced the interview process, particularly in scenarios in which I interviewed older Yoruba women in the presence of my research assistant. During these interviews, I observed that the women talked above me and spoke directly to the research assistant. This was also evident in situations where the women accessed contraceptive services from the facilities the research assistants were associated with. In these scenarios, my position as interviewer was reduced to one that guided the interview but who was not centrally involved in the conversation with the participants. Here, performing to cultural expectations based on my age, marital status and ethnicity influenced the interview process. My position as young woman implied that I was not eligible to have conversations around reproduction and contraceptive use more so because I was unmarried and without children.

By contrast, the research assistants were of similar backgrounds and more importantly, were married with children and had social relationships with the women because of their role as health-care providers in their communities. Additionally, shared ethnicity meant I understood the cultural implications of intervening when older women were speaking. In researching Indian women's activities in Uttar Pradesh, Thapar-Bjorkert (1999) reported similar experiences in interviewing older women as they would sometimes treat her 'like a little daughter' during an interview. She suggests that insider researchers are obligated to respond to the moods and behaviours of respondents because of the commonalities that grant status, and queried whether such behaviour would be extended to researchers of European heritage or outsider status. Indeed, I observed differences in behaviour during the interviews with most participants in Edu where I had less similarity of ethnicity and culture. As an outsider, I had achieved guest status and, as such, participants seemed much more eager to engage in conversations with me.

Comfort in solidarity and acceptance can also impede the research process as participants make assumptions of understanding and therefore, fail to elaborate fully on their lived experiences (Dwyer & Buckle 2009). In researching the contraceptive decision-making processes within the home, participants often made an assumption about the researcher's understanding of 'our people' (*'you know how our people are'*) or a gendered understanding of women (*'you know how troublesome you women can be'*). The former phrase was used in trying to explain experiences of accessing contraceptive services in localities where public knowledge of contraceptive use is sensitive within the community, and the latter in discussing experiences of negotiating fertility preferences and the use of contraceptives in the household. It is in scenarios like this that questions of objectivity and reflexivity come into play. Regardless of the similarities between a researcher and the research community, there are personal views and life histories that shape people and thus differentiate the researcher and the researched (Apentiik & Parpart 2006). More problematic is the notion of a gendered understanding of 'troublesome' women, women that do not conform to the norm and women who attempt to exercise their agency within the home. It can be

suggested, tentatively, that the notion of shared understanding might arise from my positionality in the research. Being an unmarried woman in higher education is not particularly common in this society, a situation that is further exacerbated by researching a sensitive issue like contraception. It was in scenarios such as these that I professed a lack of understanding and asked participants to elaborate on their responses in order to avoid perceptions or assumptions that might cloud the research.

This study acknowledges the tension between conducting joint or separate interviews with men and women (Valentine 1999). Separate interviews were thought to be more appropriate given the social context and subject matter as they provide participants with the freedom to express themselves, especially in situations where they might be doing something without their partner's knowledge (LaRossa *et al.* 1981). It would have also provided an opportunity, especially for women, to talk about some of the challenges of engaging in conversations about their fertility and other issues that contextualize the decision-making process. This was not the case, however, as only a few interviews were conducted separately with men and women. Most of the men involved in the study did not consent to having separate interviews as they expressed the need to be present when their wives were interviewed. *'What you want to say to her you can say to me too'* or *'you can interview us together, we are the same thing'* were some of the responses given to the researcher when asked if the interviews could be conducted separately. While this situation limits the voice of women, especially in cultures where husbands are revered and women do not commonly speak in their presence, it demanded more engagement with the participants so that women aired their opinions and versions of the 'truth' as much possible during the interview process. In addition to this, conducting couple interviews granted access to some of the couple dynamics and communication (both verbal and non-verbal) that proved useful in understanding women's agency and contraceptive use in the household.

My research diary was an important tool during the interviews because it assisted reflexivity and documented some of the power dynamics between couples that were demonstrated during the interviews. Women's responses were often

complementary to those provided by the husband, particularly during sections of the interview that focused on gendered division of labour in the home and issues around their experiences with the use of contraception. However, these complementary responses were more common with couples in Edu than in Ilorin East for cultural reasons. In Edu, women are expected to follow patriarchal codes of behaviour by speaking after the husband has spoken and to mirror his responses because he is the head of the household. This however should not be interpreted that women in Edu lack the agency to participate fully in discussions.

Because of the length of time spent in the field, the study was able to track women going through different stages of their reproductive lives. Women who were not using contraception at the time of the interview due, for example, to pregnancy could talk about their experiences with their method of choice and how and when they were re-negotiating the use of contraception and, perhaps, potential changes in the method used. Other interviews coincided with some women experiencing the side effects of their method of choice and engaging with the research assistant about their concerns. The table in Appendix II shows the background characteristics of the participants recruited for the study. The names provided are pseudonyms for the sake of confidentiality and are used throughout Chapters Five, Six and Seven.

#### **4.5.2 Focus Group Discussions (FGDs)**

Focus Group Discussions were used in this study to complement and strengthen the narratives from the interviews. They were used to examine group/community perspectives and dynamics on the role men and women play in negotiating their fertility interests in the household. FGDs are useful in highlighting social dynamics and the ways in which people collectively make sense of a particular phenomenon and construct meanings around it (Bryman 2008; Kamberelis & Dimitriadis 2008). As qualitative research tools, FGDs rely on the strengths of interviews and observations and are thus conversational and observational (Morgan & Spanish 1984).

Group discussions serve as a unit of analysis by generating joint polyvocal texts that allow the researcher to see the ways in which people position themselves with each

other as they try to articulate questions, issues and topics in focused ways (Kamberelis and Dimitriadis 2008). The data produced in these interactions reveal social and cultural contexts for individual beliefs (Green & Hart 1999; Kitzinger & Barbour 1999) as the conversation generated is a mixture of personal beliefs and available collective narratives that underlie the personal circumstances of participants (Warr 2005). FGDs limit the role of the researcher to that of a facilitator/moderator, allowing the researcher to observe group dynamics and housekeeping rules that can affect the outcome of group discussions (Bryman 2008; Longhurst 2010).

The participants recruited for the FGDs were purposively sampled from the survey as discussed in section 4.4. Eight FGDs were proposed, each consisting of six or seven participants, with each FGD lasting for up to 90 minutes. The groups were to be divided to allow for participants from each LGA, rural/urban settlement and gender. In total, five group discussions made up of between five to eight people were conducted. This reduction was due to conflicting schedules between participants and, also, lessening interest among participants in participating in the research which stresses the earlier point made by Bernard (2002) about availability and willingness to participate with the phenomenon under study.

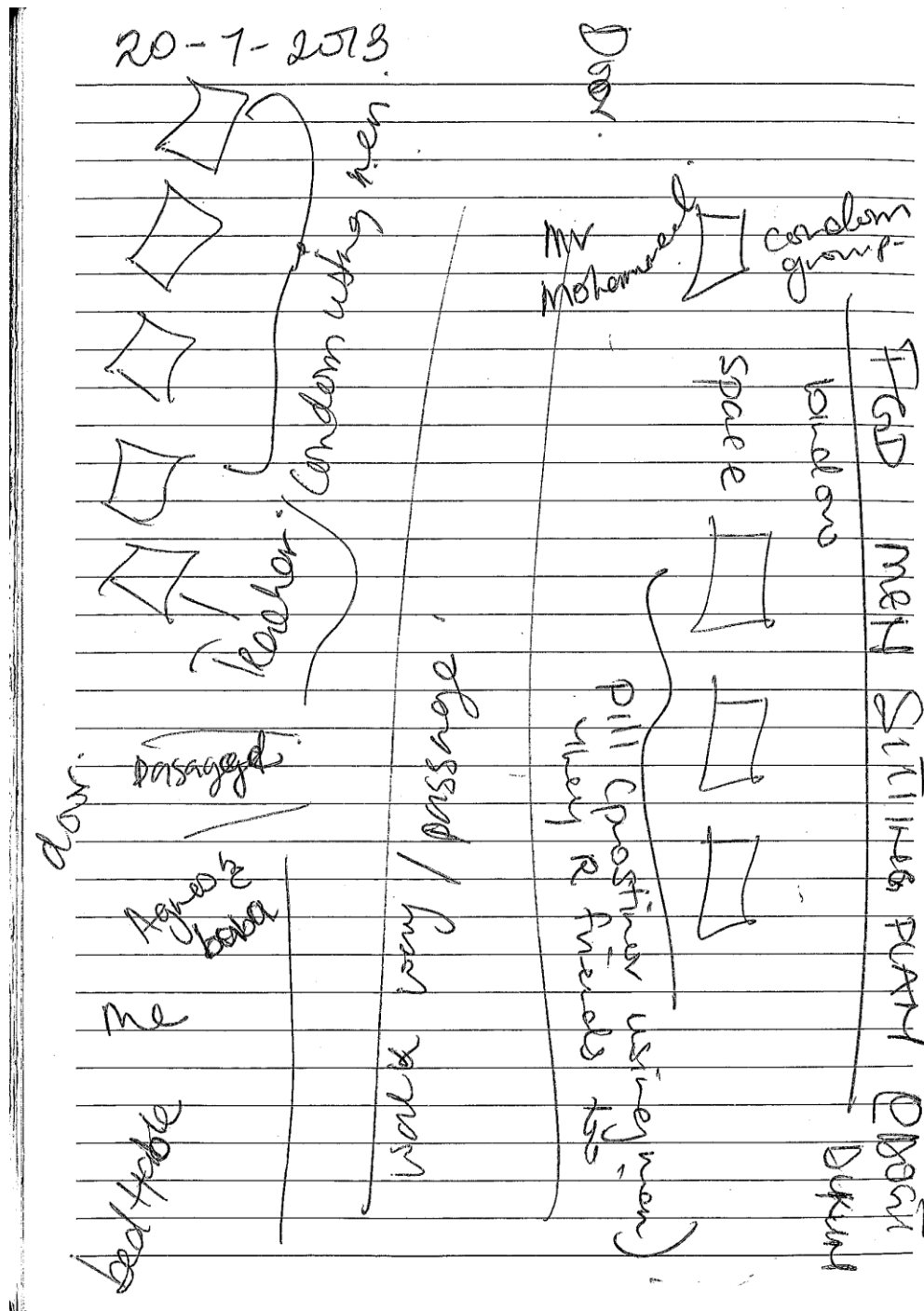
It is important to note one of the challenges faced during the organization of these group discussions. In practice, the group discussions were as follows: four sessions in Edu (two male and female groups in each settlement) and one session in Ilorin East (an urban and mixed gender group). A mixed gender group was conducted only in Ilorin East because many of the participants who consented to, and agreed upon, the scheduled day and time of the session were absent or turned up with one or other partner missing. The number of participants present made the proposed group sessions too small to be conducted as separate groups based on gender. Consequently, improvisations were made and a group session containing a mix of men and women was formed, making this mixed group the only group discussion session in Ilorin East.



The mixed group session further enhanced the understanding of power dynamics and interactions in focus group discussions. Men and women have different spheres of existence in Muslim communities and this was evidenced in the seating arrangements of this particular session. Men and women sat in different areas in the location used for the session and it was observed that women waited for the men to speak first before they contributed to the discussion. Because of this, I guided the conversation to allow this 'natural' flow but probed more and permitted the conversation to last slightly longer when women were contributing to the discussion. It was, however, interesting to see how men and women - either as a couple or with one partner absent interacted with each other and explored issues based on the subject matter, particularly on the issue of polygamy. Here, women were quite vocal on their fertility preferences and strategies, even in the presence of their husbands. This, as well as the interactions in the other FGDs, drew attention to the power dynamics within group discussions (Morgan 1998).

My role as moderator was heightened during the male group discussion in Urban Edu. Here, there were a few conflicting personalities that affected the tone of the discussion especially among older participants who sought to be the 'voice of authority' in the discussion. In this scenario, I took a more active part in the discussion in order to direct cues to every participant, ensure that all voices were heard and manage dominant personalities to limit their control over the discussion. Both female group discussions were largely conducted in the local language (Nupe) by the research assistant which was problematic as the researcher was distanced from the original scripts and dialogue during the discussions (Squires 2008). In anticipation of this problem, transcripts and translated data were crosschecked by an independent translator and the research diary was useful for documenting non-verbal communication and other forms of interaction during the sessions. However, because the Yoruba language was used occasionally by participants, the researcher was not entirely excluded from the conversation. Power dynamics observed during these discussions differed between groups.

Figure 4.2: Seating arrangements of the male FGD in a rural settlement in Edu.



Source: Research Diary, 2012

Group discussions allow an analysis of communal and collective fertility practices. This was particularly obvious during the FGD at a rural settlement in Edu LGA where men not only sat close to people they knew but also close to people that used the same method of contraception as evident in Figure 4.2 above. This arrangement revealed plural voices and attitudes and permitted the observation of collective

human interactions (Madriz 2008). In addition, it proved useful in illustrating how friends and family members serve as a source of both contraceptive knowledge and contraceptive technologies. More importantly, it elaborates on the complexity of the decision-making process and highlights the intersection between community politics and women's ability to participate in the decision-making process, all of which will be analysed in Chapter Five and Six.

#### **4.5.3 Participant Observation**

Participant observation was a useful research tool in understanding the role of service providers in the decision-making process. It allows for an exploration of the way participants construct contraceptive knowledge, the language used in describing contraceptive methods and an observation of client-provider interactions can highlight embodied practices and behaviours that may not be provided in interviews with service providers (see Richey 2004) (Mason 2002; van Donge 2006; Crang & Cook 2007; Laurier 2010). Consequently, the knowledge produced by 'looking around' and engaging with the community provided linkages in identifying the key stakeholders involved in family planning service provision. As a direct tool for researching people's lives, participant observation offers directness in seeing what people do as opposed to listening to their views or attitudes about a particular phenomenon (Robson 2002). Burgess (1981) suggested the use of research diaries to provide detailed accounts of observations. Research diaries can be used to record substantive, methodological and analytical field notes, generate data to complement interviews and serve as means of comparing observational and interview data. This is particularly important because there might be discrepancies between what key informants say about the subject matter and an account of the situation at the time of the research based on observational data.

Methodologically, the research diary provided accounts of the circumstances in which the observations were made, my role as a researcher, ethnographic location and how the key informants were selected for the research (Burgess 1981). Ethnography was carried out across two sites in Ilorin East but none in Edu LGA. This was because of the ways in which contraceptive services were accessed in the area. Many community members rely on a network of friends, associates and

service providers both in the private and public sector, to access contraceptive services discretely as members of the community do not overtly support their use in Edu. In Ilorin East, tertiary (Federal Government) and primary (Local Government) health care institutions were selected. This was done to reflect the sources of funding and level of engagement with the community with regards to health care delivery. The two facilities have been assigned the pseudonyms Local Clinic 1 and Local Clinic 2 in the subsequent results chapters. Their selection also provides a comparison between clinics that receive contraceptive commodities from the same NGO and therefore, an analysis of the costs, practices and interpersonal communications between individual hospices and their clients.

The observations at both sites officially began overtly in mid-October 2012 and ended in August 2013. At both sites I was formally introduced to other staff members in both clinics and to clients at the start of the day's activities. My research diary was used to provide substantive and analytic accounts of a series of conversations, both informal and formal, for questions and clarifications, as well as taking notes of all the activities observed within the public spaces in both facilities. In addition to this, some photographs were produced alongside the field diary. The knowledge produced during observation is situated within the confines of, and engagement with, what is considered 'public' in these spaces. The earlier stages of the observations included informal conversations that complemented observed activities in these facilities. These conversations were used to clarify some of the events and practices that were useful in situating the decision-making process.

Entering these public spaces as an observer requires an awareness of some of the methodological implications especially the situations where the researcher is classed as 'one of their own' (Haniff 1985). The issue of representation provides a hidden dilemma for insider researchers in so far as there is a heightened awareness of the impacts that *'any false representation of the phenomena, either real or perceived, could lead to feelings of betrayal on the parts of participants'* (Labaree 2002, p.109). Hertz (1997) and Nadin & Cassell (2006) suggest the use of research diaries as a means to create spaces where researchers can be reflexive of the research process, particularly when conducting independent research. Because of

the potential danger of self-absorbed reflection of the research process, DeVault (1997) stresses that reflexivity should be applied only in relation to making analytic inferences in the study. Furthermore, Nadin & Cassell (2006) point at the implications of reflexivity in praxis in the context of a researcher's position in the research process. This was very important at this stage of the research because there was a tendency to overlook some practices due to my familiarity with the challenges faced in healthcare service delivery in Nigeria and only observe things that were seemingly out of place.

During observations at one of the sites, I was asked by the service provider to shed any foreign acquired ways of being and doing resulting from my educational background and contextualize the situation in the facility based on the technology and resources available. As *arà ilé* (one of our own<sup>4</sup>), the researcher was responsible for telling a different story and extending the analysis beyond pre-determined boundaries of population policy discourse by contextualizing these activities within the dominant discourses around population policies and service provision in the global South. The issue of representation also extends to the area of integrating one's self into these public spaces. Participant observation requires a measured and methodological way of sharing information and building rapport that is perhaps even more pronounced for researchers that share more than one degree of commonality with the researched. This includes an attention to modes of dressing and other significant social norms (Brydon 2006; Hay 2010) that require some act of performance on the part of the researcher in order to fit in. So, 'slipping out of character' by, for example, wearing Western clothing and showing the researcher's difference within the group was not acceptable even on days when the researcher was not in the field because of the socially accepted ways of being a young Muslim woman in these communities.

As an observer, I was able to strategically listen to and observe client-provider interactions without being part of the conversation. Gradually, I gained the status of 'student' and it became easier to introduce my presence at these facilities to

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<sup>4</sup> A community sense of home is implied here.

other non-departmental staff. For clients who arrived later in the day, I made sure introduced myself before they engaged in conversations with me based on the notion that I was either a staff member or a potential client at the clinic. This was done to avoid clients revealing confidential personal information. This usually occurred later in the day or as new clients came arrived at the facility. Additionally, over time, observations began to lose shock value and practices became predictable as, for example, clients could be given their injections in the waiting area in front of other women. Predictability also meant that staff members knew the particular day of the week I was likely to come to their facilities thus, I occasionally attended clinic on different days of the week to make comparisons between daily procedures and provide a more nuanced version of its daily activities and practices. Note taking in my field diary during the observations raised a few concerns about trust as, sometimes, members of staff asked the researcher about the contents of the field diary. In order to avoid any potential conflicts or confidentiality issues, the field diary was never left unattended.

The observations were also supposed to serve as a recruiting point for the exit interviews after the counselling sessions. This was to capture a client-centred experience of using contraceptive services and explore how they chose their method of contraception if they opted for family planning. Although, over time, rapport was built with a few clients based on the number of times they had encountered the researcher at the facility, it was still challenging to recruit participants for the exit interviews because of the length of time clients spend accessing services and, for those who did consent to being interviewed, it was difficult to secure the interview due to scheduling conflicts. Overall, one couple was recruited and their exit interview was incorporated into the semi-structured interviews in which they also participated.

#### **4.5.4 Key Informant Interviews**

Key informant interviews are qualitative in-depth interviews with people who have first-hand knowledge of what is going on in the community in the case of this research. This is important as they can provide insights into the nature of problems and the beliefs of community residents around the subject matter (Bryman 2008).

These interviews, although important, are still subjective opinions of these key informants. In this research, these interviews elaborated upon discourses around service provision and the roles different stakeholders play in shaping knowledge around contraceptive behaviour outside the household. These interviews were conducted with professional stakeholders involved with service provision at different levels. In total, seven interviews were conducted with Local Government health officials in both Edu and Ilorin East (the interview with the health official from Edu LGA involved a series of informal conversations); service providers at primary and tertiary health care institutions in Ilorin East; the Kwara State family planning co-ordinator; the State Director at the local NGO working closely with Ilorin East LGA; and service providers at one of the local hospitals in Edu.

These interviews were fairly easy to organise, primarily due to the length of time spent in the field and to having engaged with the communities long enough to determine what services were available and who was providing them. The interviews with the different stakeholders were used to compare and complement the data collected during the participant observation and to obtain formal accounts from the service providers at the sites of data collection. They were also used to provide links to some of the changes observed during the participant observations at one of the data collection sites. The atmosphere during the interviews was formal and each lasted for between 30 and 60 minutes. All interviews were recorded digitally with consent from the interviewees. Recording elite interviews provides a verbatim account of the interview and allows the interviewer to engage with the participant (Byron 1993; Richards 1996). However, the recorder presented some trust issues during the interviews as some service providers and Local Government officials were conscious of its presence and chose their words carefully. These providers also asked to listen to the contents of the recording after the interview. Harvey (2011) argues that the benefits of recording elite interviews must be weighed against its disadvantages, particularly because off the record information about the subject matter might be lost due to the presence of a recording device. Losing potential off the record information from these interviews was not an issue for this research because the data collected supplemented the

participant observations at the associated facilities. By providing a cautious account of the 'truth' thanks to the presence of the recorder, the interviews provided some contrasting accounts of what was observed during the participant observation and what was said during these interviews, especially pertaining to the cost of contraceptive commodities.

#### **4.5.5 Data Analysis**

Data analysis is an on-going process in qualitative research (Taylor & Bogdan 1998 p.128). In this research, data analysis began during data collection by reading through field notes and observations and listening to recordings of the interviews. This allowed for a preliminary analysis and cross checking of the information during fieldwork. Full data analysis commenced after data collection and began with transcription of the observations in the field diary, interviews and focus group discussions. As described above, some of the FGDs were conducted in the Nupe language and required translation into English. Independent translators were used to examine the transcripts (back translation) to check for irregularities in the documents produced (Edwards 1998). Although time-consuming, I transcribed all other data. This was done to get familiar with the dialogue, making note of hesitations, use of sarcasm, pauses, laughter and proverbs to make commentaries (Jackson 2001) especially in situations where participants were talking about sex or female body parts (see Abdul and Halima in Chapter Six). Confidentiality was maintained by blacking out sections of the quotes when presenting individual verbatim responses and/or when the identity of the participant was obvious in the text. All quotes used were left as spoken without making changes in grammar and use of Pidgin English in the texts. All transcripts were placed in Nvivo to store, organize and ease retrieval of codes when necessary (van Hoven 2010). The data from the participant observation in the form of extracts from the research diary were also coded and included in the analysis.

Thematic analysis was the form of qualitative analysis used in this study. As a form of narrative analysis, it was useful in identifying, analyzing and reporting recurring patterns within data (Boyatzis 1998; Bryman 2008). Pattern/theme recognition in seemingly random information, consistent and systematic coding of data and



conceptual interpretation of data are some of the underlying competencies needed for thematic analysis. By making use of descriptive (and this may include 'in vivo') codes and analytical codes, coding the data 'encourages a thorough analysis of the transcripts', thus avoiding 'cherry-picking' of data (Jackson 2001 p.202; Cope 2010). Emerging themes and subthemes are products of iterative analysis of transcripts and field notes and are linked to broader literature around the subject matter. These emerging themes provide the foundation for Chapters Five, Six and Seven for crosscutting themes throughout the whole thesis.

#### **4.6 Ethics and limitations of the research**

This research was covered by the ethical clearance obtained from the University of Sheffield. Conducting ethical research requires an awareness of what ought to be done in research and how our actions as researchers affect the lives of people and places involved in our research. Ethical considerations range from an awareness and positioning of the researcher (see Section 4.4) to informed consent, confidentiality and codes of conduct (Brydon 2006; Hay 2010). Because of the sensitive nature of the subject matter, anonymity of the participants involved in the study was crucial.

Gaining informed consent involves providing information about the research to participants with an emphasis on what is required of them as participants and of the boundaries of the research in terms of what it can and cannot do. This presented some issues in the field as some potential participants asked if they would receive monetary compensation for participation and would not consent to taking part in its absence. One unanticipated dilemma relating to the issue of compensation was receiving gifts of food when entering participants' homes and involving them in the research. These acts of kindness were appreciated but made me uncomfortable and raised some emotional concerns about taking 'too much' from these participants. To ease some of these tensions, all gifts received were passed to people in need in communities far away from those involved with the research.

The ethical dilemmas of 'giving back' have been debated within geographical research. What constituted 'giving' in this research placed me in a situation where I set the standard for other academic researchers who then have to follow established relationships rather than me contributing to issues of 'post-colonial dependency' (Sultana 2007; Staddon 2014). In respect to this, all the participants that agreed to be interviewed or involved in the FGDs were given items of food such as pasta and wheat flour, firstly, because the interviews occurred during preparation for the Ramadan fast and, secondly, because participants took time off from their livelihoods to take part in the study. The food items cost less than one British Pound and were sourced from local markets, other participants and research assistants that sold food items.

The participants that were involved in the interviews and FGDs were reminded about the confidential nature of the study and were assured of anonymity where parts of their dialogue were introduced into the thesis. Thus, all the names and identifications used within this thesis are pseudonyms. With regard to the participant observations, informed consent was sought, firstly, from the health service providers at both sites and, secondly, in every observation the researcher was present at. However, it is important to recognise the difficulty in gaining consent in spaces such as these. Thus, in situations in which participants attempted to initiate conversations with the researcher, the researcher clarified her presence and introduced her research before any information exchanged could breach ethical research practices. Although the observations were limited to the public spaces within the clinics, the researcher could not ethically approach and recruit participants for the exit interviews within the health care facilities. Potential participants were to be recruited outside this space and given the long length of time clients often spent at the clinic when accessing services, it was difficult to approach them outside the clinic and engage their interest in the research. Successful recruitment of clients required a prolonged exposure to the researcher in order to generate trust. Four participants were recruited from one of the facilities but due to scheduling conflicts only one of them was included in the study (see Emeka and Adanna in Appendix I). This served as a limitation on the study

because client-centred experiences of accessing and using contraceptive services from these facilities have the potential to further illustrate the concept of informed choice in the decision-making process and supplement the data from the observations.

Working with research assistants presents a set of dilemmas that are layered in power and wealth inequalities especially for non-native researchers (see Molony & Hammett 2007; Hammett & Sporton 2012). However, the power asymmetries for researchers from 'home' are quite different and should be elaborated upon. Local ways of performing community obligations were important in the relationships between me and my participants, partly because of the ways in which social networks ease access into the field and forge a sense of community and cultural solidarity. Here, researchers are expected to 'appreciate' research assistants and members of the community, beyond the agreed-upon financial remuneration for services, in ways that non-native researchers are not expected to. These can include favours and/or promises regarding the potential outcome of research, promise of scholarships and other forms of financial aid (see Ite 1997; Mandiyanike 2009). '*Olowo ti n fowo sanu*' is a local saying within my ethnic group (Yoruba) about the rich showing mercy with their money. Being a student from a Western university is a privileged position, signals access to resources that most community members' lack and can lead to situations where research assistants make certain demands based on obligations to community. In an attempt to mitigate some of these requests, the researcher relied heavily on her personality (see Moser 2008) and used every-day coping mechanisms common to most people in the community to deflect requests for assistance above and beyond my ethical positioning as a research student.

#### **4.7 Conclusion**

A multi-method qualitative approach was adopted to address the aim of this research. Field work started with the participant observation, followed by the more in-depth interviews and FGDs. This permitted a nuanced understanding of the subject matter. Field notes in the research diary complemented the data collected at each stage of the research. The importance of reflexivity on the outcome of

conducting ethical research was emphasized here, particularly because I was researching 'home'. Reflexivity called for greater sensitivity to power relations between researchers, the researched and local codes of behavior, details of which have been discussed in relation to particular research tools. These issues have an effect on data analysis and the interpretation of results reported throughout this thesis. The following chapters provide an analysis and discussion of the results of the data analysis and begin with Chapter Five where couple dynamics in relation to contraceptive use among couples will be discussed in detail.

## **CHAPTER 5: COUPLE DYNAMICS AND WOMEN'S AGENCY IN THE USE OF CONTRACEPTION**

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### **5.1 Introduction**

Women's contraceptive decision-making depends upon their ability to negotiate their fertility preferences with their partners. The ability to negotiate these preferences relies heavily on the socially constructed ways of being a man and a woman both as a couple and as members of the community. Identity performance in marital relationships is influenced by the gendered divisions of labour as men and women in the household. The dynamics created by enacting these identities is influenced by marriage and the payment of bridal wealth, culture, religion and patriarchy as discussed in Chapter Two. In this thesis, reproduction and the practices integral to its performance including the use of contraception are examined as part of the gendered division of labour. Doing so allows an analysis of the couple's decision-making processes, the extent to which women can initiate and control discussions about their fertility and how women negotiate and/or resist structures that constrain their reproductive agency.

Therefore, the aim of this chapter is to understand couple dynamics in relation to contraceptive use among couples in Ilorin East and Edu LGAs. This chapter situates the decision to use contraception between public and private structures and institutions that influence the fertility and reproductive practices of couples. The following sections within this chapter draw on data from FGDs and interviews (both Semi-structured and Key informant interviews). These methods allow for individual/couple and group based perspectives, narratives and understandings of contraceptive use in these LGAs. Section 5.2 begins with an analysis of the couples' general decision-making processes and draws attention to the use of gendered scripts to explain partner dynamics and male dominance in the relationship. Section 5.3 examines couple dynamics in fertility decision-making by focusing on which partner initiates, controls and determines the outcome of reproduction. Section 5.4 will discuss clandestine use of contraception particularly in relation to spousal and method related issues associated with using contraception. Lastly, Section 5.5 summarizes the key finding in this chapter.

## 5.2 Couple dynamics in relation to general household decision-making

The ways in which couples relate with each other must be situated within the structures and institutions that govern marital relationships in their communities. These structures and institutions differ between ethnic groups in Nigeria and create the socio-cultural identities of men and women in their communities (Izugbara 2004). Common within these diverse ethnicities is the gendered power relations between men and women in every aspect of their lives. These gendered relations are visible in what men and women are entitled to as couples, in the household and as members of their communities (Connell 1987; Acker 1992; Izugbara 2004; Martin 2004; Risman 2004). Sexual relationships and reproduction are interesting sites for the examination of these entitlements but first, these entitlements must be explored in the most basic and primary form of interaction and performance, which is decision-making in the household. This is important because contraceptive use is often a reflection of the influence of social structures on the wider decision-making processes among couples in the household.

Regardless of the form (husband-or wife-dominated and joint decision-making) in which decision-making occurs, decision-making suggests a dialogue between men and women. What men and women have control over in the household is enforced institutionally by gender and is performed as such in their relationship as a couple. Thus, regardless of the ethnicity and LGAs men and women have clear responsibilities and duties with each partner exercising control over the decision-making process in those areas. The quote below exemplifies the gendered script used in constructing the responsibilities of men and women in marital relationships.

***Faizal:*** *I am the only one that does that all that. That's how it is. That is how God has made it to be. The husband's right is different from the wife. He is supposed to bring money home and I am supposed to use the resources he has brought home wisely. That's how is in the bible and the Quran. God had divided the duties of the man and the wife and therefore we are not supposed to cheat ourselves. We are to do it the right way. So that's why. (Couple interview (urban, Ilorin East): Yusuf and Faizal)*

Women are culturally and socially situated in society on the basis of gender (Connell 1987; Risman 2004) and, as such, they are considered responsible for taking care of the home and the children. According to Faizal, performance is

embedded in the cultural and religious notions of women as wives and as mothers. For women in this research, performing these roles empowered them socially within the household and also within the community. Because of this (see quote above), women have absolute control over decisions regarding the physical and emotional aspects of reproductive labour. It is important to note here that control over reproductive labour does not include control over sexual relationships and fertility outcomes with their partners. This is because of the politics of bodily ownership that confers the rights of women's bodies to their husbands upon marriage as discussed in Chapter Two (Izugbara & Undie 2008; Tolhurst *et al.* 2008). The effects of 'ownership' particularly in relation to the initiation and control of fertility related discussions will be examined in Section 5.3. Joint decision-making, however, occurs when reproductive labour meets general household expenditure such as tuition fees, health care or major household purchases. Most men are the dominant breadwinners in the home. Consequently, they were responsible for and dominated most of the financial decisions in the household. These decisions include general household purchases, tuition fees, healthcare, food and household maintenance.

**Box 5.1: Gendered scripts constructing the dominance of men in decision-making.**

**Abdul:** *I am the owner of the house. I use my order on her and her children.*

**Interviewer:** *Who gave you the order?*

**Abdul:** *God. [...He quotes a verse from the Quran] "You are the commander of the home" both your wife and children. You have to be responsible in that area. If not on that day (judgment day) Allah would ask you. I would not even bother to do anything that is not good for them. If they need something in a good way I would do it for them. I am supposed to command them to the right way and not to the bad way. They are supposed to follow me to the right way. If I don't go the right way they may leave me. (Couple interview (urban, Ilorin East): Abdul and Halima)*

**Peter:** *Even in the bible we are made to understand that the man is the head of the house. If God can tell us the man is the head of the house definitely I have the right to decide what I want to do. She is my helper. I would take 70 and she would take 30. Even in terms of decision making sometimes I would like her to follow my own because I would always feel my own is superior to her own. (Couple Interview (rural, Edu): Peter and Anita)*

**Yusuf:** *As far as I am the head of this house, this room I am the head of it so it's what I want they must support me on it. If I didn't want this thing she must agree with me.*

**Interviewer:** *Why must she agree with you?*

**Yusuf:** *Because I am the one that marry her come to my house and God supports me to be the head of the family. (Couple Interview (urban, Ilorin East): Yusuf and Faizal)*

The quotes in Box 5.1 above exemplify how most men responded to issues around male dominance in financial and general decision-making in the household. Male dominance is ascribed and disciplined by cultural and religious hegemonic patterns of masculinity (Connell 2013). As heads of the household, husbands expect their wives and children to accept their decisions and act accordingly. There are subtle religious disciplinary differences in the quotes below, which highlight the ways in which religion sanctions gender identities. Peter acknowledged the fact that Christian doctrine suggests that women should be viewed as helpers but stressed the level of inclusion and his superiority over Anita in their marriage. This dominant position is further intensified by the marriage process itself as evidenced in the quote by Yusuf. Through the payment of bridal wealth men gain ownership of their wives who are then positioned in the home as their husband's property and/or that of his family (Isiugo-Abanihe 1994; Ogunjuyigbe *et al.* 2005). Religion and culture act as techniques of power that allow men to have control over these discussions (Foucault 1988). It can also be observed that compliance with the preferences of their spouse was supported through the use of gender-based scripts that reinforced male dominance in the household. The use of these scripts highlights provide insights to the dynamics and attitudes towards relationships between couples.

**Saratu:** *If he says I should not do something when I want to do it, if he says I should not do it, it is compulsory that I should not do it. Because he is the *olori ebi* (head of the family). He is the *baale ile mi* (king of my house). If he does not want me to do certain things I have to be obedient and listen to him. (Couple interview (rural, Edu): Nda and Saratu)*

Among the Yoruba people in Nigeria, husbands are referred to as *olowo ori mi* (*the one that owns me*) by their wives (Ogunjuyigbe *et al.*, 2005). Several Yoruba women interviewed also referred to their husbands as *baale ile* meaning *King of the house*. Saratu uses this script to justify compliance. Words like '*compulsory*' and '*obedient*' signify a lack of decision-making autonomy. For Saratu, lack of decision-making autonomy exists despite her secondary level of education and her occupation as a tailor.

**Hafsau:** *When my husband married me he said that he would take the responsibility for me. I sell *wara* (local cheese) sometimes and I use the money to buy clothes and other things I need. He provides for the children and I use my money by myself. (Single interview (rural, Ilorin East): Hafsau)*



For women like Hafsau, a Muslim Fulani woman based in a rural cattle herding community, marriage and, subsequently, the lack of freedom and decision-making autonomy associated with her particular culture is not entirely an undesirable position. For her, it means having a spouse that is responsible for her and her children and having personal control over her occasional disposable income that is accessible within the spatial boundary of her household. Marriage to Muslim men is an attractive option for many African women because of the religious duty on men to support their wives financially (Boserup 2008). Although research suggests that lack of freedom and decision-making autonomy are adverse influences on reproductive health outcomes (Dudgeon & Inhorn 2004), it is not always the case and this will be evident later within this chapter and also in Chapter Six where irrespective of spatial confines and limited access to resources, women do have some agency and it can be exercised in their marital relationships and, in reproductive health decision-making.

**Interviewer:** *Education?*

**Abdul:** *That one comes from me*

**Halima:** [makes a face] *it's the two of us*

**Interviewer:** *Your wife said it's the two of you?* [Asked husband to comment]

**Abdul:** *Wait I am coming. This area I am the one to decide and then she would follow me.*

**Interviewer:** *She would follow you?*

**Abdul:** *Yes*

**Halima:** [she laughs and makes a face] (yimu). (Couple interview (urban, Ilorin East): Abdul and Halima)

There is a gendered script around ways of being in the household. Smith (2001) suggests that although urbanization, education (formal), and other structural changes towards individualism produce forces that push against institutionalised norms and cultural and social organization, gendered division of labour continues to shape many spheres of social life in Nigeria. However, there is evidence of contradictory non-verbal conduct during the interviews as some women employed sarcastic non-verbal cues such as 'yimu'<sup>5</sup> (see conversation above) when their husbands commented on issues relating to household decision-making. While men may report dominance around certain issues, these facial expressions indicate that

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<sup>5</sup> 'yimu' is a local word in the Yoruba language that loosely translates to making a face or grimace. It is usually used to indicate sarcastic disagreement with what someone has said.

perhaps, women are not always docile partners in the relationship. Observing non-verbal cues and mannerisms is an artefact of conducting couple interviews. Interviewing men and women has some methodological advantages, particularly as each partner can discuss issues they might not wish to raise in the presence of their spouse. But there are also advantages to joint interviews with both partners, as it then becomes possible to observe how they interact and negotiate differences of view between themselves (and it also becomes possible to see how each partner can express dissent or agreement with the other in both overt and less overt ways (for instance, by using ironic facial expressions to express distance from their partner's statement). Referring back to Scott's (1985) analysis of resistance, women can and do use different ways to communicate differences between what is said (*I am the owner of the house. I use my order on her and her children*) and what is done (*yimu*) even in the presence of their partners. Older women in this study were often more able to challenge their husbands and voiced their opinions during these interviews.

**Ummi:** *he is the one that brought me home. I can assist him if there is need to. We don't make decisions. It's the husband that does that.*

**Interviewer:** *Why*

**Ummi:** *It's not good. It goes against Islam. It says the husband is the head of the wife. So Because of that the husband can make all the decisions (Couple Interview (urban, Ilorin East): Yunus and Ummi)*

**Leila:** *Why I don't like paying by myself is if you don't want to expose your issues outside you don't do certain things. In my religion we believe that we are helpmates for each other. If I have the funds and he doesn't have it at the time I would give him so that they don't chase the children from school. That is why I give him and if I give him nobody outside would know that I am the one that gave him. That's the reason. (Couple interview (urban, Ilorin East): Samson and Leila)*

Performing gender roles is not as rigid as it may seem. Given the current economic difficulties in Nigeria where 68% of people live below \$1.25 per day (UNDP 2014), many men are in situations that require some form of financial assistance from their wives. It is important to note how Ummi mentions providing assistance where necessary, but further maintains the fact that as women they do not make decisions. Here, assistance is financial and there is a nuance to the way it is

introduced, thus highlighting one of the ways in which women become agents in their households. From an external perspective, women may appear to consent to male dominance within the home; however, women do have different ways of navigating power and their interests whilst maintaining the status quo within the household and not necessarily upsetting the hierarchy of relationships therein (Scott 1985). This supports the notion established in Chapter Two that the household is a site for bargaining and negotiation (Barker & Feiner 2004) where a relative power imbalance within marital relationships can be observed at different times and exercised in different ways (Ramazanoğlu & Holland 1993; Foucault 1988).

Assistance was not unique to Ummi. Many of the women interviewed offer some financial contribution in relation to the income of their husbands. Some go as far as 'stepping in' during times of financial difficulty, but maintain the status quo as secondary or temporary providers for the sake of preserving gender identities. By providing resources, however limited, women become active agents in the household decision-making process. This is particularly common for major purchases or expenditure in the household where their financial input and opinion is valued. Women in this type of relationship emphasize the shift from a breadwinner/homemaker model to a dual income earning relationship (Padavic & Reskin 2002).

Women entering the labour force and engaging in income generating activities form part of couples' response to the austerity measures attached to SAP (see Chapter Two) and the growing economic difficulty experienced by many people in Nigeria. This response has in turn weakened men's taken-for granted role as the breadwinner and head of the family and created spaces for women to redistribute reproductive labour including child rearing (Cornwall & White 2000; Kabeer 2007; Hoang & Yeoh 2011). Mannon (2006) suggests that marital power is a complex interplay between economic contributions to the household and the prevailing gender norms. A hybrid of both theories is evident in this research and highlights some of the difficulties in performing masculinities in situations where women offer financial assistance in the home. In this type of relationship, there is some form of

redistribution of domestic labour as men do assist their wives when they can. The way people perform gendered identities is relational and it differs between couples as some men reported assisting their wives with reproductive labour.

**Malik:** *Wait o. let me explain. If she is not around, I can bath for them and take care of them but if she is at home I can't do it. If the work is too much for her I can assist her but other than that I can't. There is also the issue of people saying I wear the skirt in the house.* (Couple interview (urban, Ilorin East): Malik and Inka)

However, men only assisted their wives when they are away from home and where tasks are performed within the confines of the household and cannot be seen by other members of the family and community. Members of the extended family will understand this behaviour as weak and a man in this position will be viewed as the woman in the relationship. Here, the hegemonic male gender identity operates not only by the subordination of women but also the marginalization of other male identities (Connell 2013). Several couples contested the implications of assistance by reinforcing women's role as a secondary earner. Comments like '*Adam: we do things together but my input is more than her own*' (Separate couple interview (Rural, Edu): Adam and Eve) indicate a struggle with the gender implications of female income when asked about contributions towards general household purchases. Given neoliberal policies and an increase in women's activities in the labour force, the struggle is more obvious in situations where income similarities exist between couples.

**Adam:** *It's because you are receiving salary and I too I'm receiving salary that's the reason why you want to feel pompous with me. And she has B.Sc. and I'm doing my HND, so she feels she is more educated than me.* (Separate couple interview (Rural, Edu): Adam and Eve).

For Adam, higher levels of education and the corresponding increase in income of his wife caused difficulties in their relationship as a couple. Over the course of their marriage she became more educated than him, and this, along with her income, has caused some tension in the home. Here the husband is struggling with the power, possible authority and autonomy associated with the wife's income. These tensions usually influence their dynamics and relationship as a couple more at the household level than in the community where men and women have to maintain

certain identities and hierarchies. Potuchek (1992) suggests that the struggle is more about the gendered meaning associated with such income than it is about the sex of the earner. As men face diminishing job opportunities in the current economy, research has shown that they struggle with the implications of increased female financial contribution in the home in terms of their identity as providers and the relative power imbalance with their spouse (Schroeder 2001; Perry 2005). For Adam and Eve, as with many other couples in this research, dual income means joint decision making and this also trickled down to joint decisions about their reproductive health outcomes, as will be evidenced in Chapter Six which explores how couples negotiate reproductive outcomes and the use of contraception.

The section that follows focuses on how couples negotiate fertility-related decisions. Here, reproductive agency is unpacked in relation to who initiates fertility related decisions, which partner controls/ dominates these decisions and examines the contextual factors related to the shift in control between men and women over the outcomes of fertility.

### **5.3 Couple dynamics in fertility related decision-making**

Women's ability to use contraception depends on their ability to communicate about and negotiate their fertility preferences with their spouses (Feyisetan 2000; Ogunjuyigbe *et al.* 2009; Izugbara *et al.* 2010; Link 2011). Most women in this study have to navigate hierarchies of governance in the household before they can have discussions about their fertility. For other women in this study, their overall fertility preferences were not discussed because of religious reasons.

**Interviewer:** *Did you ever discuss your fertility as a couple?*

**Halima:** *We didn't sit down to discuss it*

**Interviewer:** *Why*

**Abdul:** *Because that one is a religious matter. God decides the children you would have in your life. God is the one that decides for you. If Allah says 4 its ok. If Allah says 3 or 8. [.....]*

**Halima:** *It's only when you want to give birth to children you do it (refers to sex)*

**Abdul:** *you know I sex her but I know the way I used to sex her. Safe period and we even use withdrawal method. You understand. Sometimes we use what they call ehñ fila daddy (condom). When I newly married her and when*

*we got children we did like that. (Couple interview (urban, Ilorin East): Abdul and Halima).*

**Participant (Woman):** *We all know that it is God that does children and it's what he gives us we accept. So if I'm pregnant now and I end up with 7 children I would accept it.*

**Moderator:** *Are you ok with her having 7 children?*

**Participant (Man):** *I would run away from home. (FGD Mixed: Urban: Ilorin East).*

**Salim:** *We did not have such discussions*

**Salma:** *Yes it is true (She smiles). It is whatever God gives us we would take. (Couple interview (Urban, Edu): Salim and Salma).*

**Participant:** *[Most] - it's whatever God brings*

**Participant:** *It's God that gives children so we leave it up to him*

**Participant:** *It's whatever God brings o (FGD: women: urban: Edu)*

Through the disciplinary action of religion, procreation can be viewed as enacting religious beliefs and the frequency of an offspring is controlled by God. This disciplinary act and, consequently, the religious interpretation of fertility behaviour affect men and women's ability to talk about and potentially use contraceptive services (Sawicki 1991; Macleod & Durrheim 2002). In light of this, fertility intersects with perceptions of 'God's will' and the human body and, as such, health promotion strategies such as contraceptives are perceived not just as 'planning' your fertility outcomes, but interfering with God's will and working against your body (Tober *et al.* 2006). Religion therefore acts as a first tier of governance on how couples frame their reproductive preferences in their relationship.

Similar to the general decision-making processes discussed in Section 5.2, men exercised more control than women over their fertility outcomes by firstly, having greater control over the initiation of such discussions and secondly, the ideal number of children that they were likely to have as a couple.

### **Box 5.2 Husband's control of fertility related decisions**

**Interviewer:** *What about family size?*

**John:** *I told her I want 4 and I have 4 now.*

**Interviewer:** *So when you told your wife what did she say?*

**John:** *She has to obey my request now. We say we want four and one is a boy.*

**Interviewer:** *Why does she have to obey you?*

**John:** *Na me marry her come house. (Separate couple interview (Rural, Edu): John*

and Mary).

**Interviewer:** Family size? Did you ever discuss it?

**Mary:** We sit down and discussed it together

**Interviewer:** Who brought it up?

**Mary:** He did but we discussed and agreed together. (Separate couple interview (Rural, Edu): John and Mary).

**Interviewer:** Did you ever discuss your fertility with her?

**Anita:** jokingly we used to say it

**Interviewer:** Who brought the joke up?

**Anita:** He is the one

**Interviewer:** Why

**Peter:** Because I am the man. Sometimes I tell her that I want 12 children

**Interviewer:** Are you up to the task?

**Anita:** [She laughs]. This first experience I had [refers to pregnancy] was not easy not to talk of 12.

**Peter:** I want my name to be in every part of the community. [He laughs]

**Anita:** you know its two tribes that give birth to children. One set would go to his side and the rest would go to my side.

**Peter:** [.....] we want to have four children.

**Anita:** well we don't know what the country is still saying because everything is expensive now. It might be smaller. We are talking of the school fees. The extent we didn't go to [refers to education] we want our children to be better than that. (Couple Interview (rural, Edu): Peter and Anita).

**Participant (Woman):** [.....] the husband is the one that can decide the number because the husband is the head of the wife. In the bible, it says that the husband is the head of the wife. The Quran also says the husband is the head of the wife. So the husband has authority in the home. When I said I wanted 7 what did he say? He said he would run away. If I say I want 20 and he says he has the power to have only 4 I would have to accept it because I want to live in his house. (FGD Mixed: Urban: Ilorin East).

**Emeka:** Actually, I think it's the husband that should have the final say because if you put the issue of all this western things aside, for our own Africa here we do believe that all men should be the head of the family and he is supposed to decide that I want to have more children as he is the one that would take care of them. (Couple interview (urban, Ilorin East): Emeka and Adanna)

The narratives above reflect the construction of fertility related discussions by most of the couples involved in this research. Marriage and the expected ways in which men perform masculinity in the household and in their relationship reinforce men's dominance over women's reproductive lives (Isiugo-Abanihe 2003; Wusu & Isiugo-Abanihe 2003). Although most men initiated these conversations and were in

control of the decisions made, it can also be observed that some women felt that decision-making was mutual. Included in the narratives above are two couples that were interviewed separately (John and Mary) and in the presence of one another (Peter and Anita). Whilst John was more outspoken than his wife Mary during his interview regarding his control over the discussions and decision made, Mary's interview suggested that the decision was mutually made by the pair of them. This conflicting narrative of how fertility related decisions were made highlights some of the issues around conducting separate interviews with either partner of a couple. Whilst separate interviews allows for women to talk freely about their experiences, there is the issue of truth claims by either partner and highlights the complicated nature of having fertility related discussions. Fertility related discussions might perhaps require ownership of outcomes, personal agency and performing expected gendered identities to the interviewer by John as the dominant partner and the man in the relationship. It might also mean for Mary that she also wants four children even though it was the number suggested by her husband and not necessarily because he felt that she had to obey him as the head of the household.

In Anita's case, it is in the way she inserts *it might be smaller* in the conversation about their fertility especially when she had narrated her previous experience with pregnancy. For other women, accepting their husband's fertility preferences resulted from a lack of female agency in initiating and discussing their preferred fertility choices as some women felt that only their husbands had the right to initiate and control fertility discussions which is further evidenced in the quote below.

**Amina:** *You know he is the head. He is the only person that can bring it up and he said it, I accepted it.* (Couple interview (rural, Ilorin East): Asaki and Amina).

Cultural and religious scripts that support men as the head of the household were also used by some women to express their lack of agency in initiating fertility related discussions. This lack of agency is also supported by a study in Ibadan, South West Nigeria where married men disapproved of women who initiated fertility and family planning discussions (Okwor & Olaseha 2010).



However, most women commented on the fact that as mothers and caregivers, they should be allowed to discuss and control their fertility but lacked the agency to do so. Other women articulated a different position by reinforcing male control over the outcome of a couple's fertility. This was not because they felt men should exercise control over their bodies and the outcome of their fertility but because of the consequences of conflicts arising from trying to discuss their fertility.

**Participant:** *it's the woman that is supposed to be able to have the final say*

**Participant:** *it's the woman*

**Moderator:** *Why*

**Participant:** *it's because the taking care of children is stressful. Even when you are pregnant it is stressful*

**Participant:** *The men don't want us to rest. Left to me I would have only four*  
(FGD: women: rural: Edu)

**Participant:** *Can a woman tell a man that this is the number of children she wants, her husband would not agree.* (FGD: women: urban: Edu)

Women are supposed to conform to hierarchies of governance within the household and not challenge, firstly, God and, secondly, their husbands. Communicating fertility intentions can be met with violence especially in communities where reproductive outcomes are associated with some of the ways in which men instantiate masculinity.

**Aliya:** *When he didn't give me any money when I had the child, I said I was not having any more children. He beat me. Beat me. We tore each other's clothes. Nurse that works at the clinic was the one that intervened. She asked why we were fighting and I explained to her. We settled it and I had another baby.*  
(Single interview (urban, Ilorin East) Aliya)

Aliya is a young woman that has had six births and five of her children are still living. She works as a butcher at the local market in Ilorin East and although she is in a polygamous union as the first wife, she lives in a separate household with her children with sporadic visits from her husband. The quotes above and the experience shared on the outcome of communicating fertility preferences exemplify some of the issues such as gender based violence when attempting to discuss their fertility outcomes. This is further substantiated in the quote below.

**Participant-** *He would beat her very well and after that if she does not agree with him and what he wants he won't accept her in the house. It's not up to*

*the woman o. It's the man that can decide because he would do what he wants to do. He would tell you that you can't count children for him that God is the one that would do that. What is the point of God doing something for you when you don't have the money to care for them? Anyone that knows what the time is saying would know that before you send your children to university you would struggle but after you have done that the children would take care of in your old age after all the wahala<sup>6</sup> you have been through. Men don't understand. All they want is plenty children. When they don't have brain. They would stress the woman. A woman that is supposed to have 3 clothes is having just one. You have to think of what your children would eat and move forward in life. That is why some women do not have clothes to put on (FGD: women: urban: Edu).*

Several studies have associated gender-based violence with the inability of women to achieve their desired fertility intentions (Stephenson *et al.* 2006; Stephenson *et al.* 2008; Ogunjuyigbe *et al.* 2005). Gender-based violence cuts across both local government areas. Also, 9.3% of women between 15 to 49 have been physically abused in Kwara State (NPC & ICF Macro 2014). Gender-based violence, including domestic violence in these communities needs to be understood as part of the wider socio-cultural context of family relations in Muslim societies. Sharia (Islamic) law operates in Kwara state alongside federal laws, and provides a framework that situates the family relations, norms and values that exist at all levels (Suberu 2009; Abdussalam 2012). Suberu (2009) further argues that sharia represents and drives the Muslim-Christian conflict, North-South divide, inter-ethnic and majority-minority binaries that have shaped the socio-economic and political landscape in Nigeria. Violence therefore, reflects what is permissible or prohibited within communities, more so in Edu as compared to Ilorin East where the population is predominantly Muslim and sharia operates at a fundamental level to foster gender inequalities and maintain hierarchies of governance between couples based on religious and cultural terms (Hajjar 2004).

The above quotation also questions the value of using God and, by extension, religion as a means of validating high fertility, especially in the presence of poverty. '*Anyone that knows what the time is saying*' signals a move towards thinking about children as consumers of food and household resources but also out-of-pocket

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<sup>6</sup> Wahala means problems in Nigerian Pidgin English.

expenditure on, for example, higher education. Research suggests that changes in desired fertility size are dependent on changes in employment and economic performance (Eloundou-Enyegue & Williams 2006; Eloundou-Enyegue & Giroux 2013). Many women are of the opinion that men lack an understanding of the impact that having many children on their ability as parents to provide for them and give their children a fighting chance in an economy that lays emphasis on the importance of education and formal forms of employment. This participant particularly draws attention to the many faces of poverty. From major expenditure and decisions to comparatively minor issues like dressing and propriety, the participant stresses the physicality of childbirth, childcare and the sacrifices required to ensure the well-being of their children. Here poverty works in two ways; by limiting investments in children's educational attainment, and by constraining women's roles in society and the labour market through excessive childcare (Sachs *et al.* 2001).

**Participant:** *If you have like 10 now the benefit is different and plenty, children are a blessing. Like me now if I don't have money and I have 8 children, I would send them to school so that they can have a degree and when God bless them before I die I would benefit from them. Among them there would be one that would have money. But women would complain and be thinking of what we would eat. God is the one that would give us food and you don't know what luck the child would be. That is my opinion. God is the one that gives us food to eat. You can have a child today and I don't have money and tomorrow I would have. God is the one that would provide. It is not good for women to be saying there is no money there is no money. You don't know which of your children is good out of all the children that you have. (FGD: Men: urban: Edu)*

Some men presented a counter-argument about women's financial concerns within the home. They appropriated the absence of discussions around fertility to prevailing cultural norms that support pronatal tendencies between couples and, more importantly, stressed the importance of having faith in God to set their affairs and provide resources for them. For them, having many children increases the odds that one child would be successful and take care of their financial needs in their old age. The disciplinary power of religion is exercised on the mindset of men in these communities through the production of certain kinds of knowledge, belief systems and more importantly, hope in the fact that God would set their affairs in order.

Through disciplinary practices that create the division of labor and responsibilities in the home, men take financial responsibility in the home as heads of household. However, in the space that fertility outcomes occupy, it can be observed that women have a greater concern about the impact of market forces within the home. Relying on God to improve their financial situation without a concern for increasing numbers of mouths to feed is not enough to quiet women's anxiety about the future.

However, control is relative. For Emeka, a conflict of ideas exists on how discussions on fertility occur between couples. Emeka is a businessman and a prophet at his local church in the city. He and his wife Adanna (35) are well educated and have five children with no intention of having more. Adanna owns a boutique in town. I first made her acquaintance during my observations in the family planning unit at the government hospital in Ilorin East. In *'put (ting) the issue of western things aside'*, Emeka acknowledged how decision-making occurs among couples in settings where the effects of patriarchy are not as visible as those evident in many African societies. Here, his education and level of exposure intersects with his identity as an African man (Ampofo 1999; Silberschmidt 2004; Ampofo & Boateng 2011; Connell 2013). This position plays a role in the conversations Emeka and Adanna have about their fertility and contraceptive use that will be discussed in Chapter Six. The quotes in Box 5.3 highlight the scenarios in which women appeared to have greater control over fertility related decisions. Women who can exercise their reproductive agency by discussing and controlling their fertility outcomes did so in different ways and also in a number of scenarios.

### **Box 5.3 Wife's control over fertility related decisions**

**Samira:** *Ever before I came in I told him I would not have more than 4. So he agreed.*  
(Single interview (urban, Ilorin East): Samira)

**Participant (Woman):** *I told him that I wanted 4 children*

**Moderator:** *Was he the one that brought it up or you?*

**Participant (Woman):** *I did. We both discussed it and he agreed with me that time but now we want 3.*

**Moderator:** *Why 3?*

**Participant (Woman):** *It is the amount of children that can enter my room (eyi to lo*

wo yara mi). (FGD Mixed: Urban: Ilorin East)

**Emeka:** *But in terms of who has the power to decide, I hear some women saying that their husband says that they must continue having children. I have also heard some men say that ... [pauses to give example]...There is a kinsman of mine whose latest child is a girl. It's like they having boys up to 4 so now the man was saying that the wife wanted a girl. In such a situation the woman had the power. The woman exerted her power and wanted a girl. It shows that a man even as the head of the family cannot have all the power. (Couple interview (urban, Ilorin East): Emeka and Adanna).*

**Samuel:** *She insisted that she needs a male child  
[....]*

**Interviewer:** *why did you insist on having a boy?*

**Ruth:** *because the boy would stay behind in the house and the girls would go.*

**Interviewer:** *how many boys do you have*

**Ruth:** *one. (Couple Interview (urban, Edu: Samuel and Ruth).*

**Moderator:** *Who has the final say in deciding the number of children a couple can have?*

**Participant:** *it's the woman*

**Participant:** *Na woman o*

**Participant:** *man*

**Moderator:** *Why?*

**Participant:** *it's because if I want more children and my wife does not accept it would be a problem*

**Moderator:** *How so?*

**Participant:** *I would not be able to do that unless the woman agrees*

**Participant:** *They can go and use drugs and when you ask them why they are not pregnant they would say God has not given me the pregnancy.*

**Participant:** *and you would be working hard at it. (FGD: Men: urban: Edu).*

Samira is the second wife in a polygynous union. She maintains separate living arrangements from the first wife and works as a teacher at one of the community schools in Ilorin East. As suggested in the quote in Box 5.3, Samira had clear intentions to have no more than four children when she initiated the conversation about her fertility with her husband. It can be argued that Samira exercised her agency regarding her fertility outcomes for the following reasons. First, being the second wife in a polygynous union allows her to negotiate the timing and number of her children because her husband already has children and there is less pressure on her to have as many children as her husband wants. Secondly, Samira has tertiary levels of education and is a lower-middle income wage earner, both of which have been observed among women who can discuss their fertility preferences and also use contraception (Monjok *et al.* 2010; Ankomah *et al.* 2013;

NPC & ICF Macro 2009; NPC & ICF Macro 2014). The same can be said for the participant in the mixed focus group discussion, who explicitly talks about her fertility intentions and how they have changed over time. *The amount of children that can enter my room* is very important in understanding the change in her fertility preferences. Again polygyny plays a key role in the meaning behind the interpretation of the room. In most polygynous households, wives have separate living quarters and more often than not sleep in the same room with their children. Therefore having too many children in a small space is deemed unsatisfactory particularly when some form of insecurity exists around the possibility of being in a polygynous union coupled with living arrangements like the face-me-I-face-you housing described in Chapter Two. In this type of housing, women in polygamous unions are usually allocated a room where they maintain residence with their children. These insecurities will be further elaborated upon in Chapter Six.

The scenario relating to the sex preference of the offspring is double-edged. Where there is a preference for male children as evidenced in many African and Asian cultures, women's apparent control over fertility outcomes is often a reflection of internalized patriarchal control of women's identities as 'good' wives/mothers/women in their communities (Isiugo-Abanihe 2003; Bélanger 2006; Saavala 2013). In most parts of Nigeria, male preference is associated with successorship and also the fact that male children stay at home as opposed to female children who join the homes of their future spouse upon marriage. Successorship may also explain continuous investments in male children than in female children. In Nigeria, succession is influenced by marriage patterns, persistent belief in the breadwinner system, inheritance rights and the demand for farm labor in agrarian communities (Isiugo-Abanihe 2003). Study results in Ekpoma report a high preference for at least one male child regardless of educational attainment. Women attached security in their marriage and community to having male children and the internalized perception of male preference in the home (Eguavoen *et al.* 2007). Women also exercised greater control over reproductive outcomes where there was a need and/or preference for a female child. This need, however, can in most cases be operationalized when women have at least one

surviving male child and have become more established in their relationship with their husband and his family (Gipson & Hindin 2007).

Men also felt powerless in some situations particularly where they wanted more children and their wives appeared to be less co-operative with the prospect of having another child. *They can go and use drugs* shows an awareness of the clandestine use of contraception among women. This stressed some of the frustrations experienced by men especially when they are actively trying to conceive a child. Again, God provides a useful way for women to shift the blame for their inability to conceive at that time. Acknowledging this also meant that some men are perhaps beginning to rely on dialogue and affection in order to address their disagreements with their wives over their fertility desires.

**Participant:** *if you have a wife and you have a talk with her and she says she does not want to have a child again. If you talk to her again, let her come down she can agree with you. But if she says she don't want a baby again and you say by force she must deliver one it would be very difficult. But if you talk to her with a sweet mouth she would come down and whatever you want she would do it. It depends on the kind of wife that you have.* (FGD: Men: urban: Edu).

Phrases like *talk with her* and *sweet mouth* signal affect that describes intimate attachments or relationships between couples that moves away from force and/or violence towards women in order to accept their fertility preferences. These phrases suggest a reliance on intimacy and continuous dialogue as a practice of love between men and women. For men, using *sweet mouth* in communicating with their wives produces changes in moods (*she would come down*) and attitudes (*whatever you want she would do it*) towards the subject matter thus making women more amenable to their preferences. *It depends on the kind of wife that you have* suggest that being amenable relies on mate selection, love and intimacy and its associated ability to use *sweet mouth* with your partner. Also, it can suggest that even in the presence of intimacy women can still decide to exercise their agency and not have more children. In the last several decades, research in Nigeria has reported the increasing importance of love in marriage and the selection of partners and also stress that this 'growing emergence' should not be interpreted as

romantic love did not exist in pre-colonial times (Obiechina 1973; Okonjo 1992; Smith 2001b; 2010).

This thesis acknowledges that men exercise greater control than women over fertility related decisions but, it also stress that women have different ways of being part of the conversation and making their preferences known. As discussed in Chapter Three, spousal communication about fertility preferences is positively associated with the use of contraceptive services (Meekers & Oladosu 1996; Feyisetan 2000; Bawah 2002; DeRose & Ezeh 2010). Whilst this is true, the narratives presented in this section complicate the idea of communication by unpacking the societal structures and institutions that grant men greater control over the communication process. However, the dynamics between men and women have appeared to be fluid and either partner's ability to control fertility outcomes largely depended on the reproductive situation, type of marriage and the relationship between the couple. The following section explores the clandestine use of contraceptive technology in detail.

#### **5.4 Clandestine use of family planning**

Women's ability to control their own fertility is a precondition for the fertility transition to lower birth rates (Caldwell & Caldwell 1990; Caldwell *et al.* 1992; Castle *et al.* 1999). To do this, women need the freedom to be able to act on their fertility desires which includes the use of contraception. It is however, very important to acknowledge the difficulty in exercising the right and freedom to use contraception particularly in African countries like Nigeria. As established in Chapters Two and Three and evidenced further in Section 5.2 and 5.3 , women's bodies and their reproductive outcomes are governed by many institutional structures that shape the dynamics and relationships with men in the household. Women's covert use of family planning had been reported in communities similar to those found in Nigeria (Biddlecom & Fapohunda 1998; Castle *et al.* 1999; McCarraher *et al.* 2006; Harrington *et al.* 2015). As far as agency is concerned, the clandestine use of family planning suggests that women are exercising their reproductive agency even in settings and/or situations designed to control their reproductive outcomes. The following quotes in Box 5.4 highlight some of the



perceived reasons for women who use contraceptive technology without their husband's knowledge.

#### Box 5.4 Reasons for clandestine use of contraceptive services

**Participant (Man):** *it is possible the woman is the one taking care of the home and her husband is a striker [means someone that always wants to have sexual intercourse] and doesn't care if you are menstruating or not. So she would feel the need to use family planning. (FGD Mixed: Urban: Ilorin East).*

**Participant:** *Maybe the man is not taking care of her. When you don't give the wife food you know say men would not capable like that.*

**Participant:** *They come because of home. Maybe food is not enough in the house for the children; maybe their husband is not caring for them so they would be thinking about using family planning. (FGD: Men: urban: Edu).*

**Participant:** *wahala<sup>7</sup> and the food the children would eat*

**Participant:** *and the school they would go to*

**Participant:** *and the money you would use*

**Participant:** *Men don't think about what they [here refers to children] would eat. They expect us [here refers to women] to manage what they have. (FGD: Women: rural: Edu).*

**Service Provider:** *Nowadays women would carry themselves here and say they want to do child spacing because when Anko<sup>8</sup> [also known as Aso Ebi] comes and they tell their husband and he refuse to pay or he didn't give her money for soup, fish, maggi<sup>9</sup> and salt you only give her guinea corn and she has to bear the responsibilities she would say ah let me go and take something. If the husband has been sexing her and no baby she would now tell him you want me to born for you when you didn't buy me cloth you didn't give me money for soup. That is why they come without their husband knowledge. (Private Clinic, Rural: Edu).*

**Participant (Woman):** *the man would not want her to go out free. [That is without pregnancy] they would want her to be pregnant or should carry a child so that another man would not approach her. Stuff like that. If a man married a woman that is very pretty they would not want her to be free. So she would be having more children. She might use it because of that. (FGD Mixed: Urban: Ilorin East)*

The quotes in Box 5.4 highlight the possible reasons for the clandestine use of family planning in these communities. The primary motivation articulated by men and women for covert use of contraception was associated with women's response to financial hardship (see also Bawah *et al.* 1999; Castle *et al.* 1999; Agadjanian 2005). These concerns ranged from child-care responsibilities to fear and anxiety

<sup>7</sup> Wahala means trouble or problem in Nigerian Pidgin English.

<sup>8</sup> Anko or Aso Ebi refers to items of clothing worn by individuals to signify that they were part of a group or association. This item of clothing is predominantly associated with weddings, community group meetings and/or associations, funerals and other social gatherings.

<sup>9</sup> Maggi is an international brand of food seasoning used by most women in Nigeria.

about household resources particularly in situations where women shoulder most of the responsibilities. The quote from the interview with the service provider at a private clinic in rural Edu illustrates the complexity of how reproduction has been and is still a crucial part of spousal relationships and of the dynamics between men and women in the effort to gain material resources in the household.

Accessing contraceptive services allows women to bargain their reproductive outcomes in exchange for greater household allowances and social identity as members of the community. The word *Anko* [the same fabric] is important here. Also known as group uniform or *Aso Ebi* (cloth of the family), *anko* is associated with the cultural commodification of identity and/or being in Nigeria (Familusi 2010; Ajani 2012). From associations to weddings and funerals, wearing *anko* and identifying as part of a group or family in the community has its origins in Yoruba culture and has diffused into other ethnic groups in Nigeria (Familusi 2010). Wearing *anko* has its global capitalist relationships and framings but also plays a key role in women's identity and status as members of the community, so much so that women are willing to withhold procreation as a trade-off for material resources.

Secondly, there is also the issue around fidelity. As evidenced in the quote in Box 5.4, there is a concern for infidelity among men who happen to be married to women who can be described as beautiful. Men in these unions therefore prefer for their wives to either be visibly pregnant or to be obviously caring for a young child than for them to be visibly without a child. Women that find themselves in such scenarios might exercise their reproductive agency by accessing contraceptive services without their husband's knowledge.

*.....Anybody that is your sexual partner is your partner. Some people go out there and do extramarital affairs. That one is not my concern as a FP provider. My concern is about my client. It can be an individual who is not married. All I know is that you come to me for counseling and I give you what you want. That is all. Some women come without their husband's knowledge. We have their cards hidden here. (Local clinic 2, Urban: IE)*

The relationship between people's perception (especially men) of women who use contraception without their husband's knowledge and fears of infidelity have been documented (see Biddlecom & Fapohunda 1998; Bawah *et al.* 1999; Castle *et al.* 1999; McCarraher *et al.* 2006; Ntata *et al.* 2013; Harrington *et al.* 2015). This

fear/anxiety is associated with male insecurity particularly around the possibility of sexual networking among women. The extract below situates the reproductive health implications of sexual networking with specific forms of contraception. Because the IUD is a foreign body within the female reproductive organ, sexual networking without the use of the condom increases the risk of reproductive tract infections.

*Some of the women on the IUD have multiple partners and have recurring infections. They always come back to the clinic even after they have been warned not to have extramarital affairs when they are on the IUD. They say their husbands are irresponsible and they can't leave their 'helpers'. (Diary Extract: Informal interview, Local Clinic 1, 281112)*

*Baba alanu* (loosely translates to 'man that has mercy on me'), 'helpers' or sugar daddies play a role in the way women respond to financial hardships within the household especially in situations where they are in relationships with 'irresponsible husbands'. Performing the role of *Baba alanu* is attached to the identities of many men in Nigeria, particularly those that have access to resources and those that want to and/or are practicing polygamy. This often leads to situations where the women involved enter polygamy and become co-wives in the household (see Abdul and Halima in Chapter Six). This also relates to the primary argument for the clandestine use of family planning where contraceptive use is associated with concerns over the availability of and accessibility to household resources. Whilst this can be said for some women, it may not be the only reason for sexual networking and infidelity. Thus, having conversations about contraceptive use might create suspicions and insecurities about their wives' fidelity. Whilst women are concerned about the economic burdens of the family, men have to weigh the risks associated with the sexual and reproductive freedoms allowed by the use of contraception (Harrington *et al.* 2015).

#### **5.4.1 Marital issues and clandestine use of contraception**

The tensions concerning clandestine use of contraception as perceived by men and women relate thematically to marital discord and the possibility of divorce.

*Participant: family planning is very delicate, if a woman insists on doing it alone she doesn't know what may happen or complications that may come up outside her control that the husband will eventually find out about and it*

*would not be good. It can end in divorce. For me it is better you take such decisions with your husband. (FGD: Women: urban: Edu).*

**Participant:** *Maybe...some women think the husband can't sponsor the children. Using it behind the husband's back is bad because it can lead to divorce. (FGD: Men: urban: Edu).*

**Aliya:** *When he started getting close to me and I didn't get pregnant. We now fought. He gave me the Quran to swear that I was not using family planning. Because I knew I was using so I could not swear (Single interview (urban, Ilorin East) Aliya).*

As earlier mentioned in Chapter one and earlier in Section 5.3, Aliya has had some difficulty discussing and managing her fertility. Even in the presence of the tensions and gender based violence experienced with her partner, Aliya accessed family planning services without her husband's knowledge. This highlights the fact that women do exercise some form of agency and control over their reproductive outcomes even in the face of structural opposition. Because of these tensions, some service providers have set up procedures that limit access to family planning services to women who intend to use contraception without their husband's knowledge as evidenced in the quotes below. Spousal consent requirements suggest an acknowledgement of male opposition to the use of family planning services. These themes support existing research within the African context that suggest possible difficulties in marital unions as without consent, husbands can accuse their wives of infidelity (*we would educate her that she must not go outside and just do it with her husband*) that may perhaps result in the dissolution of the union (Miller *et al.* 1998; Stanback & Twum-Baah 2001; Mugisha & Reynolds 2008). This situation is more common in Edu than in Ilorin East. This may be because both service providers and the general public in Ilorin East have been sensitized and exposed to family planning messages that encourage spousal communication and improve interpersonal provider-client relationships. Details of these promotional messages will be elaborated upon in Chapter Seven.

*We used to tell them that they should go and bring the husband first. If we hear what the husband says and if he had interest we do it for her. But sometimes if the husband says he wants plenty children and we think of the health of the woman we would do it. So that we can help the women but we*

would educate her that she must not go outside and just do it with her husband. (Local clinic, Rural: Edu).

**Service Provider:** .....Yes now. I will attend to her because I need my own money. When the woman start to explain and talk about all the bad things the husband does to her. Now is that I would pity her. That is what they call health worker. A health worker does not speak out. Because if you just go outside and talk I give so so woman injection and the woman no come get bele<sup>10</sup> people would now say ah see this person how he is talking. You would now drive your patient away. Tomorrow you go open mouth say you no get patient meanwhile na you send them away. (Private Clinic, Rural: Edu).

The above quotes also contrast access issues for both public and private health care facilities in Edu LGA. Both service providers acknowledge providing services to women based on their personal circumstances (both reproductive and financial hardships) that lend support to the argument in Section 5.4. However, the service provider at the private facility also stressed the importance secrecy for women who use contraception covertly. *I will attend to her because I need my own money and Tomorrow you go open mouth say you no get patient meanwhile na you send them away* highlights the importance of discretion for women and also for the service provider particularly because the facility is privately owned and therefore, concerned about meeting demand and making a profit. As discussed in Chapter Two, privately owned facilities are first of all made for profit businesses and thus dominate contraceptive service provision in Nigeria (NPC & ICF Macro 2009; Monjok *et al.* 2010; NPC & ICF Macro 2014). Research also suggest that women were more likely to face restrictions due to a lack of spousal consent in government funded facilities than in privately owned facilities (Mugisha & Reynolds 2008).

**Service Provider:** *They have attacked me before about it in this our village before. But that one I lied o. I told the man that I didn't give the wife anything. They just wanted to rub [here he means scare] me but I didn't give them face o. I have even given the wife the second dose now sef [means at the moment].....The husband. He is also my friend. He would think I came to greet the wife. And you know it's injection so it's easy. There are some clients with this very family planning that they don't used to talk. If they say person would not hear about it nobody will.* (Private Clinic, Rural: Edu).

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<sup>10</sup> Bele means pregnancy in Nigerian Pidgin English

Similar to the study conducted by Mugisha & Reynolds (2008) in Uganda, service providers like those in Edu have on occasion been confronted by unsupportive husbands that suspect their wives are using contraception without their permission. Also evidenced in the quote is the existence of some kind of relationship between the service provider and women in the village that point to and stress the importance of interpersonal relationships and patron-client ties that are useful in navigating Nigeria's political economy and access to public and private services (Bledsoe 1980; Smith 2001; 2004). These interpersonal relationships will be discussed further in Section 5.4.2 and Chapter Seven.

#### **5.4.2 Method related issues regarding the clandestine use of contraception**

In order to fully understand clandestine use, this thesis elaborates on the extent to which contraception allows women's bodies to be manipulated and acted upon i.e. what contraceptive use allows women to reveal or withhold. Silence and secrecy are ways in which women are resisting power in the household. However, women also have to navigate the bodily signs (side effects) that threaten to expose their secrecy in the use of contraceptive technology. Most modern forms of contraception have side effects that are of critical importance to continuing the use of family planning with or without husband's knowledge of use (Khalaf *et al.* 2008; Barden-O'Fallon *et al.* 2009; Cleland *et al.* 2014). Experiencing side effects, however, are of more importance to women who choose to use contraception covertly because the side effects can provide evidence that they are using contraception when they tell their partners that they are not (Castle 2003). Also, what women chose to reveal or conceal regarding their experience with contraception during the interview was an artefact of combining couple interviews with interviews where women narrated their experiences in the absence of their husbands (single interviews).

Amudat is a trader of raw food items in Oke Ose, a rural community in Ilorin East. As the second wife of a polygamous household, Amudat gave birth to five of the six living children of her husband. She has three girls and two boys and expressed the need to have another boy in order to have three of each sex. Because of the reproductive challenges her husband experienced with his other wives and the

death of two of his eight children, the use of contraception was never discussed between the pair of them. Her husband wants more children and was already struggling financially to take care of the children she already had. Currently using the injections (Noristerat), Amudat started using contraception after the birth of her third child and has used a range of methods including the pills, injections and the IUD. She accessed services from a private hospital in the area and had a good relationship with the hospital owner who also happened to work at a local government health facility in the area and the gate keeper for the research in the community.

**Interviewer:** *why did you change your method of contraception?*

**Amudat:** *that ogun onikoro [means tablets in Yoruba language] used to make my tummy pain me .....the injections too. That one was the main problem. My period didn't come and when it comes its small small and irregular. That's how he knew that I was using. It was not a small matter o. There is nobody he didn't tell that I was using it. It caused serious fight between us so I stopped. I tried again because the wahala was becoming too much. After the fourth one or so. That IUD would have been good. But after 5 months my menses came for 12 days so I removed it. He does not know I have started using it again. (Single interview (urban, Ilorin East): Amudat).*

The reasons for trying different methods of contraception were similar to those identified by Castle (2003) which includes women's experiences with side effects that symbolized what women attempted to conceal. *It was not a small matter o. there is nobody he didn't tell that I was using it. It caused serious fight between us so I stopped* further substantiates the husband related issues discussed in the previous section. These issues however were not influential enough to permanently stop her use of family planning. For women that did not experience any side effects, discussing contraceptive use with their husband were not done (*one would not say it loud that one is using contraception. You just use it*).

Finding the best method of 'fit' is integral for clandestine use. This is because of the need to use methods that are not associated with irregular changes in their menstrual cycle. In many settings, especially those that restrict women's participation in various aspects of social life that also includes sexual activity, increased irregular bleeding or amenorrhea are signs that show a deviation from

the norm (Casterline & Sinding 2000; Renne 2001; Castle 2003). These signs are easily observable if women keep taking 'days off' and creates the suspicion that women might be using family planning (see Castle *et al.* 1999). Real and/or perceived side effects of contraception are negatively associated with the use of contraception (Abbasi Shavazi & Khademzadeh 2004; Imbuki *et al.* 2010; Monjok *et al.* 2010; Ankomah *et al.* 2013). At the time of the interview, Amudat was still actively seeking a method that allowed her two things: discipline her menstrual cycle and control her fertility.

Nabila used the pill not to entirely prevent pregnancy, but to ensure better birth spacing for her six children. Clandestine use of contraception for her was achieved partly because of the living arrangement with her husband. Nabila is a secondary school level educated wife of a civil servant in Lafiagi, an urban settlement in Edu LGA. Although she is a housewife, she does sporadic farming activities and occasional administrative work with a local private clinic in the area.

***Nabila:*** *I did not inform him. I only did it myself. Just to give them space*

***Interviewer:*** *Why*

***Nabila:*** *If I inform him he would not agree. Although I have never discussed it with him*

***Interviewer:*** *Why did you not discuss it with him?*

***Nabila:*** *I know he would not agree. You know when people talk generally about one thing you would know here they stand. Better not to just talk.....Now that he has been informed about family planning. You know the radio and all these things. I can discuss it with him. I want to use the IUCD now.*

***Interviewer:*** *Why*

***Nabila:*** *You know that one last for some people 3 years or more*

*[.....]*

***Nabila:*** *He would not take it easy with me. But since when I used it he had been enlightened now there would be no problem now. But that time there would have been problem if he found out. (Single interview (urban, Edu): Nabila).*

Like Amudat, Nabila used oral contraceptives but did not experience any side effects. More importantly, her household living arrangement included having rooms separate from her spouse perhaps, allowed for secrecy and continuous use of the pill without her husband's knowledge. Also like Amudat, there was a lack of spousal communication about their fertility and possible use of



contraception because she was of the opinion that he would not permit her to use family planning. The attitude of men towards family planning has been documented and positive changes in attitudes have been suggested after exposure to and counselling in family planning (DeRose *et al.* 2004; Odu *et al.* 2005; Onwuhafua *et al.* 2005; Izugbara *et al.* 2010).

Regardless of men's attitude towards contraceptive use, particularly if issues around fidelity are to be considered clandestine users have found ways to access and use contraception. From navigating mobility constraints to hiding oral pills in already used bags of food items or under items of clothing, women have found and are continuing to explore different ways in which they can exercise their agency regarding the use of contraception (Castle *et al.* 1999; Chikovore *et al.* 2002). Having separate sleeping arrangements builds on existing research on some of the strategies women employ to conceal their use of family planning from their husbands. Both Amudat and Nabila rely on interpersonal relationships with service providers to grant access. Although the cost of contraception was not an issue for Amudat, Nabila lacked the finances to go beyond the pill and used the method easily accessible to her. The cost of contraceptive services has been identified as one of the barriers to scaling up the use of family planning particularly among poorer women (Feyisetan & Ainsworth 1996; Tuoane *et al.* 2004; Monjok *et al.* 2010). Nabila now has to rely on communicating her fertility and reproductive preferences to her husband in order to fulfill her desires to use a different method of contraception.

## **5.5 Conclusion**

This chapter discussed the relationship dynamics that have a bearing on the ways in which men and women control their fertility choices within their relationship as couples. Gender infiltrated all aspects of the relationship between men and women and affected the construction of masculinity and femininity among and between men and women. Religion and sub-institutions like marriage were important factors that established men and women's rights and governing frameworks in the household. The resulting gendered differences accounted firstly, for the division of labour and secondly, the ways in which men and women socialized and interacted

with each other. Therefore, men appeared to exercise greater control over decisions as couples than women. The dynamics created through these interactions emphasizes the importance of understanding women's choices and their ability to influence their reproductive outcomes as a reflection of how they are situated within the household and also within marital relationships.

Men's dominance was identified as incomplete as control over who initiated, dominated and determined the outcome of fertility related decisions was relative. Men thought they exercised control (and sometimes they do) but the reality was that women different ways of exercising their agency regarding their fertility outcomes. For example, the outcome of these discussions depended on the type of union, the nature of the relationship and the time in their reproductive life course. Therefore it is essential that fertility related decisions move from being overwhelmingly framed as male dominated to include a more contextual understanding of how men and women make certain reproductive decisions. This is particularly important because women are making decisions, even if it goes against their partner's desires. Contextual understandings provided insights to the ways in which gender power relations are being contested in the household, men's insecurities and their association with infidelity, marital discord and clandestine use of family planning. Women's clandestine use symbolized resistance and was contextualized in relation to struggles with reproductive labour and poverty. The tensions that arose from clandestine use of contraception related thematically to marital discord and the possibility of divorce and stressed the importance of the method of contraception used in embodying the practice of covertly using contraceptive technology. Although clandestine use of family planning is a means to an end for some women, family planning programs need continuous advocacy and awareness to improve communication between couples in order to eliminate demand related issues and increase the use of contraceptive services.

Method related issues were identified as an important factor for use especially because the side effects of contraceptive technology exposed what women sought to conceal. This demonstrated how women's bodies were also in negotiation with the very methods that aimed to provide reproductive freedoms. It also highlighted

the role of service providers in enabling clandestine users. Assistance was both an empathetic and financial response to women's agency and the demand for family planning with the latter resulting from the dominance of the private sector in contraceptive service provision in Nigeria. This chapter therefore provided a framework for understanding the communication process in spousal communication and built on existing knowledge of how men and women communicate fertility preferences and the complexities of maintaining certain identities attached to people's perception and attitudes towards family planning. Also, this chapter unraveled the dynamics that will be useful in examining why communication occurs particularly in relation to the use of contraception that is explored in Chapter Six.

## **CHAPTER 6: 'I SAID 3 SHE SAID 4 AND I LATER AGREED': CONTRACEPTIVE DECISION-MAKING AMONG COUPLES IN KWARA STATE**

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### **6.1 Introduction**

The previous chapter examined the couple dynamics that have a bearing on women's agency and the use of contraceptive technology. This dynamic and/or relationships between men and women were observed to be a reflection of the gendered social organization of men and women in the household and also within marital unions. Consequently, these dynamics affected the ways in which men and women discussed and negotiated their fertility preferences and often determined who had control over the outcome of these discussions. This chapter continues from the previous chapter to include an analysis of spousal communication on the use of contraception.

This chapter begins by acknowledging the complexity in using contraceptive technology and understands this process as fluid. Section 6.2 examines the effect of spousal communication on the use of contraceptive technology and emphasizes the importance of the timing at which spousal communication occurs on women's contraceptive practices. Here, attention is drawn to women's level of inclusion in the decision making process in relation to men. The chapter moves on to Section 6.3 to include a meso-level analysis of the decision-making process by stressing the importance of informal social networks (friends and family members) in the acceptance and use of contraceptive technology. However, communicating fertility intentions alone is not enough to determine the use of contraceptive services, and therefore Sections 6.4 and 6.5 will explore triggers, life events or circumstances that allow decision-making to move across the spatial boundary of the home to the public domain. Lastly, Section 6.6 summarizes the key finding in this chapter.

### **6.2 Men, women and reproductive decision-making**

Regardless of the forms in which decision-making occurs, reproductive health choices which include the use of contraceptive technology cannot be separated from the wider gender division of labor and decision-making processes among couples. Therefore, the freedom to use contraception and the timing of childbirth

does not resonate with the social reality of couples in Edu and Ilorin East LGAs. Contraceptive use has to be negotiated within structural influences on marital relationships in the household (Moultrie & Timaeus 2014). Decision-making about reproductive choices is not a rational, one-size-fits-all, process. Although reproduction is social, it is also private. It is, therefore, layered within the institutions that govern the permeability of the household. A part of the social aspect of reproduction is the community and the sense of belonging, support and acceptance provided through being a member of it. It is against the backdrop of the permeability of the household that this section explores the ways in which couples negotiate their reproductive health choices.

Communicating about fertility intentions and management choices allows couples to plan the number, spacing and limiting arrangements of their overall fertility goals. Spousal communication, as discussed in Chapter Two and Three, is critical to the use of contraception. It can be used to predict contraceptive behaviour and facilitate the transition to lower fertility rates (Ngom 1997; Feyisetan 2000; Bawah 2002; Iklaki *et al.* 2005; Yue *et al.* 2010; Hartmann *et al.* 2012; Mon & Liabsuetrakul 2012). This thesis analyses spousal communication based on inclusion and the level of involvement of each partner in the decision making process. The first dimension to this analysis applies to couples that actively discuss their fertility intentions and the use of contraception with each other. The level of inclusion in the conversation varies between couples and can be initiated by either partner. Within this dimension, it is important to stress the fluidity of spousal communication. Therefore, this thesis argues that spousal communication and thus, decision-making, involves a series of conversations that occur at different stages in the reproductive life course of a couple. The second dimension concerns the level of passivity, the extent to which women are coerced into using contraception by the action of their husbands and their lack of relative power in representing their reproductive interests in the relationship.

The following subsections provide an account of these dimensions and begin by discussing the extent to which women are deprived of knowing their bodies,

discussing their fertility intentions and making informed choices about contraceptive technology.

### **6.2.1 Accounts of passive inclusion in the decision making process**

As heads of households and custodians of culture, men heavily influence the outcome of reproductive decisions. Because of this women, by comparison, lack the agency to discuss fertility intentions and control their reproductive outcomes. Although women in both LGAs were mostly aware of contraceptive methods such as the male condom, pills and the injection in varying degrees, many of the women interviewed in Edu, particularly in two Nupe communities (Lafiagi and Edogi) were not fully aware of their rights to contraceptive information and their choice of contraceptive technology. Spousal communication about fertility preferences was uncommon among these couples. For these couples, the rationale behind this is centred on God having the ultimate control over their reproductive outcomes. The relationship between God and procreation has been explored in Chapter Five and the use of God and, by extension, religion has been queried in relation to poverty.

Women in these communities however, reported the use of contraceptives for spacing or resting between births. Contraceptive knowledge and access to contraceptive services was however, heavily policed their husbands which, links back to concepts on body ownership and transfer of reproductive rights that is characteristic of the marriage process in many Nigerian communities. Women's bodies are performed and enacted upon though the control of knowledge and, as such, pose a challenge to the notion of informed choice and active inclusion in the decision-making process around their fertility. Commonly used methods of contraception in these scenarios are more traditional and religiously sanctioned forms of family planning such as withdrawal method, fertility awareness methods and modern forms such as the male condom. The withdrawal method also known as *AzI* in Islamic texts is one of the oldest forms of contraception. It is a male-dominated method sanctioned by many religious institutions and, as such people have a positive attitude towards using it as a means to manage their fertility (Omran 1992; Ladipo 1996; El Hamri 2010). Knowledge of the withdrawal method is

passed on from generation to generation through the teachings of Islamic scholars (*mallams*) and, it is accessed by male members of the community.

**Participant:** *Because that withdrawal method has been prescribed by our mallams and everyone knows it. (FGD Men: urban: Edu)*

Here, knowledge of religiously sanctioned methods highlights one of the ways in which religion and gender act as techniques of power. *AzI* is a by-product of ideologies and truth claims about what is normal or acceptable within Islamic discourses on family planning (Foucault 1984; Ramazanoğlu & Holland 1993). Thus, couples included in the analysis of this dimension use religion in a way that creates the norm in which they police themselves and their bodies, providing an acceptable way of thinking about and performing fertility practices and possibly sharing blame in the event of infertility and unwanted pregnancy. These norms are gendered thus, knowledge and use of this method, together with the male condom, are controlled by men and form part of the wider social context in which women's fertility practices takes place, particularly when discussions around fertility outcome are not encouraged.

Through mechanisms such as withholding adequate contraceptive information and control of the method used, most women are rendered powerless with regards to the use of contraceptive technology. More importantly, their husbands did not feel the need to educate them on the choice of family planning used as a couple.

**Wali:** *No need. She knows that I can't do without it (relations) now. So no need to tell her. When I brought it she understood that that is what I am protecting*

**Kami:** *Yes I do. I didn't need to ask questions when he brought it home. I understand (Couple interview (Urban, Edu) Wali and Kami)*

Wali and Kami, a young couple living in Lafiagi are students at the College of Education in town. As a couple they have one child and they have used the pill and the male condom to prevent unwanted pregnancies. However, the introduction, use and acceptance of the two methods differ from one another. Also, their fertility preferences differed as Kami reported the need to have three or four children but mentioned, however, that she could not discuss her fertility desires with Wali who seven children as his ideal number children. On the use of contraception, it was not discussed explicitly as, according to Wali, they were in the early stages of their

marriage (*You know I told you we just got married. We are new to the system*). They were currently using the male condom and there was a non-verbal acceptance of the presence of the condom in their intimate relationship. One possible explanation for such acceptance might be that people generally do have an awareness of the male condom especially since its use has been championed as a universal preventive method for sexually transmitted infections which include HIV/AIDS (Bhattacharya 2004).

The situation is, however, quite different for the Pill.

**Wali:** *She is not supposed to know. I am the one that is supposed to prevent her from that so I am the one that knows the purpose of giving her.*

**Kami:** *He did not tell me when I asked him. I was told to take it every day* (Couple interview. (Couple interview (Urban, Edu) Wali and Kami)

There is a clear denial of the reproductive rights of the woman. Here, Wali saw no need either to consult his wife on the use of contraception or to explain to her the method being used to prevent pregnancy, even when asked for an explanation. The decision to use family planning and the decision about the method used (both male - and female-controlled method) were made solely by him. At the point where his actions and decisions intersect with hers, the only information given was ‘take it every day’, an instruction with which most women in Kami’s situation complied. This act of coercion was more common in Edoji but with the use of the progestin-only (levonorgestrel) Emergency Contraceptives (EC) pill branded locally as *postinor* or *sendinor* (see Figure 6.1).

**Figure 6.1:** A sample of the emergency contraception sold at the local pharmacy in Lafagi



Source: Photograph taken by author



**Moderator:** *Can you describe the pill you use?*

**Participant-** *You take it after service*

**Participant-** *There is one you take until after 3 days and there is one again that if I use after connection that has 10 inside. (FGD: Men: rural: Edu)*

This EC comes in either 2pills or 10pills progestin only regimens. Many of the women in this community did not entirely understand in entirety the type of contraceptive method that they were using. Focus group discussions provided insights to the type of pills men purchased for their wives. Based on their descriptions, men were aware that this form of contraception should be used immediately after intercourse. The use of emergency contraception among youths and unmarried adults is abundantly documented in the literature (Arowojolu & Adekunle 2000; Baiden *et al.* 2002; Obi & Ozumba 2009; Okonkwo & Okonkwo 2010; Both 2013). This situation is further evidenced by an interview with one of the local pharmacies in Lafiagi that supplies contraceptive services to members in the community. As evidenced from an interview with a staff member of the pharmacy, young people especially women are '*very smart these days*' and favour the use of emergency contraception. Men too can purchase emergency contraception if it is for their partners but it was often difficult to distinguish between those that are married and those that aren't. Results from these group discussions indicate that men generally have poor knowledge about the methods of contraception suitable for married couples given that they rely on the use of emergency contraception as opposed to other oral contraceptive pills like the Combined Oral Contraceptive Pills (COCP) and the Progesterone Only Pills (POP). Inadequate knowledge of the different methods of contraception is a reflection of the type of contraceptive services available and accessible to members of the community. The use of emergency contraception as a primary source of contraception has led to a situation where these pills have been abused by people in the community. This situation has been documented in other parts of Nigeria (Lang *et al.* 2012) exemplifying the need to improve contraceptive service delivery, particularly in rural and underserved communities. It is also plausible that married men are seeking one off temporary methods of preventing pregnancy as opposed to short - or long-acting methods of contraception.

Men have the ultimate power in decisions around their fertility as a couple; and women are aware that the pill prevents pregnancy but lack the agency to complain or comment on its use.

**Participant:** *when we are on our period, the men give us 15 days rest*

**Moderator:** *how do you know to count 15 days?*

**Participant:** *our husbands taught us.*

**Participant:** *they are the ones that taught us*

**Moderator:** *have any of you made the effort to understand how this works*

**Participant:** *if we do our husbands would beat us*

**Moderator:** *if you then have sex after the fifteen days, doesn't it scare you that you will get pregnant?*

**Participant:** *yes, we get scared but our husband assures us we won't get pregnant. Also if we don't agree he will beat us. (FGD: women: rural: Edu)*

The prevalence of the use of Emergency Contraceptives (ECs) among couples in this community works in hand with their commonly used natural form of family planning: the safe period. Based on the discussion extract above, women lack an understanding of their bodies and are provided with information about this form of natural family planning on a need-to-know basis. Knowledge and the agency attached to understanding of the safe period as a method of family planning can sometimes be met with violence. Women who do not conform to their gender identity as wives whose sexuality and body should be acted upon are often met with violence. According to Weiss & Gupta (1998), sexual coercion occurs when women experience the physical or social consequences of refusing their partner's sexual advances. Justifications for these acts reinforce gender norms that place women, their sexuality and reproduction under the control of men (Khan *et al.* 1996; Heise *et al.* 2002; Bawah *et al.* 1999). For women like Aliya (see Chapter One and Chapter Five) and other women that exercise their reproductive agency through the clandestine use of contraception (see Chapter Five: Section 5.4), their actions suggest an *'in betweenness'* in the categories of spousal communication. Their resistance or challenge to the status quo suggests that there are various levels of activity that occur within both categories. Resistance also suggest that these women have more active roles in using contraception than would be the case with women that appear to be involved in discussions around their fertility with their husbands.

### 6.2.2 Accounts of active inclusion in the decision-making process

The second dimension is around active inclusion in the decision-making process. It is argued that decision-making involves a series of conversations that occur at different stages in the reproductive life course of a couple. The origin of these conversations begins from an awareness of fertility intentions between couples. The analysis of these conversations revealed three levels of spousal communication based on the period in which communication occurred: spousal communication at courtship, spousal communication after an event of unintended pregnancy and spousal communication resulting from reproductive health complications. Because of the fluidity of spousal communication, couples may go through more than one stage of communication before accessing contraceptive services.

#### *Courtship and spousal communication*

For some couples, spousal communication occurred during their period of courtship. In this study, courtship here means the period before marriage where the life expectations of each partner were assessed and discussed. At this stage the overall fertility intentions of the couple were discussed. It is important to note that these fertility intentions are not static therefore; they can change over the reproductive life course of a couple. Although the intended number of children may not be fixed, the intentions to use some form of fertility management option (traditional or modern forms of contraception) operates at a level where the probability of using family planning will only be operationalized at the point of need. In most of these cases, fertility discussions were initiated by men and have economic undertones. Discussions initiated by men reinforce the case for male involvement in the use of family planning services as it increases the chances of women using contraception. This also corroborates existing research on spousal communication in Nigeria that reports the significance of involving men in the use of contraception (Ogunjuyigbe 2002; Oyediran *et al.* 2006; Ogunjuyigbe *et al.* 2009; Okwor & Olaseha 2010).

*Yusuf: When we met we started talking about it small small. When it was getting serious I called her and told her this is what I wanted and if she was going to do it or not. She said anything that I want is what we were going to*

*do. I told her that I wanted only 4 children. I didn't want many children that would give me problem. I know how much I earn and she agreed with me.*

**Interviewer:** *When your husband said he wanted four children what did you say?*

**Faizal:** *I told him what he wants is fine by me. It's what he wants because he has the final say at home. (Couple Interview (urban, Ilorin East): Yusuf and Faizal)*

Yusuf and Faizal, a Yoruba couple living in Ilorin East, had a conversation about their fertility during courtship. It was a gradual process as evidenced in the quote above. Yusuf is a civil servant and Faizal sells meat at the local market in their community. Yusuf weighed his fertility intentions based on his income and understands that having too many children would be difficult for him to afford. However, when asked about their desired number of children, Faizal expressed a need to have six children while Yusuf maintained that he wanted to have four. Faizal masks her need jokingly in the local language by relating her fertility to one of the avian food chains where hawks prey on baby chicks.

**Faizal:** *The remaining two a hawk has eaten them. [She laughs] My husband said no more again.*

**Interviewer:** *Do you want more children?*

**Faizal:** *Yes. But my husband said education is very expensive and we want the children to have good education and that's why we stopped at 4 because we want our children to be up to their mates. That's why I supported him when he said that was what he wanted. (Couple Interview (urban, Ilorin East): Yusuf and Faizal)*

Acceptance should not be interpreted solely as resignation or an institutionalized lack of agency. A change in the tone of the conversation could be observed after her husband mentioned the expenses attached to education. From 'I' (representing the husband) to 'we' (signalling a joint need), Faizal now appropriates the decision to have four children based on the need to improve the quality of life for their children. This supports research that suggests that people make family size decisions based on the changes in the cost of child rearing that have a bearing on the demand of children in the society. Mass education has played a role in shrinking family sizes, in changing the men's attitudes towards high fertility, and in the evolution of parent-child relationships (Caldwell 1980; Dow *et al.* 1994; Dadoo & Frost 2008; Casterline 2010; Alonge 2014; Kanayo *et al.* 2014; Smith 2015). People also have to

weigh the individual and societal costs of childrearing. Although many families in Nigeria rely on extended family members to share the cost of childrearing, these members are not without their own expenses and couples like Yusuf and Faizal who maintain a nuclear household might fare better without the added pressure of social obligations to extended kin (Caldwell & Caldwell 1987; Cleland & Wilson 1987; Bruce *et al.* 1995; Ocholla-Ayayo 1997; Wusu & Isiugo-Abanihe 2003; Campbell 2006). Therefore understanding 'acceptance' needs to be conceptualised within the wider changes in the demand for children and family size formations.

Acceptance for most other couples may also be due to an understanding of their financial situation, the socially and culturally accepted conventions of marital relationships and the possibility that the suggested number of children mirrors the woman's fertility intentions as well. There is also the possibility of non-verbal agreement between most of the couples as often witnessed in the interviews. This non-verbal agreement may be as a result of affection towards their spouse and a much deeper understanding of their journey together as a couple. Love, intimacy and emotion between couples are factors in this study (see also Chapter Five) that play a role in the ways in which people talk about their fertility preferences and contraceptive use, particularly who has control over initiating and determining a couple's fertility outcome. Thus, these categories are important in understanding the power dynamics between couples (Saavala 2013).

Although Yusuf and Faizal discussed their fertility and have used the injections (Depo-Provera) to space their children, the timing of the 4<sup>th</sup> child happened to be unplanned.

**Faizal:** *She laughs. It was 3 before but God made it 4. I missed the injection. The time I was supposed to go I did not go. I forgot. When I missed it and I went back to collect it they said I was pregnant and I cannot collect the injection again. They told me to come back after I had the child and make sure I don't miss it again in future. That's what happened. I waited for a while. Like almost six months before I went back. They told me to do a test. I didn't know I was even pregnant. I had not seen my period in a while and I didn't have any signs that I was pregnant. They gave me a bottle to pee in and bring back the next day. They test it that I was pregnant and it was almost 4 months. They said to come back after I had the child and make sure I come regularly when it was time.*

**Interviewer:** *Why did you forget?*

**Faizal:** *I didn't forget I travelled and I was scared of using another service in a place that I did not know. I didn't want to change hands and something would now happen. They can give me something that is not good for me. When I came back it was too late and I missed my date.* (Couple Interview (urban, Ilorin East): Yusuf and Faizal)

The above narrative exemplifies Faizal's experience using contraception and her unplanned pregnancy was associated with her imperfect use of Depo Provera, which in turn, was related to issues around the accessibility of contraceptive services. Again, God provided a means of shifting the responsibility for the pregnancy. However, 'forgetting' contextualized some of her concerns with changing service providers, which when taken into account, can be argued to have resulted in having an unplanned pregnancy. Whilst methods like the pills can be easily accessed from PMVs or pharmacies, methods like the injections are affected by issues around proximity to service providers, confidentiality, trust and privacy (Okech *et al.* 2011; Onwujekwe *et al.* 2013). Forgetting is also associated with pill and service providers have often claimed that women cannot be trusted properly discipline their bodies with the use of the pill (Richey 2008). For Faizal however, forgetting is related to insecurities around accessing services from a different provider. *Change hands, something would now happen* and *they can give me something that is not good for me* all highlight issues around trust, side effects, possible change in method and quality of contraceptive services available to her at the time. This narrative suggests an ongoing negotiation between women and their bodies. Even when women are allowed to use contraception there are other circumstances that can influence the continuous use of family planning.

For other couples, the prospect of polygyny influenced decisions around fertility preferences and consequently, the use of contraception. Women exercised their agency in situations where for example, their husbands initiated the discussion about their fertility, where there is some disagreement between their desired fertility preferences and in scenarios where there is not room for negotiating the outcome. Saratu and Nda live in a rural community in Edu. Nda is a student and Saratu is a tailor. Together, they have two children but husband Nda has a desire to

have eight children and enter a polygynous union in the future. In anticipation of this, Saratu has decided to have four children based on her personal ability to cater for them. Nda and Saratu started using the male condom after the birth of their first child and the injections (Noristerat) was introduced after the birth of their second child. Method change for them was related to an increased awareness of and access to other methods of family planning.

**Saratu:** *So the 4 I want to give birth to are for me. Because when we are now plenty and he does not give me attention or answer me I would know how I would take care of my children and myself.* (Couple interview (rural, Edu): Saratu and Nda)

Women in focus group discussions also expressed this sense of insecurity as they felt the need to protect themselves from possible financial struggles by limiting their births after having several children. It was left to them as women to explore any means to manage their fertility, with or without their husband's approval. Although these women might well have at least four children, which in itself is high, these findings suggest a change in the way women view polygamy and childbearing and challenges the conventional wisdom that polygamy fosters high fertility. Here, women are not particularly concerned about inheritance but more about feeding and caring for their children when their husband's attention is divided. This sense of insecurity is further heightened if the additional wife and the consequently, polygyny arises as a result of a love match (Boserup 2008).

**Participant (Woman):** *See even when people sit down and agree on the children the man can go and bring another wife in less than a year from the last child they have had together. Yet you told me the ones I have are enough. We would both start from the scratch and start having babies.* (FGD Mixed: Urban: Ilorin East)

However, the above quotation provides a counter-argument in support of the conventional notion that polygamy fosters high fertility (Izugbara *et al.* 2010; Sargent & Cordell 2003; Duze & Mohammed 2006; Izugbara & Ezeh 2010). Here, a sense of betrayal can be observed in the quotation and having more children than discussed can perhaps be a way to confront those feelings. This was evidenced in a single interview with a woman who happened to be in a polygynous union as the second wife. Samira, a teacher, joined the family during the latter stages of her

time in higher education and has four children with her husband, making a total of ten children for the family as a whole. As indicated in the quote below, Samira used natural methods of family planning before switching to the pill.

**Samira:** *We were dating when the discussion went on. We met when he has 4 children. I joined the family when the children were 5. So then I had my first child. I was in level 4 when I went in and there wasn't any pregnancy before then. After my final paper I had my first pregnancy. Ever before I came in I told him I would not have more than 4. So he agreed. That time my senior wife also had one. 3months after she had her own I had my first which came as the 7<sup>th</sup> child.*

*[.....]*

*So initially we wanted to space them with contraception but before my first child I used safe period method so after we had the baby I started using the pill*

**Interviewer:** *Which pill did you use?*

**Samira:** *The 28days one.* (Single interview (urban, Ilorin East): Samira)

Competition as a means to sustain their husband's attention and investments is evident in this case. The age difference between the sixth and seventh child in the home is close suggesting that both women conceived around the same time. Samira's position as the second wife, along with her level of education, might explain why she was able to initiate and control her fertility to a degree found acceptable. In this study, insecurity and betrayal are associated with polygamy and it is embedded in ideas of love and neglect. Women are seen to respond to and navigate the complexities of polygamy differently.

For some other couples in this category, fertility related discussions were influenced by their personal family backgrounds where one or both partners belonged to huge families and had a personal understanding of the struggles associated with having too many children influenced discussions.

**Emeka:** *You see personally the thing is that before I married I had my mind made up on having just a small family. I did not discuss it with anybody. It was personal. Maybe that is the orientation that God gave me. I saw my father and fore fathers struggle while trying to take care of their children. They were suffering. They didn't have much money and they were still having many children and trying to bring them up and it was not easy for them. I told myself I wasn't going to be part of that.* (Couple interview (urban, Ilorin East): Emeka and Adanna)

This position is evident in Emeka and Adanna's situation but there was some disagreement with their fertility desires, as Emeka wanted one less child than



Adanna. Again the husband initiated this conversation and it was based on his personal reflections on his ancestral struggle with high fertility and its association with poverty. There is a positive link between lower fertility rates and poverty reduction (Birdsall *et al.* 2001). Smaller numbers of children allow for increased investments in education per child especially in the Nigerian situation where the cost of education is borne primarily by parents. Children from smaller families are better equipped to make decisions, manage their fertility and provide education for the next generation which can potentially halt the transmission of intergenerational poverty (Merrick 2002). Nevertheless, there is still evidence of some form of negotiation about fertility preferences.

**Emeka:** *I started it. I said three she said four and I later agreed.*

**Adanna:** *this is Africa o*

**Emeka:** *and eventually God gave us five. We have no choice*

**Interviewer:** *What do you mean by this is Africa?*

**Adanna:** *you know Africans like children. It's not like Whites that even if they have one, they are ok. We cherish more of them. (Couple interview (urban, Ilorin East): Emeka and Adanna)*

More importantly, Adanna could negotiate the outcome of their desired fertility size as a couple. Although Adanna acknowledges the lower fertility rates are associated with Western cultures, she leans on culture to negotiate her interests, thereby making it an enabling factor in this case. However, divine power was used to explain the fifth child and also shift the responsibility for the timing and result of coitus. Like Yusuf and Faizal, supernatural control of births provided a safe and non-threatening way to accept their family size. Unlike the afore mentioned couple, Emeka and Adanna used the Billings method to prevent pregnancies throughout their reproductive life course and only sought to use more modern forms of contraception after the 5<sup>th</sup> child, the narrative of which will be analysed in Chapter Seven.

#### *Marriage, unintended pregnancies and spousal communication*

The next level of spousal communication is the conversation that occurs in marriage. Here, spousal communication can be observed when couples are concerned about the possibility of having closely spaced children. This can be

further intensified after an incident of unwanted pregnancy. Results from research among couples in Pakistan suggests that couples discussed fertility management options only *after* an incident of unintended pregnancy (Kamran *et al.* 2011).

**Adam:** *Because of unwanted pregnancy. When the child has not reached one to two years. If you are meeting with your wife without using pills she would get pregnant.* (Separate couple interview (rural, Edu): Adam and Eve)

Adam and Eve, a couple living in Edu had one child at the time of the interview and another on the way as Eve was 6 months pregnant. As a couple, they did not have any conversation about their fertility until after marriage. Adam initiated the conversation about their fertility and suggested they have four children, which Eve disagreed with as she expressed a need to have more children. Regardless of this difference in fertility intentions, Adam prompted the use of contraception because of the risk of having an unwanted pregnancy. For other couples with the intention of avoiding unwanted pregnancies, these conversations were also initiated when the men (see quote below) felt the current child was old enough and it was acceptable for them to resume intercourse with their wives.

**Interviewer:** *So how long do you breastfeed your child?*

**Hauwa:** *1 year and 6 months*

**Interviewer:** *Do you have sexual relations during that time?*

**Hauwa:** *No*

**Interviewer:** *So for that long you don't have relations with you husband*

**Both:** *yes*

**Mahmud:** *when you are used to something it's not an issue.*

**Hauwa:** *from the beginning that's how we have been*

**Mahmud:** *that is how we have trained ourselves [.....] When we want to start having children we continue.* (Couple Interview (urban, Ilorin East) Hauwa and Mahmud)

Prolonged sexual abstinence after childbirth is a socio-cultural phenomenon practiced among different cultures in Africa including Nigeria. Sexual abstinence has been used historically to control fertility and prolong the birth intervals between children (Caldwell & Caldwell 1977; Orubuloye 1979; Benefo 1995; Zulu 2001; Mbekenga *et al.* 2013). The period varies in different societies and has been known to exceed two years in many West African societies including the Yoruba people of Nigeria (Caldwell & Caldwell 1977; Orubuloye 1979; Benefo 1995). Abstinence is a

key determinant of fertility particularly in the absence or low use of modern contraceptives. Its use has declined over time, particularly in many societies with the increased supply of contraception and is implicated in men's sexual networking patterns (Cleland *et al.* 1999; Ali & Cleland 2001), which will be discussed later in this chapter. Breastfeeding and subsequently amenorrhea were also used as a natural means of preventing pregnancy. Because the duration of amenorrhea varies from woman to woman, it motivated those couples in between births to explore their fertility options in order that they could resume intercourse and avoid unwanted pregnancy. The importance of contraception cannot be overemphasized as it is critical in reducing maternal mortality by preventing unintended pregnancy and subsequently, unsafe abortions (Bongaarts & Sinding 2009; Oye-Adeniran *et al.* 2002; Cleland *et al.* 2006). For most women an abortion is a challenging experience (Dudgeon & Inhorn 2004), one which can alter future attitudes towards the use of contraception (Omideyi *et al.* 2011).

For Anisa (housewife) and Jega (carpenter), the path leading to communication about their fertility as a couple and accessing contraceptive services was difficult. They did not have a discussion about their fertility intentions because they have lost three children to miscarriages and under-five infant mortality. Jega did express a desire to have 40 children and has intentions to enter into a polygynous union.

**Anisa:** *Before he bought it he told me that he wanted to have relations with me. I told him that he knows that it is not good for him to come close to me because I want to rest for three years. Because of all the things that happened with the one before this child. The child was a year and half but could not walk. After a while the child died. With this one it was not time to have another child but I got pregnant. We took drugs and the pregnancy came down. I don't want that again. When we went to the hospital they explained to us (the drug we can use). That's why he went to buy the drugs. (Couple interview (urban, Edu) Anisa and Jega)*

There are a number of issues explored in the above quotation: intimacy, birth spacing, loss of a child, unintended pregnancy and abortion. For Anisa, contraception was not seen as an option until she experienced these issues. Spousal communication occurred after the loss of her child but she was denied the

use of family planning because her husband did not approve of the use of contraception.

***Anisa:** I told him and he said he is not in support because ‘someone’ told him that if he allows me to do family planning I won’t have any more children.*

This decision was based on extra-household conversations that influenced the way Jega constructed knowledge on the benefits of family planning. This provides a slight nuance to the effects of people’s social networks on validating contraceptive knowledge and improving access to family planning services as in Chapter Five. Friends and family, and by extension the community, provide a meso-level of analysing the decision-making process. Regardless of this, the wife exercised some form of agency and sought contraceptive services only for her to be denied access because the service provider asked to meet her spouse.

***Anisa:** He now said he is not in support. When I even went to the hospital to access family planning they didn’t attend to me. They asked me to go and bring my husband. Unless I bring my husband they would not do it for me.*

In their literature review of the barriers to fertility behaviour, Campbell *et al.* (2006) suggest that provider and medical bias impose unnecessary restrictions in accessing contraceptive services and these restrictions will be elaborated upon in the consideration of ‘punitive quality’ in Chapter Seven. Furthermore, Geda & Lako (2013) reported the major reasons for the failure to prevent unwanted pregnancies among married women in Southern Ethiopia as lack of knowledge, husband’s disapproval, difficulty in accessing contraceptive services and method failure. For this particular couple, it was a combination of all of these factors apart from contraceptive failure. It might be concluded, albeit with caution, that the use of family planning became an option for Jega only when he was denied sexual relations with his wife. This is not to say that he did not feel any compassion for losing a child or aborting an unwanted pregnancy. However, spousal communication that led to the seeking of information and subsequently, the use of the pill, this time not from a friend (‘someone’) but from a service provider - occurred as a result of his desire to resume marital relations. In a similar way to behaviour studied in Pakistan (Kamran *et al.* 2011) other couples discussed their fertility choices after an unwanted pregnancy which in many cases led to the use of

contraception after the birth of the associated child. Research has shown a positive link between unplanned births and the use of contraception as most couples would rather adopt a method of contraception than have a repeat occurrence of an unintended pregnancy (Kamal & Islam 2011).

***Aliya:** What happened was you know I told you I have birth within a year to two children. I was thinking it's the relations I am doing with this man that lead to pregnancy and people used it to insult me that I don't want my husband to marry other wives that's why I'm having many children. I now thought we can't in the name of relations (means intercourse) have another pregnancy that's why I came to the clinic and did family planning. I was taking the two months injection. (Single interview (urban, Ilorin East) Aliya)*

The quotation above does not relate to an explicit spousal communication but is more about a woman acting on her perceived risk of having another unintended pregnancy. Having two children within the space of one year not only had reproductive implications for her, but also social implications. Her concern, as implied by the conversation, was as much about community perceptions of the timing and frequency of her births. Clearly, she did not want to associate her reproductive outcomes with the social implications of high parity. Studies have shown that couples that have closely spaced children within a year of one another commonly reported using contraceptive technology thereafter (Gipson & Hindin 2007; Yue *et al.* 2010), much as demonstrated by Aliya in the quotation above. At this stage, spousal communication did not necessarily lead to the immediate use of contraception, highlighting the complexities around the use of family planning services. Here, external factors such as community approval - of fertility choices and intentions to use contraception - can be seen to have an effect on people's reproductive practices.

#### *Spousal communication and reproductive health issues*

For the remaining couples studied, spousal communication and the subsequent use of contraception occurred after pregnancy-related complications such as spontaneous abortions or caesarean births.

**Hafsau:** *I have told you before. My children were dying (refers to miscarriage here) so we decided to use family planning so that I can rest small before another one. (Single interview (rural, Ilorin East): Hafsau)*

Hafsau is a housewife with five living children. She does not mention how many pregnancies she has had in total and only makes reference to this aspect when reporting her use of contraception. At the time of the interview, Hafsau had only recently experienced another miscarriage. Because of this, Hafsau decided with her husband that they would not have any more children.

The situation is quite different for Malik (security guard) and Inka (petty trader) in the sense that their scenario cuts across all three levels of spousal communication. As a couple they decided to have six children but had an unintended pregnancy out of wedlock just before Inka completed her secondary school education. Because of this, they were encouraged by health care providers to use contraception in order to prevent further unintended pregnancies before they got married.

**Malik:** *Yes we did. We said six. But when things changed we thought differently. She has had two operations now and the doctors have warned us not to have children again. So we have four now. (Couple interview (urban, Ilorin East) Malik and Inka)*

**Inka:** *You see they called us aside and offered suggestions as to how to avoid getting pregnant. And then some people at the hospital spoke to us about family planning too. They told us using family planning would allow me rest and also give us peace of mind as a couple. So that's how we went back and had the family planning done. (Couple interview (urban, Ilorin East) Malik and Inka)*

After her parents arranged her wedding ceremony she moved in with Malik and continued using family planning, which resulted in an eight-year gap between her first and second live birth. In all, they have five pregnancies and four live births.

**Interviewer:** *Ok. So the next child how many years gap in-between?*

**Malik:** *two*

**Inka:** *no its three years. I remember because I was told in the hospital to wait a bit before having the next child that the earlier miscarriage has almost spoilt my uterus. I got pregnant for the third child after three year. (Couple interview (urban: Ilorin East) Malik and Inka)*

It is interesting to see how they go back and forth in recounting their reproductive history as a couple. The use of contraception is evident again in Inka's description of the effects of her miscarriage on her uterus. Inka had her last child eight years later

and, as suggested in their interview, they have had to adjust their desired fertility goals because of the perceived risk of having more children to her health and mortality. Caesarean section is associated with lower fertility among women in Sub-Saharan Africa because the odds of childbirth occurring in the future are lower among women with previous experiences of caesarean births (Collin *et al.* 2006). Research has also suggested that, among other factors, concerns about the mother's health influences the desire to limit childbearing among Ghanaian women (Kodzi *et al.* 2012).

Thus far, this section has focused on couple's experiences in communicating their fertility preferences to one another. Communicating and making decisions about their fertility intentions is not linear. It is layered in between gender and power relationships that influence spousal communication and, consequently, the use of contraception. Because fertility practices and behaviours are socially constructed and re-enacted by members of the community, spousal communication is particularly subject to external influences that play key roles in the decision-making process. Those most relevant in this research are the family and friends that constitute part of a couple's wider social network.

### **6.3 Social networks and contraceptive decision-making**

Community based knowledge and ways of being are important factors in providing a nuanced understanding of how contraceptive knowledge is validated in the community, how people perceive modern forms of contraception and child spacing practices, how people access contraception and how these factors come together to affect the decision-making process. Drawing on the theoretical focus that stresses the role of networks of people in the communication of ideas (Casterline 2001b; Casterline *et al.* 2001), social networks are relevant in this research not only in the provision of contraceptive information but also in the acceptance of family planning, the use of particular methods and the construction of lived or perceived experiences of using contraceptive devices. Montgomery & Casterline (1996) and Lin (1999) add that social influences on reproductive behaviour feed off networks that forcefully maintain the traditional status quo. Social networks can, therefore,

structure the flow of information and impede or enable the adoption and/or practice of family planning.

People social networks in this study include friends, family members and other members of the community. Because these people are members of the community, friends and family can also be health professionals or representatives of state authorities. The multiple identities taken by friends and family members therefore intersect with the private realm of decision-making as a couple, and with the public domain in which family planning services are accessed, to generate a meso-level at which to analyse the decision-making process. Regardless of the LGA and social context, these groups of people play important roles in social learning and behavioral change in their communities (Kohler *et al.* 2001). Not only do they provide information, they aid in the acceptance of family planning, the use of particular methods and the construction of lived or perceived experiences with using contraceptive devices. Kinship and the networks provided by its association serve as a third party in discussing fertility and available methods of management (Godley 2001; Montgomery *et al.* 2001; Musalia 2005). According to Musalia (2005), community members may not be as influential as friend and immediate family members in the distribution and use of contraceptive technology. Several studies have documented the role social networks play in weighing pros and cons of high parity in the course of their everyday activities (Sharan & Valente 2002; Godley 2001; Kohler *et al.* 2001; Musalia 2005; Campbell *et al.* 2006; Yee & Simon 2010).

The quote below is an example of how family and friend provide information and aid the use of contraceptive technology.

**Mary:** *Another of my friend. But she is not using pills. She is using injections. She said she did not like the pills. She said that when she has a baby in her hand that her husband would not want to meet her. So I told her that this was what I was using so that I won't get pregnant. She has only one child. So she now went home and discussed with her husband. She said she does not like pills. So they went to one clinic and started taking injection (Separate couple interview (rural, Edu) John and Mary).*

This quote highlights the perceived risk of pregnancy especially when there is the fear of having closely spaced children. It also highlights the use of post-partum



abstinence as a means of managing their fertility as a couple. Based on gender, women find it easier to have conversations about fertility with one another. Therefore, agency can be acquired and/or exercised through social networks and kinship groups. The use of contraception by her friend made it acceptable for her to think about family planning, discuss its use with her husband and then access contraceptive services. This form of social learning is based on trust and a believed reliability of the information provided by these networks.

These networks also facilitate the construction of myths and misinformation about contraceptive devices especially the side effects which may be misleading as women's bodies are different from one another. As discussed earlier (see interview with Anisa and Jega) and in the quotations below, the perceived side effects of contraception as constructed via a couple's social circle influenced their use of contraceptive technology.

**Anita:** *I have a nurse that is closer to me and she was talking about injections and the pills. So I was thinking which one would be preferable for me. Some of them said like the pill because I have not used it before when they take it turns into another thing by making them to look more fatty and some when you are looking for pregnancy it would not come. So I was thinking which one would be preferable but I said to myself that when the time comes I would figure it out (Couple interview (rural: Edu): Peter and Anita).*

**Participant (woman)** - *there was one lady that used the one they dig into the arm. The arm disturbed her so bad. When they removed it the arm was eaten up (mucus, pus and all). So because of that I have not had interest in it. (FGD: mixed: Urban: Ilorin East)*

In the case of Anisa and Jega, there is visible evidence of interference in their communication about contraceptive use as a couple. Jega's extra-conjugal conversation with 'someone' impeded the use of contraception based on the information provided during that conversation. It can also be observed in this instance that the husband had prior knowledge of contraception and, at the point of spousal communication, rejected the use of family planning based on knowledge acquired from interactions within his social group. For Anita, the use of 'they' refers to what is being said in her immediate environment about contraceptive methods. The participant is separating herself from the narrative by saying *because*

*I have not used it before* but relies on the narrative used by (*they*) her social network on the effects of contraceptives on the body. By expressing her concerns about weight gain and fear of infertility, phrases like *'more fatty'* or *'looking for pregnancy'* can be interpreted as accessible ways of constructing information about family planning methods. There is some truth in their assertions as there is evidence of contraindications with many of these methods. Some do cause considerable weight gain and the return to fertility for a few methods are not immediate compared to others (Gilliam *et al.* 2004). Therefore, people assess the social acceptance of behaviours within the community through social networks and, where the use of contraceptive technology is concerned, people are confronted by information about the pros and cons of high parity in the course of their everyday activities. Consequently, people are likely to behave like those with whom they frequently interact (Musalia 2005).

There is a gendered nature to these social networks. Men and women control different spheres of the household and these extend to gendered spaces in the community. For women, these spaces are not limited to areas around reproductive labour and may include feminized spaces such as salons. The same can be said for men too as ethnographic data in Edu suggests that men gather in informal spaces such as public transport garages and mechanic's workstations to rest in between shifts or farming activities and potentially discuss various events or situations in their lives or in the community. According to Avong (2004), men that receive encouragement from their social networks are more likely to use contraception. Thus, social approval of contraception stimulates spousal communication on their fertility as a couple.

**Wali:** *We boys when we are together we talk. This person would bring his own that person would bring his own. You know.* (Couple interview (urban, Edu) Wali and Kami)

Research suggests that verbal encouragement from social networks on the use of contraceptive technology may increase the probability of use by stimulating communication with spouses at home (Kincaid 2000; Avong 2004). This is particularly common in regard to the use of the male condom (Chimbiri 2007). A number of studies have shown the effect of social networks on fertility behaviour

(Valente *et al.* 1997; Godley 2001; Kohler *et al.* 2001; Madhavan *et al.* 2003; Benefo 2010; Kincaid 2000; Avong 2004; Musalia 2005). These studies build on the premise that an understanding of the role social networks play in the uptake of contraceptive technology is important in reducing the risk of unintended pregnancy.

However, research has also shown that - compared to socio-demographic characteristics and religion - the effects of social networks on the use of contraception can be minimal (Alvergne *et al.* 2011). Nevertheless, it is worth noting that the effects of social networks are more visible at the point where couples access contraception than on the overall reproductive outcome of a couple (Madhavan *et al.* 2003). Participants rely on these networks because of trust and a belief in the reliability of the information provided by them. This is particularly important especially when it comes to the choice of contraception used. People weigh the pro and cons of using specific methods on the basis of the type of information they have access to. Narratives from their social networks can be interpreted as a sign of approval of local knowledge of family planning and the type of method to use based on their perceived or real experience of using family planning.

These networks also facilitate the construction of myths and misinformation about contraceptive devices especially the side effects which may be misleading given the differences that exist between women's bodies. Recycling this information from one person to the other based on lived or perceived experiences permeate the construction of the 'myth' behind contraceptive devices. These myths and misinformation then become very important, especially when it comes to the choice of contraception used. The following quotations illustrate some of the construction placed on IUDs and their effects on the female body.

**Samira:** *Why we don't like the IUD is because I have an aunt, [mentions her name] She had four children then. After a while she had stomach problem and was taken to the hospital. She was later operated on about the IUD. It's like fat had grown around it or whatever so that's what happened. So since then we had the fear of the IUD.* (Single interview (urban, Ilorin East): Samira)

**Mary:** *Plus I am afraid that I would lean because I hear people used to lean if they change method. Some people they would lean. You would see it in their body that they are taking something. Some people say that if you take the IUD and get pregnant the baby would come out and hold the IUD.* (Separate couple interview (rural, Edu) John and Mary)

The various ways in which the effectiveness of the IUD is constructed within different social networks can be observed in the quotations above. There is a sense of fear associated with its use. It is interesting to note that in both cases women weighed the IUD as a contraceptive option based on experiences of the IUD use constructed by members of their social network. In this context, women's bodies are viewed as identical and there is a perceived risk, therefore, of having similar experiences when using an IUD. For Samira, the concern is less about any contraceptive outcome and more about the adverse effects of the IUD if the story told is taken at face value. *'It's like fat had grown around it or whatever so that's what happened'* indicates caution, as she is unconcerned by any other events surrounding the surgery and is positive it resulted from the use of the IUD. Either way, such events influence the way women think about the IUD as a method of contraception.

For Mary, the concerns are twofold. Firstly, there is a fear of losing weight (*'lean'*) and the social implications of visible weight loss such that community members could comment upon it. Secondly, there is the issue of unwanted pregnancy and expulsion of the IUD in the birthing of a baby. 'Non-expert' knowledge is affecting her decision to change her method to a long-acting form of contraception. The perceived effectiveness of the IUD now plays a role in her decision making process regardless of the fact that she has access to 'expert' knowledge from service providers. This narrative of the IUD shows how discourses around its effectiveness perform the reliability of the IUD as a means of preventing unwanted pregnancy. By so doing, it reduces the long-term benefits of the device to the 0.1% chance of having an unplanned pregnancy (Takeshita 2010). Irrespective of the version of these non-expert forms of knowledge, there are elements of scientific truth within these stories. It has been documented that pregnancies do result from incorrect or inconsistent use of contraception (Trussell 2004b). However, some of these pregnancies are true failures of the method of contraception (Peterson & Curtis

2005; Trussell 2004b). In the case of the IUD, its efficacy has been known to increase with age (Avecilla-Palau & Moreno 2003), thus increasing the possibility of these kinds of discussions among younger women in the community.

*Mary: But some people say the pill is not good so I used to advise them that it is good. Why I say my sisters know is because she is taking injection and when she took it she didn't see her menses again. It stopped. Then when I said that this pill is good and if you take it now you would see your menses regularly she just started using it. She is familiar with it now and her period is regular.*  
(Separate couple interview (rural, Edu) John and Mary)

With this quotation, Mary is taking part in a series of conversations about the effectiveness of contraceptive technologies, which in this case is the pill. Firstly, she reports talking about the pros and cons of the pill with people who could be family, friends or general members of the community. Secondly, she personalizes the narrative by drawing on her conversation with her sister on the benefits of the Pill especially since there was a concern about the frequency of her sister's menstrual cycle. Knowledge sharing through her lived experience of using the pill influenced her sister's acceptance and subsequent use of the pill (Montgomery & Casterline 1993; Basnyat & Dutta 2011). Kinship and the networks provided by its association thus serve as a third parties in discussing fertility and the methods available to manage it.

Narratives, spread through immediate family, social groups and networks, of the effectiveness and side effects of different forms of contraception form part of what people know about contraception, and the ability of men and women to talk about family planning (how it is known) is based on their experience of using contraceptive technology. Such diffusion also frames how side effects of contraceptive technology are constructed (Montgomery & Casterline 1993; Casterline 2001a). Couples may get professional knowledge from service providers but also rely on their social networks and kinship groups for local knowledge of real or perceived use and effectiveness of contraceptive technology. According to Miller (2005), it is not about the authenticity of the knowledge produced but more about socially approved production of contraceptive knowledge. Knowledge production and the narratives used in telling these stories show how women as contraceptive users challenge hierarchies of knowledge and resist the hegemonic discursive

framings of contraception by creating their own information on contraceptive technology.

*One of the main hindrances that we have in FP provision is rumours and misconceptions. That is our major problem. All the side effects are nothing. Rumours and misconception is our problem. If you finish counselling your client there is another counsellor out there within themselves. They would counsel themselves again. 'Ah you want to do this one, in fact you see that IUCD the one that they insert, the woman said they can't find it again and when she wanted to deliver in fact the baby held it in its hand like this'. How on earth can you believe that a baby can hold IUD to life? How can it penetrate into the uterus? There are so many. It is our problem rumours and misconceptions (Local clinic 2, Urban: IE).*

Based on the above quotation and interviews with service provider, local knowledge or what is professionally known as myths and misinformation is one of the barriers in scaling up the use of family planning services (Campbell *et al.* 2006) and the effects of these barriers, as mentioned in Chapter Three, will be examined in detail in Chapter Seven. The other counsellors can be interpreted as the client's family and friends that form part of their kinship network. These myths and misinformation have been documented as one of the barriers to using family planning (Ankomah *et al.* 2011). This according to some of the service providers is one of the key issues affecting the uptake of family planning services. Stories of use are woven in ways evoke different feelings about family planning. Fear, the invasiveness of some methods and the idea of controlled fertility are but a few. Relief from reproductive labor for some women is unimaginable and foreign that the possibility of counting births within their reproductive years is not part of their social reality. Nonetheless, it is clear that women are not always powerless subjects and are able to negotiate with different sources of knowledge in the contraceptive decision-making process.

Communication - both as a couple and also with members of the community - is not however, enough to guarantee the use of contraception. It is therefore imperative to understand the economic, structural and social contexts in which communication occurs in order to ensure a more realistic interpretation of couples' need to plan their families. In other words, what are the underlying factors, events, or triggers that enable spousal communication on fertility goals and management options to

move from the private sphere of the household to the public domain of service provision?

#### **6.4 Economic Triggers**

This section discusses the economic triggers, life events, motivations or circumstances that motivate couples to actively seek contraceptive services and builds on the findings throughout this chapter and, earlier in Chapter Five that point at the economic motivations in the use of family planning.

The quotations in Box 6.1 situate the economic contexts of contraceptive decision-making. These quotes show that couples with economic triggers like rising costs of education and unemployment use contraception to ensure that they have the number of children that they have the financial capacity to cater for. The economic reasoning ascribed to the use of family planning is a reflection of the financial difficulties experienced by couples. Educating their children meant better employment opportunities especially in an economy that places value on the qualifications of prospective employees.

Asaki, a blacksmith and Amina, a trader, live in a rural community in Ilorin East. Asaki has 5 children from a previous marriage and had two with Amina. As a couple, they both have primary school education and have a lived experience of the economic limitations associated with the lack of higher levels of education. *May our children not be the help (servant) of their mates* is a comment said as a prayer when Asaki stressed the importance of educating their children. For them, as with other couples in this situation, educating their children meant improving their children's quality of life, their ability to live up to their potential and to avoid being outcasts within members of their age group. Many of the conversations surrounding their fertility occurred during courtship or at the early stages of their marriage.

An analysis of the quotes reveals that men do have some agency even though it departs from the reproductive health status of their wives and focus more on the overall welfare of the family. Phrases like *'I didn't have a job'*, *'the economy is not good'*, *'University fees are up to 200 000'* and *'there was nothing in my husband's hand'* all

highlight the context in which men (and women) frame the events that lead to the use of contraception.

**Box 6.1: Economic motivations for the use of contraception**

**Asaki:** *At the time of our marriage I didn't have a job and she had not started her trade then talk more of school fees. Regardless of the situation children must go to school. That is why we decided then to have 4 children and stop from then on. (Couple interview (rural: Ilorin East) Asaki and Amina)*

**Participant (men):** *In the olden days there was nothing like family planning in this our area. When we get married if it is 20 children she can give birth to that's what she would give birth to so far she has the strength to carry it. But it's the economy that is saying oh I want this child to go to school and I want it to be a lawyer or doctor. University fees are up to 200 000 now and we don't know what it would be in the future. That is why people are now thinking about having 2 or 3 children so that they would be easier to train. (FGD Mixed: Urban: Ilorin East)*

**John:** *The economy is not good. The children have to go to school if you born berekete [means plenty] how would you sponsor them. At the end of the day they would be cursing you. (Separate couple interview (rural: Edu) John and Mary)*

**Jacob:** *Let's go biblical. My bible tells me go ye and multiply and then there is a clause: multiply and look after them. So that is number one. That means he is telling me to have the ones I can cater to. I want to give birth to children I can cater for in terms of education, domestic relief and all what the children would need. If I have more than I can cater for that is a problem. Secondly, to better their education. As you are seeing me I am an applicant. I don't have a job. You have seen my shop. If I have five, six or seven children with that little shop how would I cater for them. That is why I am doing it so that I would be able to send them to school. (Couple interview (rural, Edu) Jacob and Jane)*

**Yusuf:** *I was working with one textile that time at Kaduna. By the time the company closed down I don't have any work to do and I didn't have any money to sponsor children. That is why I decided to stop it for that time in order to get another work then we can continue. (Couple Interview (urban, Ilorin East) Yusuf and Faizal)*

**Tami:** *Because that time there was nothing in my husband's hand so I don't want to have another pregnancy that is why we did family planning. (Couple interview (rural: Ilorin East) Zain and Tami)*

Seeing men plan ahead and show concern about the welfare of their families diminishes the idea of the problematic and dominating man. This is not to say that this hegemonic gender ideology does not exist in many couples interviewed in this study. However, it allows room to think about a different type of man and other ways to perform masculinity. This might also be one of the ways men try to mitigate the potential economic changes in the home for women thanks to increased opportunities for paid work and, perhaps, resultant changes in gender relations and



the balance of authority in the home (Kabeer 2007; Hoang & Yeoh 2011). Only having the number of children they can financially provide for may mean that, regardless of any financial threats in the future, they can still maintain the status quo of the breadwinner/ caregiver division – or accommodate some of the changes representative of increased female women’s earnings - since they have fewer mouths to feed. Having up to four children can be treated as having many children or having just enough to begin some kind of fertility transition (Smith, 2004). In these circumstances, contraception improves the reproductive health status of women on the one hand and allows couples to be financially stable before continuing childbirth on the other.

Children are consumers not only of food but also of resources. With declining economic conditions in the country, parents weight the options of the when and how of childbearing in the course of their marriage. For other parents, childbearing is put on hold until their current economic status improved. Thus contraception provides a means for couples to avoid the responsibilities of parenthood until they can better provide for their families. Postponing child birth is therefore a critical family building strategy employed by couples in this research. This supports the argument presented by Moultrie & Timaeus (2014) that claimed postponement, particularly in the context of high fertility preferences is perhaps a response to both personal and institutional situations experienced by many African women. This lays further emphasis to the ways in which women (see *Anko* in Chapter Five) withhold or postpone procreation when they lack access to material resources. In this thesis, postponement employed by both men and women (see Asaki, Yusuf and Tami) provides a more nuanced understanding of contraceptive use than spacing or limiting child bearing. Poverty and/or lack of financial resources are precursors for stalling fertility intentions amongst these couples. Phrases like *no money yet* or *we can't afford to born now* exemplify the association of children with sustained expense, at least to the point at which they are in gainful employment. Besides this association being reported in Nigeria (Smith 2004), it has also been observed in Ethiopia (Gurmu & Mace 2008), Tanzania (Hollos & Larsen 2004) and India (Saavala 2013).

Couples here are not having fewer children and using contraception because they are modern and/or want to reap the benefits of westernization. They are having fewer children because they lack the financial resources to cater for a large family. Education, food and housing are expensive and their income barely covers these expenses. As with many other Nigerian parents (Bolaji 2004), parents here are willing to struggle to educate their children and plan their lives hence the use of contraceptive technology. Obono (2003) argues that the fertility reductions observed in Nigeria, as with many other Sub-Saharan countries are mainly a by-product of structural adjustment programmes that increased the cost of having large families for many couples and motivated them to pursue fertility management options as discussed in Chapter Three. Public sector cuts have led to an increased reliance on the private sector and foreign aid for healthcare provision, as well as policy reforms that led to the introduction of user fees and payment for consumables (Buckley & Baker 2008; Pandolfelli *et al.* 2014), the effects of which would be discussed in Chapter Seven.

The implications of this are visible in the current Nigerian DHS as 13% of child births occur in the private sector and 63% of women deliver at home, citing - amongst others - cost and distance from facilities as common factors for home delivery (NPC & ICF Macro 2014). The effects of these programmes were also visible in Nigeria's educational sector. The introduction of user fees and cost recovery policies to education as a means of reducing its burden on government and the current polarization of private universities further intensify inequalities in education between rich and poor (Geo-Jaja & Mangum 2003; Geo-Jaja 2004; Akpotu & Akpochafo 2009; Obasi 2007).

Economic difficulty is currently being used by the State and supporting organizations to promote small families and stimulate spousal communication about family planning at a household level, serving as the narrative couples use to justify their use of contraceptive technology. However, for most of the couples in this research that use family planning, managing fertility is more about spacing births than limiting (see Chapter Five). Couples have strong pronatal tendencies even when using contraception, which could explain why contraception is practised

from an economic standpoint and not from a reproductive health perspective. Overall, couples expressed the need to have as many as four children at the bare minimum, despite any economic difficulty. There is a sense that parents still feel the need to insure themselves against unforeseen circumstances such as the sudden loss of a child.

## 6.5 Sexual activity triggers

Although the economic situation of couples can be used to explain their current contraceptive practices, this factor alone cannot provide a nuanced understanding of the decision to use contraceptive technology. Instead, several other factors come into play in motivating couples to act a decision to use family planning. Intimacy, a return to sexual relations after childbirth and avoiding unwanted pregnancy are some of the other factors that triggered the use of contraceptive technology.

### Box 6.2: Sexual motivations for the use of contraception

**Hauwa:** *I told her that I am weaning a child but I'm not ready to have another one. That's how she tested me and gave me the pills.* (Couple Interview (urban, Ilorin East) Hauwa and Mahmud)

**Anisa:** *You know. If we keep meeting each other I can get pregnant and at this stage where I am now, I told him that the child at my back after it I want to rest for three years.* (Couple interview (urban, Edu) Anisa and Jega)

**Faizal:** *'They' said we should use so that our husbands don't go outside. We should use family planning so that he would be coming home. That's what we were told at the clinic during health talks when we go. That is why I am using it.* (Couple Interview (urban, Ilorin East) Yusuf and Faizal)

*"A new client came in. She had triplets. She said she has come here before but was not listening to the counselling because she was not feeling too good. We remember her how. She was very big when we saw her. **Her husband has started having sex with her and she has not completed her 40days after the birth of her babies.** She said it hurts her and he keeps pressing on her stomach. Madam commends her for coming in time to access family planning because she could get pregnant especially since she is very fertile. Mama starts counselling her and she says she wants the IUD".* (Diary Extract: Local Clinic 1, 281112)

These relationships differ between couples and forms part of their wider social life in their communities. The use of contraception, by traditional or modern methods, is also an integral part of performing these sexual relationships and the links between them must be understood as part of the complexity in actively accessing

family planning services. The quotations in Box 6.2 above highlight some of the personal circumstances that triggered women's agency in using contraception. The common theme across all four quotations is sexual activity with undertones of preventing unwanted pregnancies and sexual fidelity. Because of this, women's bodies are governed to remove the biological responsibility of sexual relationships from them within a couple. The act of being responsible is constantly reconstructed through family planning practices. From traditional to modern methods, women's bodies are controlled and governed through a nexus of knowledge and power relations that guide contraceptive practices within sexual relationships. This knowledge is gendered and although women act on their agency through the use of contraception, the personal power (both in thought and action) behind the use of contraception is conditioned through the sovereign power of the State and through social ways of being and pleasure as techniques of power. Sovereign power is exercised on women not just via the State but culturally through their husbands as well. Within sexual relationships between a couple, power is exercised through increased access to contraceptive services, especially when a husband's perceived sexual right is threatened by the possibility of pregnancy.

Through service providers (the *'they'* to which Faizal refers), the State encourages the construction of knowledge relating to marital fidelity and perhaps shifts the responsibility of extramarital affairs onto women that do not use family planning (as per Faizal's comment above). For the client mentioned in the diary extract, there are a number of issues explored in her accessing contraception. Post-partum access to family planning was motivated by an early return to sexual activity as indicated above. Her situation was one in which the return to sexual activity happened within the first six weeks post-partum; a period of time that is associated with maternal mortality (Ronsmans & Graham 2006). The same analysis can be applied to Anisa, whose reproductive history has been discussed in earlier sections within this chapter and who finally got the approval of her husband to access family planning only at the point where she denied him sexual intercourse post-partum.

This post-partum abstinence plays a role in the way family planning messages are constructed and conveyed to women, especially in Ilorin East where the population

is predominantly Yoruba. In the past, child spacing among this group of people and also in other African societies depended on post-partum abstinence, longer periods of breast feeding and post-partum amenorrhoea (Caldwell & Caldwell 1981; Lesthaeghe 1981). Post-partum abstinence was culturally designed to help couples manage fertility and, ideally, the bodies of men in these relationships were trained to abstain from sex until such a time as their wives were ready (see also Section 6.2.2). Thus, post-partum abstinence allowed women to negotiate when they resume intimate relationships with their husbands (Desgrées-Du-Loû & Brou 2005). However, the length of post-partum abstinence has declined in Ilorin East and also in many other societies. This decline can be explained partly due to the increased sexual desire among couples and/or an increase in sexual networking by men particularly among those whose wives are practicing abstinence (Cleland *et al.* 1999; Ali & Cleland 2001).

Through health talks, campaign messages and group counselling sessions, the language used in communicating family planning messages promotes the idea that contraception allows frequent physical intimacy between couples thus enabling the husband to remain at home and spend his resources on his wife and their children. It is positioned as a win-win situation. This type of promotional strategy reproduces sexual activity and procreation from both an intimate and socio-economic point of view. Contraceptive use is then justified within these frameworks without necessarily upsetting conservative views on the use of contraceptive technology. In the scenarios cited above (those of Faizal and the client at the clinic), the two women have different motivations for accessing contraceptive services. These reasons have married love at their core but have different levels of agency. For Faizal, it can be inferred that her use was mutually agreed on with her spouse. Their personal relationship plays a role in the importance they attach to married love. For the client, however, there is a 'helpless' feeling attached to her attendance at the clinic. Given her health status and her need for a long-acting method of contraception there is a sense of powerlessness over her body and a lack of control or mutually agreed upon return to sexual activity after the birth of her children.

Women's bodies are 'sites of domination' (Foucault 1984) and it can be argued that their bodies are '*controlled to meet the needs of those in power*' (Marcellus 2003).

However, there is room to think that giving women a means to control their bodies to encourage the allocation of resources to them, and to have relations not only to keep their homes but also for their own pleasure, allows women to navigate the structures that reinforce their domination (see Ampofo 1999). However, it can be inferred from the two scenarios described above that some women lack the agency to control the timing of sexual relations post-partum.

Becker & Ahmed (2001) have shown a relationship between unintended pregnancy and long post-partum periods especially when women are not using contraceptive technology. They also suggest that breastfeeding decreased the likelihood of early return to sexual relationships with their spouses in Peru and Indonesia and decreased the likelihood of using contraceptive services for women in Peru. In both countries however, they suggested that ten per cent of subsequent pregnancies occurred before the women resumed menstruation. Further, women in rural Gambia are most likely to use contraception once they have started weaning their children. This was clearly the case for Hauwa (see interview extract in Section 6.2) as she sought contraceptive services during this period. Her actions indicated that she had resumed intercourse with her spouse and wanted to prevent unwanted pregnancy.

**Abdul:** *You know what happen. I wanted to marry another wife. But now I don't like again*

**Interviewer:** *Why did you want to marry another wife?*

**Abdul:** *Because I want to take care of the children that I have now that is why I decided not marry another girl*

**Interviewer:** *Why did you want to marry one initially?*

**Abdul:** *You know I don't want to do fornication*

**Interviewer:** *But your wife is here*

**Abdul:** *I know. But sometimes she does like [referring to sex]. Sometimes if I like to do it she would say she does not like. Sometimes she may dislike for 3weeks. 2 to 3weeks she may dislike.*

**Interviewer:** *Asked wife to comment [in local language]*

**Halima:** *When I have given birth to my children why would I stress myself*

**Abdul:** *You see now. If she does like that she make me go outside now. You yourself know that. In my heart I love her very well. I dislike to marry another girl and I want to cater for my children. All of them to have progress in their life. Are you understanding me? But now she allows me to do what I like sometimes. She may likely send me outside to do what I like. But I don't want to do that. So anytime she likes it I would get.*

**Halima:** *[In sarcasm] ok I would accept to have relations with him. Is it food?*

***We laugh.***

***Halima:*** *You are not saying that we should cater for the children so that they would have money so that they can take care of themselves. You are taking about sex. Someone would just be looking [Yoruba understanding]. (Couple interview (urban, Ilorin East): Abdul and Halima).*

Abdul (civil servant) and Halima (trader), a middle-aged couple in Ilorin East have four children, the last of which was born in 2003. Halima has started her menopause but during her reproductive years she used the male condom and withdrawal method with Abdul. Data from the interview suggests that Halima had a relatively high level of control of their sexual activities as a couple such that Abdul sought means to augment the lack of sexual intimacy by attempting polygyny. By likening the occurrence of sexual activity to food, Halima constructs the desire for sexual relations on a basis of necessity. This is not to suggest that the act in itself was not pleasing to her but rather a lingering effect of traditional values and ideologies around sexuality. Furthermore, her comment on the values of children's education, progress and wellbeing echoes the issues discussed in Section 6.4.

Post-partum abstinence has been exploited by men to network socially and have extramarital relations (Lawoyin & Larsen 2002). This was particularly evident in situations where women were perceived to have sexual relations purely for the purpose of procreation. In research among the Yoruba in Nigeria's Oyo State, 48 per cent of husbands had extramarital affairs during their wives post-partum period (Lawoyin & Larsen 2002). This was more common in rural than urban areas with very low reported use of the condom. In Benin, longer periods of abstinence were 'offset' by an increased probability that husbands would participate in unprotected extramarital affairs, which have several implications for the spread of STIs including HIV/AIDS. In Cote d'Ivoire, these extramarital relationships are more common in polygamous men that observed post-partum abstinence than in monogamous men (Ali & Cleland 2001).

***Abdul:*** *I did my effort. I looked for someone like you but she did not marry me*

***Halima:*** *she just collected his money*

***We laugh***

***Abdul:*** *You see she is laughing at me. The girl was at Maiduguri University [...He tries to describe where she lives]. I even told my wife that time.*

*Halima: are you minding him? It's God that caught him. Instead of him to give me the money so that things would be better for us and I'd be praying for him he went to give her the money. Money that she would not even say thank you or well done. She would tell him it is too small. (Couple interview (urban, Ilorin East): Abdul and Halima)*

These relationships may not necessarily be only about sex but also about performing masculinity or social class, and are not without economic responsibilities (Smith 2007). As mentioned in Chapter Five this economic responsibility and its corresponding social relationships (*Baba Alaanu*) played a role in Abdul's attempt to engage in polygyny and perhaps, as implied in the narrative, increased sexual activity. Materiality and gift giving pay a role in non-marital sex and possibly in the rapid spread of AIDS in Africa (Hunter 2002). African performance of masculinity prioritizes multiple heterosexual partners such that both polygyny and post-partum restrictions have been used to justify sexual networking outside marriage (Selikow 2004; Hunter 2002). This, however, is potentially problematic as it hides the emerging material processes through which new masculine identities are formed (Hunter, 2002). Further, Hunter suggests that the debate around gift giving and sexual relations should move beyond the idea of prostitution and include ways in which men and women negotiate the impacts of changes in the national economies. The material nature of these relationships highlights how urbanisation and globalisation shape the way men perform masculinities and sexual identity in Africa (Hunter 2005; Maganja *et al.* 2007; Hunter 2002). Not only does this have implications for the spread of AIDS, it has several implications for the reproductive health of women as women as those that used the IUDs and have multiple sexual partners have a higher risk of acquiring infections and developing pelvic inflammatory disease.

With the exception of vasectomy, the male condom is the only modern fertility management option available for men (Kogan & Wald 2014) whilst the more traditional methods such as the withdrawal method and the different forms of fertility awareness method require a discussion and co-operation between couples. From interrupting the sexual act itself at the peak of pleasure to rationing sexual relations between fertile days, these methods require control over the body and



interfere with sexual practices between couples (Gavey *et al.* 2001; Braun 2013). Barrier methods or the withdrawal method come in direct contact with sexual intercourse such that distinct practices are integrated into the act (Lowe 2005). These acts of controlling and/or governing the body are not without their interference with intimacy. This is particularly evident with the male condom. For many couples, the male condom was their preferred method of choice especially where there is a concern for the side effects and cost of hormonal forms of contraception.

**Box 6.3: Pleasure and condom use**

**Abdul:** *Sometimes we use what they call ehn fila daddy (condom). When I newly married her and when we got children we did like that. (Couple interview (urban Ilorin East): Abdul and Halima)*

**Inda:** *It's because of the side effect of the injections. (Couple interview (urban Edu): Inda and Afi)*

**Emeka:** *But you know as husband and wife, it is not wise to keep using condom because we feel that it does not enable emotional contact. You understand? Let me not say emotional contact. Body contact is more like it. There is emotional contact when we have decided to play but there is no body contact. (Couple Interview urban Ilorin East): Emeka and Adanna)*

**Participant-** *We use condom because we see the work it's done. Even though we don't like it because it interferes*

**Participant-** *(All pill users) - they are not enjoying anything.*

**Participant-** *We enjoy o don't mind them*

**Participant-** *The tablet may fail (FGD: men: Rural: Edu)*

Comments like '*not enjoying anything*' exemplify the interference of the condom with marital relationships. However, these men involved maintained the use of the condom because of its observed efficiency. Focus group discussions also revealed that men who had concerns about the condom interfering with sexual intercourse did not use this method of contraception. Studies have shown that men and women reported reduced sexual satisfaction when using the male condom (Crosby *et al.* 2004; Thomsen *et al.* 2004; Khan *et al.* 2005; Fennell 2013; Chimbiri 2007). These studies highlight the effect of sexual desire and satisfaction on the method of contraception used by men. According to Higgins (2007) research is sparse on the pleasure-seeking behaviour of women and how it affects their contraceptive use.

Women and their sexual experiences matter. There is evidence to support this in this study. What is interesting about the following situation is the way in which displeasure with condom use was described not by the wife in this case but by her husband.

**Samuel:** *There was a time she was not using the pill but the other method eerrr the condom*

**Interviewer:** *Ehn (means go on)*

**Samuel:** *We don't use it because she does not like it*

**Interviewer:** *Mummy daddy (endearing term) so pe e like condom (means your husband said you don't like the condom)*

**Ruth:** *She laughs*

**Interviewer:** *Kilode (why)*

**Ruth:** *She laughs*

**Ruth:** *Ko si (means nothing)*

**Samuel:** *She does not enjoy it now. She does not enjoy it so and you know a man cannot force a woman. Whatever she say she like. So that is the essence we are not using the condom. (Couple interview (urban, Edu): Samuel and Ruth)*

Here it can be observed that Samson expanded on the reasons for discontinuing the use of the condom. His wife Ruth did not like using the condom because it interfered with her sexual satisfaction. During the interview, her discomfort was apparent during discussions surrounding their use of the male condom. Laughter and the word 'nothing' indicated a coy response to discussing very intimate parts of her relationship with her husband. It would appear that she could respond to other questions around the use of contraception with her husband but not talk about her pleasure and sexual satisfaction with him. The effect of the condom in their relationship provides a clearer picture of how sex, pleasure, contraception and experiences using its technologies intersect to shape the way people make decisions about their preferred method. Research has shown that many men report decreased levels of sexual satisfaction when they use the male condom with their female partners (Crosby *et al.* 2004). Research has shown that women were more concerned about condom interference than men and commented on the discomfort of using condoms during sexual intercourse (Higgins & Hirsch 2008). In the same study, women were able to discuss their sexual practices and behaviour freely perhaps because they were interviewed without their partners.

Clearly, these methods interfere with sexual activity and are also subject to human error. The consequences of such errors are unwanted pregnancies, which was the case for Emeka and Adanna. As a couple they employed the use of the Billing's ovulation method and reported miscalculations that resulted in several pregnancies. The age difference between their now five children is less than two years on average. By the age of 35, Adanna had a total of eight pregnancies three of which she miscarried. The birth of their fifth child initiated discussions on the use of modern forms of contraception because they had reached a point where they could not afford to have more children. Research has shown a 25 per cent pregnancy rate within the first year of using natural family planning methods among women who admitted less-than-perfect use of their chosen method, thus emphasizing the need for commitment as a key feature in their use (Smoley & Robinson 2012; Greenberg 2012).

## **6.6 Conclusion**

This Chapter has explored how men and women negotiate the decision to use contraceptive technology in Kwara State. Research findings in this chapter build on the findings in Chapter Five and argue that structures and institutions such as patriarchy, religion, marriage and gender influence the way couples make decisions in the household and by extension the decision to use family planning. The communication of fertility intentions and preferences was identified as critical to the use of contraceptives by couples in Chapter Five and here in Chapter Six.

Spousal communication can be passive or active depending on the level of inclusion, and appeared to be gendered with men having greater control over fertility decisions, use of contraception and, in some cases, the choice of method. However, active spousal communication was identified as a phase in the decision-making process that can be utilized in expanding the use of family planning services. Couples in this category identified the long-term investments of raising children and as such, recognize the need to manage their fertility. Therefore, targeting unmarried men and women in communities during awareness campaigns may, therefore, potentially increase the uptake of services and perhaps, contribute to the decreasing the annual population growth rate in Nigeria.

At the same time, this chapter brought to the forefront the role that people's informal social networks play in the acceptance and use of contraception in their communities. These networks spread across boundaries to exist at a level between the household and the public domain. Social networks (friends and family) were recognized as useful sources of information, and knowledge produced from these networks challenges medical knowledge and creates spaces in which local knowledge influence the use of contraceptive services. These 'non-expert' sources of knowledge highlighted the different voices and experiences of the effectiveness of different contraceptive methods. As members of the community and extended family members, service providers are part of these social networks. These relationships as well as the general role of service providers will be explored and discussed in the next chapter.

This chapter also revealed the principal motivations behind the use of contraceptive technology. Firstly, market forces, unemployment and economic difficulties in the country served as a major impetus in the use of contraception. Rather than spacing or limiting, men and women employed family building strategies such as postponing childbirth in response to their personal and institutional challenges. The increasing significance of managing fertility for this reason has consequences for the overall fertility of Kwara State and the country at large. Secondly, sexuality also played a role in triggering the use of contraception. Here, methods such as the condom interfered with people's sexual pleasure and further emphasized the roles men play in the decision-making process, especially when it concerns their needs. Both triggers have been used in promotional messages and awareness campaigns in the public sector to scale up the use of family planning services in Kwara State. The next chapter analyses this trend and the role of the State and supporting organizations in the delivery of contraceptive services.

## **CHAPTER 7: WOMEN AND THE STATE: THE CHALLENGES OF CONTRACEPTIVE SERVICE PROVISION IN KWARA STATE**

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### **7.1 Introduction**

The State, through its acceptance and promotion of smaller family size provides a framework for contraceptive discussions within the population. The policy directives trickle down to community wide conversations and private couple discussions about fertility, therefore, forms a part of the wider discussions on contraceptive decision-making. Chapters Five and Six illustrated the interplay between institutionalized knowledge and power and how they forge relationships that influence decision-making processes within the household. These chapters stressed the effects of institutional structures on marital relationships and how women and/or men's negotiate their fertility interests and contraceptive use in the household. This chapter will examine and contextualize choice and informed decision-making regarding the use of contraceptive services at the point of service provision.

As discussed in Chapter two, the use of contraception as encouraged at the International Conference on Population and Development (ICPD) is based on an individual's ability to choose. This pro-choice concept covers not only an individual's agency regarding the decision to use contraception but also the method used in achieving their reproductive goals (UN 1994). This notion of choice emerged from evidence that highlighted the misuse of contraceptive technology on the bodies of women in developing countries under the rubric of population control (Hartmann 1995). The ability to make informed choices about family planning is premised on an individual's understanding of the benefits and risks associated with all available forms of contraception. However, as evidenced in Chapter Five and Six, women's rights over their bodies are framed within religious and cultural conventions on what is permissible within marriage. Choice also extends to the option of not adopting any form of contraception (Solter 1998). Thus, informed choice places the decision-making power on the individual.

Since informed decision-making is predetermined by the type of contraceptive information and technology available, the analysis of choice provided in this

Chapter is derived from policy and service provision, and draws on data from participant observations, extracts from the research diary and interviews with stakeholders involved in contraceptive service delivery. The analysis of service provision in this chapter focuses on aspects of contraceptive method choice and contraceptive information that highlight the challenges of actualizing the notion of choice in accessing family planning services.

This chapter begins by contextualizing the role of the state in the implementation of its population policy and explores how the language contained in family planning messages validates contraceptive use within the community. Section 7.2 and 7.3 address the practical aspects of choice based on availability and quality of information provided to clients. Lastly, Section 7.4 explores issues around the effects of punitive quality, medical procedures and interpersonal relations on the use of family planning services. Here, punitive quality addresses issues around choice and the inappropriate application of medical standards in the provision of contraceptive services.

## **7.2 The State, the 'body' and population policy in Kwara State**

As discussed in Chapter two, the reproductive rights agenda pre and post ICPD (International Conference on Population and Development) emphasized the notion of choice as part of an individual's fundamental human rights (Bandarage 1997). In the context of family planning programmes, choice and its inherent characteristics are embedded in the way the State exerts control over women's bodies (Takeshita 2011). Where the state lacks the financial and political motivations to govern its population through population policies and family planning programmes, the international community and non-state actors intervene to collectively protect and mitigate the effects of rapid population growth by influencing the policy environment in developing countries and by funding programmes aimed at increasing the use of contraceptive technology (Gordon 1991). This section examines the way in which family planning programmes have been discursively constructed as a development prescription for rapid population growth and poor reproductive health status in Kwara State. To illustrate this, the section draws on extracts from the field diary and ethnographic data from Edu and Ilorin East LGAs.

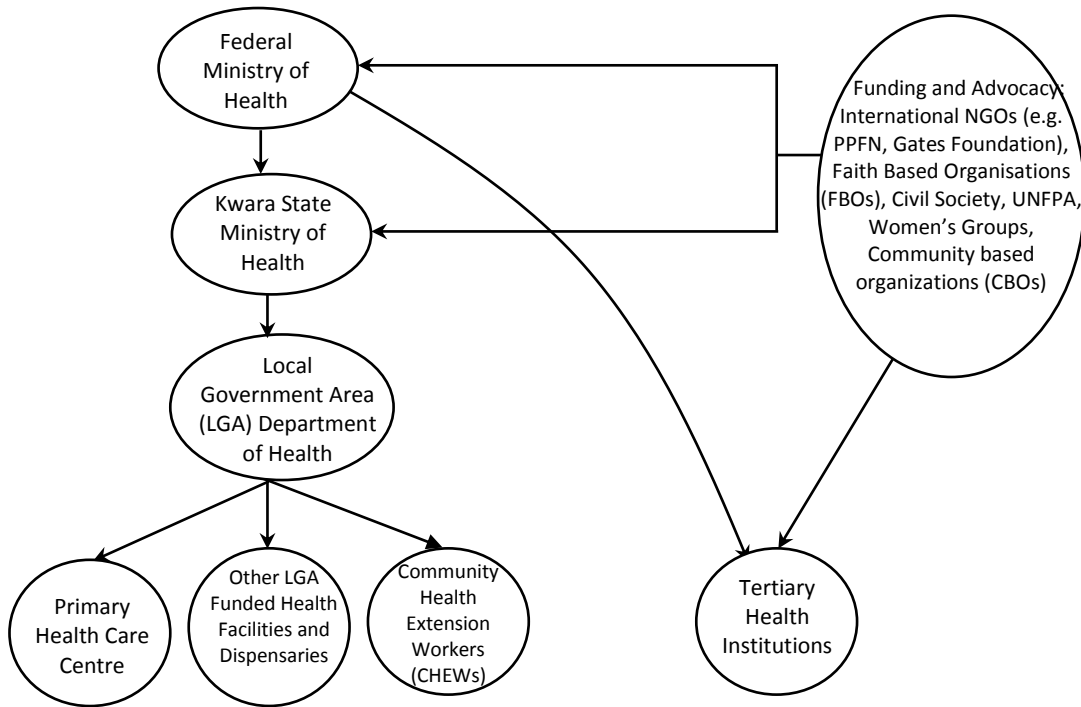
The evolution of population policies and the wider political and economic context in Nigeria, as explored in Chapter Three, show how women's bodies are governed by interventions and regulatory controls centred on the relationship between reproduction and economic development (Dixon-Mueller & Germain 1994; Renne 1996; Obono 2003; Avong 2000). However, the rejection of the global population policy in 1974 by most African countries including Nigeria and acceptance of the new population policy 10 years later at the UN population conference in Mexico highlight how discourses around the notion of birth control change over time (see Chapter Two). These discourses also illustrate the importance of institutions such as religion and culture in the successful implementation of family planning programs in the country. In so doing, they stress the political and biological nature of population policies that make program implementation a power problem. Robinson (2011) suggests that many countries in sub-Saharan Africa, including Nigeria, implement family planning programmes from a purely economic standpoint with linkages to sustainable development.

Population policies and frameworks for implementation are ways by which the government uses contraceptive technologies to discipline the body and its relationships with the Self in order to exercise control over a population with an annual growth rate of 3.2% (Gordon 1991; Foucault 1997; NPC & ICF Macro 2009). However, there is a disjuncture between policy and implementation because of the absence of political will and financial commitment to address wider reproductive health issues such as sexual health and abortion in the country. This disjuncture thus lays emphasis on women's bodies as sites of contestation over global and local development priorities. Contraceptive service provision is filtered through a hierarchy of funding and advocacy (see Figure 7.1) that arguably starts with development assistance from international bodies such as the UNFPA.

International Development assistance has created a situation where the government is largely dependent on donor funding for contraceptive commodities e.g. from 2010 procurement of commodities by the public sector was provided by the UNFPA (Goliber *et al.* 2009; Mandara 2012). Donor funding alone however, cannot meet the high unmet need (16%) for family planning in Nigeria and, despite

the nation's alarming Maternal Mortality Rate (576 deaths per 100,000 live births) (NPC and ICF Macro 2014), the government lacks its own standalone budget for family planning which coincides with an increase in unwanted pregnancies (Goliber *et al.* 2009; Mandara 2012).

**Figure 7.1: Hierarchy of funding for contraceptive services in Nigeria**



Following advocacy efforts by NGOs, feminists groups and other stakeholders, the Federal government announced a commitment to family planning service provision including the allocation of \$3 million in the 2011 fiscal year and the introduction of a new policy that provided free services to individuals with intentions of managing their fertility. This policy is implemented at state and local government levels, and it relies on budgetary allocations from the Federal government and donor agencies for logistics attached to transportation of contraceptive commodities from warehouses to service delivery points throughout the State.

*We get requisition from the federal government and all the 36 states collect from the warehouse in Oshodi Lagos. We go every 4 months. If it finishes in time we can make an emergency order. So when we make they would distribute commodities and it would be stored in the state store. When I am about to distribute to the supervisors at the 16 LGAs I call them and they would then dispense to their SDPs. But when they ask the supervisors at the*



*LGA to come and pick up commodities they can't come because they won't give them the money for transportation. The federal, UNFPA and PPFN realized that they can't pay for all them to come so I was advised to zone them into four so that the money they spend on transportation would not be much.*  
(State Ministry of Health representative, 25-7-13)

The challenge here for service provision is the release of federal funds, as lack of funding affects the availability of services, which in turn produces missed opportunities to protect women's lives. In addition, at these levels, government officials are often not committed to allocating and releasing funds for the acquisition of contraceptive commodities already being provided by donor agencies. As suggested by Mandara (2012), the declaration of free contraception is another rhetorical device employed by the government to show its commitment to reproductive health issues. There is a relationship between population policy development and implementation and the role foreign development assistance plays in the acceptance of certain types of population objectives (Richey 2003; Richey 2008). Following the inclusion of targets for reproductive health in the MDGs, non-state actors such as US, UK and Australian development agencies and the Gates Foundation announced in 2010 a 5-year plan of action with the primary aim of reducing the unmet need for contraceptive technology for 100 million women in developing countries (Shiffman & Quissell 2012).

Addressing the unmet need for family planning thus became the discursive framework within which these actors legitimize development assistance (Robinson, 2011). Given the lack of leadership in addressing reproductive health issues in Nigeria, development assistance was timely. Therefore, donor funding operates and capitalizes on the inadequacies of the State and sets the tone for the groups of people that are to be prioritised in receiving development assistance (Foucault 2007). For the Gates Foundation, this commitment was aimed at poor women in developing countries including Nigeria, particularly the urban poor. Through the Nigeria Urban Reproductive Health Initiative (NURHI), the Gates Foundation funded a 5-year project aimed at increasing the use of modern family planning methods by 20% among the urban poor in 6 cities in Nigeria including Ilorin, a city of which Ilorin East is one of the 3 LGAs that constitute the state capital (NURHI, 2011).

*The state's policy on family planning is to give commodities free to all the SDPs in the 16 local governments of the state. We are hoping for about 20% increase in contraceptive use. We also make the services to be readily available to the clients in many clinics close to where they reside and commodities are also available at all times. (State Ministry of Health representative, 25-7-13)*

The implementation of the programme is further justified by the State and consequently National Population Policy (see Chapter Three) that endorse family planning programs based on the neo-Malthusian relationship between population growth and development (NPC & ICF Macro 2009; Robinson 2012). Development assistance brings urban areas within the state to co-operate with a network of stakeholders and social institutions such that the State assumes a supervisory role in the implementation of family planning programs. Although the State has goals for all 16 LGAs that include the provision of free commodities to all Service Delivery Points (SDPs) and availability of services at all times to interested individuals, observational data revealed a concentration of efforts in creating awareness and service provision in the State capital and two LGAs with higher population size.

*The project is urban focused because it has been projected that by 2035 more than 45% of the population would be living in urban areas. If this is so it would give room for squatters, shanty areas to develop leading to pressure on infrastructure development and the little resources that the community is having. This would lead to issues of waste management and disposal, unsanitary conditions, crowded environments that would lead to diseases, unwanted pregnancies, abortions, and all sorts. That is why it is focused in the urban areas. (NGO representative 19-7-13)*

The impetus for a focus on urban areas is undeniable, particularly in relation to sustainable development. However, concentrating development efforts in this way is problematic because it leads to a configuration of women's bodies that enforces spatial boundaries and separation into rural or urban bodies. Urban bodies need to be improved upon individually for the greater collective good of the State. Through techniques of power and the discipline of urban bodies with the use of contraception, distinct characteristics of urban women are created or modified; including one that has her family planned (Foucault 1997a). Foucault adds that these techniques create a homeostatic effect that provides security from internal dangers (p.249). Regulating urban fertility is important as has been established

above and produces and normalizes bodies that serve the prevailing historical notions of the links between fertility in urban areas and sustainable development. This chapter argues that urban fertility is not more important than fertility in rural areas especially because rural women's reproductive lives are heavily policed by patriarchy. However, it also acknowledges the importance of prioritization of available resources especially in resource strained countries like Nigeria where the effects of this is most visible on a sub-national level (Ahonsi 2015). Many states in Nigeria including Kwara State rely on development aid in order to address some of the most basic reproductive health needs which include the use of family planning services.

Promoting family planning messages is not without its challenges especially in Nigeria given some of its experiences of previous population policies discussed in Chapter Two and Three. Following years of advocacy and the creation of culturally appropriate ways of promoting the use of contraceptive technology, family planning messages have evolved from the focus on limiting births after four children (Obono, 2003) to a focus on spacing and planning fertility intentions based on the needs of a couple. Women's bodies are conditioned to the notion of fertility management and part of the conditioning process includes a regime of truth that promotes smaller families, encourages communicating with your spouse and includes access to free contraception at government facilities (Foucault 1997b). Through the use of health promotion strategies that reiterate the benefits of family planning, women's bodies are conditioned to the acceptance and possible use of contraception.

*In Kwara state, here especially in the LGAs we have chosen they are quite a lot of Muslims here. So they are predominantly Muslims but I'm not sure about ifelodun LGA. The issue of using family planning has not been easy but when we came on board we had some religious bias but it was not as bad as before. With the series of advocacy that we have been doing with the religious and traditional leaders to soften the ground and now family planning is more or less becoming a household name because we have been invading the airwaves with our jingles, drama series and so on. Getting the leaders to publicly support FP was a challenge but with time and series of advocacy, we have been able to cross this hurdle to some extent. We had to make them see reason by showing them statistics on MMR and IMR. We also had issues with*

*the policy makers at the state and LGA to publicly support family planning but again with time we have gotten the policy makers at the state level to support FP. Initially these were the challenges. (NGO Representative, 19-7-13)*

The language used in constructing these messages plays a key role. Less controversial metaphors for family planning are necessary in order to galvanize support within the community. Language acts at all levels of society (Basu 2014). Words convey meaning and words like 'family' and 'planning' do not evoke meanings attached to reproductive health but meanings, feelings and emotions attached to the social and political lives of people. The meaning attached to the phrase *family planning* defines the way it is understood and, ultimately, the take-up of family planning services (Makoni 2012). Promotional messages by past government administrations promoted the idea of limiting births at four children such that the primary discourse around family planning reduced the use of contraception entirely to the limiting of reproductive activity (Isiugo-Abanihe 1994b; Butler 1999). Contraception as a public health intervention must then be understood in ways that take into account the social and cultural contexts in which fertility behaviour takes place (Isiugo-Abanihe 1994b). This, along with the growing need to involve men in reproductive health, laid the foundation for advocacy within socio-political and religious groups to initiate changes in the way people think about family planning, construct family planning messages and motivate changes in fertility behaviour (Dudgeon & Inhorn 2004; Bartholomew *et al.* 2011; NURHI 2011).

Through its '*Get It Together*' campaign the state in collaboration with NURHI, Advocacy Nigeria, the African Radio Drama Association (ARDA), Development Communications (DevComs) and the Health Reform Foundation of Nigeria (HERFON) developed a family planning programme with an overarching goal of making family planning a normal part of a healthy life for Nigerian families in urban areas (NURHI, 2011). As part of their demand creation strategy couples were encouraged to discuss family planning with one another and use contraceptive services through directed live call-in radio drama series called *ireti eda*, social mobilizers who talk to members of their community about family planning and city-wide mass-media advertisement on TV, billboards and posters. Spousal communication was promoted through weekend drama series and listeners were

encouraged to call in and ask questions about family planning. There were also opportunities to win prizes, which were used as an incentive to keep listeners engaged with the series.

Mass-media campaigns targeted at couples with the aim of promoting family planning may influence spousal communication which, in turn, leads to an increase in contraceptive use as evidenced in some of the discussions around use in Chapter Six. Studies in Nepal and Tanzania have reported attitudinal changes toward contraceptive services and an increase in spousal communication due to exposure to media programmes on family planning (Rogers *et al.* 1999; Sharan & Valente 2002; Boulay *et al.* 2002). However, the dynamics of communication exposure and behavioural change are complex. Meekers & Oladosu (1996) and Boulay *et al.* (2002) add that factors such as indirect exposure to information, previously known methods of contraception, and women who want fewer children should be taken into consideration when relating the probability of using family planning to the impact of mass media campaign. TV and billboards/posters containing information on family planning were also used as part of the mass media campaign and were found in many areas in Ilorin East (see Figure 7.2 below). Other sources media used in creating awareness include leaflets/brochures and newspapers/magazines.

**Figure 7.2: An urban billboard promoting the use of family planning, clearly indicating a couple discussing family planning and encouraging people to go and use family planning services.**



*Source:* Photograph taken by author

Moving on to the content of these promotional messages, emphasis is firstly, placed on what family planning is because it would appear that people in Nigeria have retained contraceptive messages from past governments administrations and are of the opinion that contraceptives are for only limiting births. The phrase *child spacing* is used in media campaigns to encourage the use of contraception because spacing agrees with people's cultural and religious practices (see Caldwell & Caldwell 1981; Wolf *et al.* 2008). Yoruba is the local language in Ilorin East and family planning messages are primarily conveyed through this medium. *Ifeto si omo bibi* translates to '*planning the birth of children*' which also means family planning in the classic sense but in this local context means putting a gap between births or planning the births of your children so that they are not clustered together. It is introduced in a non-threatening way such that people understand it as a way of resting in between births. More importantly the idea that one can have more if necessary is regarded as a welcomed relief in contrast to the idea of limiting reproduction in totality. Thus, in the local language, family planning is rendered acceptable but in its classic phrase, it conveys a different meaning and evokes historical emotions around the idea of counting births for the prosperity of a nation. Cost free contraceptive technology is marketed through media channels and prospective clients are encouraged to use centres with family planning logos if they are interested in using contraceptive services.

Current family planning messages use the language of well-being, intimacy, spousal communication, and economic difficulty to construct knowledge around the importance and uses of contraceptive devices. Depending on the medium and site of message transfer, these messages also highlight the benefits of contraception in improving the reproductive lives of women. This message, in particular, is limited to hospital spaces and involves direct interaction with women. Information on family planning is offered as part of antenatal, postnatal and immunization services when women come to access such services. However, its use is an entirely different matter. The use of nurses and community health education workers in disseminating contraceptive information has proved invaluable in promoting family planning especially in resource poor settings, and past research in city sites

including Ilorin has reported its usefulness in promoting the use of family planning services (Piotrow *et al.* 1990). During these visits, family planning messages are constructed through songs and health education while mothers are waiting in the clinics.

Women are informed about the use of family planning and the methods available, as with all other promotional messages through songs (see Table 7.1) and group counselling. The importance of spacing births is described by comparing the uterus as a cloth. The continuous use of the cloth would eventually make the fabric weak and it would tear.

*You see the womb is like a dress. If you keep wearing it and wearing it, it would start to fade and later it would tear. If you keep having children on top of themselves your womb would tear and you can lose your life if you are not careful. What then happens to the children you have left behind? (Diary Extract: 080213)*

By using this analogy to explain the effects of continuous reproduction, women gain a better understanding of the consequences of having very active reproductive lives. Furthermore, by appealing to their identity as mothers, attention is drawn to the quality of life their children would have if they died due to pregnancy related complications.

Songs are a practical way of providing educational development messages (Brown *et al.* 1999). Folk songs and popular music have been invaluable in HIV/AIDS awareness campaigns (Jackson & Pitts 1991; Stephens *et al.* 1998; Gallant & Maticka-Tyndale 2004; Poku Quan-Baffour 2007) and the effects have been replicated in promoting health interventions such as family planning. This form of health education is participatory and produced at a community level (Brown *et al.* 1999). Service providers control the information produced about the subject area and have access to personal interactions with women. Although these songs have been used in many primary healthcare centres in Nigeria to enable women to remember information about immunizations and the joys of motherhood, songs carrying promotional messages on contraception in collaboration with mass media campaigns increase the level of awareness about contraception and available

services (Brown *et al.* 1999). Family planning messages are constructed to highlight its economic benefits to families and the reproductive life of women and the songs contain information on the methods available at the clinic such that a client's awareness of contraception is based on the kind of knowledge retained during these visits.

**Table 7.1: Examples of songs used in promoting the use of contraceptive technology**

Yoruba version	English version
<i>Fe to sebi re o (x2)</i>	<i>Plan your family (x2)</i>
<i>Alabere n be lokelele</i>	<i>Injections can be found at Okelele</i>
Group chorus- <i>Fe to sebi re o</i>	Group chorus- <i>Plan your family</i>
<i>Onikoro n be lokelele</i>	<i>Tablets can be found at Okelele</i>
Group chorus- <i>Fe to sebi re o</i>	Group chorus- <i>Plan your family</i>
<i>Ti oloju ara n be lokelele</i>	<i>IUD can be found at Okelele</i>
<i>Fe to sebi re o</i>	<i>Plan your family</i>
<i>Kaloyun ka gbomo pan, Iwa ibaje ni yen (x3)</i>	<i>Being pregnant with a baby on your back is a bad behaviour (x3)</i>
<i>Ti n ba fe to si temi, ewo le jo yin (x3)</i>	<i>If I am planning my family, how does it concern you (x3)</i>

Source: Diary extract (110112, 080213)

The songs also contain messages about the methods available at the clinic because a client's awareness of contraception is based on the kind of knowledge retained from these visits. In these songs the methods promoted are hormonal and are described based on the mode of entry into the body or their site of action. Local words such as *ogun onikoro* (tablets), *alabere* (injections), *oloju ara* (private parts; which indicates IUCD use) and *alapa* (placed in the arms; which indicates implant use) are used to create awareness of different forms of contraception. Women might not necessarily acquire full knowledge of these methods but, at the very



least, they have an awareness of methods that can be used to manage their fertility. The language used and the modes of understanding family-planning methods are components of how contraceptive knowledge is reproduced in the society.

Additionally, these songs contain behavioural messages on the inappropriateness of having closely spaced children. More importantly, the songs attempt to encourage women to seek contraceptive services despite family and community disapproval. This is a continuation of the role of family and friends in the use of contraceptive services. However, group counselling sessions expand on the information in these songs by laying emphasis on individual agency and a detachment from the group and community ideas that encourage pronatal tendencies. They do this by drawing on the common themes used in other media: economic difficulty, intimacy and well-being.

Pamphlets, illustrated in Figure 7.3, are examples of campaign documents distributed publicly and in health facilities that provide family-planning services. An examination of these pamphlets reveals several salient messages about the role contraceptive technology plays in constructing the idealized Nigerian citizen. An analysis of these pamphlets was important because they represented the kind of information people had access to and were distributed widely both in English and Yoruba around the community. All four pictures have bold captions propagating the notion of planned citizenship, which is further emphasized by pictures of men and women representing the three major ethnic groups in the country (from left: Yoruba, Hausa and Igbo) in their cultural attire. Representation is important here because discussions around population size in Nigeria are often political at community and individual levels. Ethnic and religious size serve as sources of identity and resource allocation in Nigeria, especially since larger groups are often allocated more financial resources (Gordon 2003; Yin 2007). Thus including all three major ethnic groups in the pamphlet promotes the notion that being 'successful' and 'planning your family' transcends ethnicity and reduces the risk of people circulating notions of the use of family planning as a means to limit the size of

particular ethnic groups and all the associated economic and political connotations of a tribe's fertility reduction.

The general tone of the messages stress the role contraceptives play in improving quality of life and highlight the importance of children's education which can be linked back to the economic triggers that influence the decision making process discussed in Chapter Six. However, closer examination of these pamphlets reveals subtle differences between these messages. The pamphlets illustrate gendered ways of thinking about planning for the future. Here, messages are constructed based on the dominant view of masculinity and femininity in the society where women take pride in an idealized version of a happy home and the role of men in the home is primarily financial. Again, this links back to the household decision-making processes examined in Chapter Six. The use of family planning as constructed in these images promotes stereotypical notions of masculinity and femininity. While this may be so for many Nigerian couples, evidence from some of the narratives from couples examined in Chapter Six suggest that these roles are not rigid and although men can '*focus on the future*' and *provide for their family and caters for their needs with pride*', women also have and express these concerns and provide for their families and maintain the status quo of men as providers.

Another key difference in the messages attached to the pictures concerns spousal communication. The images of men have the caption '*he communicates and discusses with his spouse about their future dreams and aspirations*', which points at power relations between couples and emphasizes male responsibility for initiation and ownership of conversations about fertility intentions between couples. Furthermore, it also implies that women lack overall control of their bodies and can only access services through the guidance and with permission of their husbands. Whilst this depicts the situation for many, if not most, women in developing countries, evidence from some of the interviews in Chapter Six suggests that women do have some agency over the control of their bodies and have the ability to initiate and possibly control the outcome of discussions around the use of family-planning services.

Figure 7.3: Family planning promotional pamphlets



Source: Author's personal copy

The image in the top left expands on aspects of improving quality of life and welfare and a few elements explicitly refer to the use of contraception to address reproductive health issues. Where they do, the references are based on the assumption that couples will find a method of contraception that suits their

reproductive needs (*Try it! There are many choices –Safe, effective and easy to get*) based on the contraceptive methods provided by the state which, as will be seen in the next section, presents limitations and difficult choices to many couples.

The pamphlet also mentions contraception in relation to intimacy and physical appearance '*be your beautiful self-regain your pre-pregnancy figure and energy*' and '*improve intimacy- you're free to be spontaneous with the love of your life*'. This association was also used during group counselling sessions promoting the benefits of using contraceptive technology at one of the facilities visited for observation. This sexual relationship between couples has been explored in the previous chapter and will be examined from the perspective of creating demand for service provision later in this section.

***Counselling Session:*** *We are begging you now to take family planning. The government did not say you should not have children but space them adequately. Food is expensive. Tuition is expensive too. If you keep having children you would be unable to take care of them and your husband would not take care of you. If you use family planning, you would be able to meet your husband and he would be happy. He would not go outside and spend what he has on other young women outside. If the house is clean and children are not littered everywhere, he would be happy and you would be happy too. He would be giving you money when you put yourself together and look good.*  
(Diary extract: 250113)

Contraceptive technology is promoted as a consequence-free means to have sexual relations with their spouses. Being in a constant state of reproduction means longer post-partum abstinence periods, a period men have exploited to network socially and have extramarital relations (Lawoyin and Larsen 2002). These extra-marital relationships may not necessarily be about sex but may also be about the performance of masculinity or social class, and are not without economic responsibilities as already established in Chapter Six (Smith 2007). This post-partum period plays a role in the way family-planning messages are constructed and conveyed to women. These messages promote the idea that contraception allows frequent physical intimacy between couples thus encouraging the spouse to remain at home and spend their resources on his wife and their children. For both stakeholders it is a win-win situation. Therefore, the language used in constructing

contraceptive information from the highest level of policy and advocacy down to the household level creates a new form of knowledge that is acceptable to people. Contraception has been and always will be at the junction of population and reproductive health debates. Replacing 'birth control' with 'family planning' and/or 'child spacing' might, perhaps, make contraceptive discussions trickle down to the community and household level where couples can discuss contraceptive use effectively. By so doing, it produces new ways of thinking about contraception, generates demand through service provision and the proclamation of free services, and disciplines the mind and consequently the body through the use of contraception.

Local government response to population policies and the implementation of family-planning programmes in Edu LGA is quite different from that which operates in Ilorin East. In Edu LGA, fertility discussions are discouraged and family-planning promotion and any subsequent use are sensitive issues. Members of communities in Edu LGA are pronatal and place a high value on children. Overt discussions of fertility goals are unpopular and gatekeepers in these communities do not support the expansion of contraceptive services within them.

*In Edu there are only about five clinics and it's only three that are active service providers. They don't really embrace family planning there so it's also a challenge. Although we are trying, especially with the radio because it serves everybody and also those people that go in and out of town so they would also spread word. (State Ministry of Health representative, 25-7-13)*

Access to and awareness of family-planning services is limited to antenatal, postnatal and immunization clinics within the community. Again, the messages primarily take an economic and welfare-based approach. As described in Chapter Four, Edu LGA consists of three emirates: Tsaragi, Lafiagi and Tshonga. Contraceptive usage is low in all three because there is a lack of political and religious will to support the use of contraceptive technology.

*The emir is anti-family planning. He said his community (Tshonga) is small so he does not want any programme on family planning here. We get supplies through PMTCT programmes. That is how we can get commodities to give people when they come and ask for it. (Diary extract: Service provider, 29-1-13)*

This is more pronounced in Tshonga where support for family planning is constrained by community and religious leaders who are anti-family planning. Services are provided in limited capacity by the state through the Ministry of Health and indirectly through commodities allocated from funding interventions in mother-to-child transmission of HIV/AIDs. Here, technocratic elites overtly reject the use of family planning and stress pronatalist beliefs in the community under the rubric of increasing population size for their ethnic group as a whole (Robinson 2012). Informal conversations with the co-ordinator for family planning in Edu LGA revealed the family planning commodities were only accessed through private service providers such as PMVs and local medicine vendors within the community. In Tsaragi and Lafiagi, services are provided primarily through the state via directives from the federal government. Here, implementation is difficult as whilst these communities do not overtly reject these policies, they do not approve of them either, thus making awareness and demand creation campaigns difficult to implement in the community.

Access is also denied and/or controlled by men who act as gate keepers of the home. Like their northern sisters women in Edu are guarded by seclusion, a spatial boundary used to confine women's reproductive and productive activities within the home with minimal contact outside the home (Robson, 2000). Seclusion reinforces the Islamic system of marriage and gender roles (VerEecke, 1993). Information on family planning is offered only as part of antenatal, postnatal and immunization services when women come to access such services. In Edu, knowledge produced in these hospital settings is limited to available methods. Most women know of the male condom, which they call *rubber* based on the material from which it is made from, *ekin* (injectable forms of contraception) and *chigbe* (tablets which indicate the oral forms of contraception). Although some women are aware of Long Acting Reversible Contraception (LARC), these methods are not readily available in many areas and as such are not promoted as available methods.

Access to contraception is often obtained instead through interpersonal relations with service providers. Couples who discuss their fertility and want to use contraception rely on personal relationships with clinic/hospital staff for

contraceptive technology for reasons of privacy, given that the use of family planning is not overtly accepted in the community.

*Family planning here is done under the covers. Most people that require it come quietly to us and explain their situations. Sometimes they come after hours. You know.....those that don't want their husbands and other people to know. We reach out when doing antenatal, health talks and approach women based on their need. Like maybe a woman who has eight children or so. (Diary extract: Family planning co-ordinator, 20-12-12)*

*We used to tell them that they should go and bring the husband first. If we hear what the husband says and if he had interest we do it for her. But sometimes if the husband says he wants plenty children and we think of the health of the woman we would do it. So that we can help the women but we would educate her that she must not go outside and just do it with her husband. (Local clinic, rural: Edu)*

Women that access services without their husband's knowledge do so out of office hours where members of the community cannot observe their actions. Service providers have a special understanding of the situation and cater to women's needs secretly out of pity. Because of this, some service providers within these communities have PMVs and small pharmacies/chemists that sell contraceptive commodities to prospective clients but these commodities are limited to the male condom, emergency contraception, the oral pill, and injections. Also, because women's bodies are not secure and are subject to side effects, women are educated about the consequences of infidelity (as discussed in Chapter Six) especially with the use of the IUCD where its presence, coupled with having unprotected sex with multiple partners increase the risk of having infections.

Through these mass-media campaigns, community outreach and counselling services at local clinics and hospitals, family planning messages deviate for the most part from the reproductive health movement that has championed the contraceptive movement since the 1950's (Smyth 1996) and focus more on the social and economic benefits of contraception. While this shift in emphasis is troubling in itself given that it stresses a neo-liberal agenda on modernity and development (Riley *et al.* 2003; Robinson 2012), it is important to recognize why this shift is acceptable to people in Kwara State and to the nation at large. Contraception occupies a space between individuals and the government (Foucault

1997b; Gordon 1991). Family planning programmes provide women with a means to manage their fertility but hardly gives women genuine control over their fertility outcome hence the importance of involving men in family planning and the emphasis on spousal communication. In communities like those present in Kwara State where there are cultural dimensions to fertility, providing programmes centred on improving women's reproductive health are likely to encounter some difficulty in gaining community acceptance. Using a socioeconomic agenda to construct family planning messages provides a non-threatening way to discuss fertility especially in a culture where competition for resources exist between different ethnic groups, religions and regions based on group size and characteristics in Nigeria (Gordon 2003; Yin 2007). Poverty is a language that is understood by individuals regardless of their ethnic group or religion. By juxtaposing family planning with the current economic struggles illustrated by some of the couples in Chapter Six, promotional messages have created a framework within which contraceptive technology can be discussed.

On the supply side of implementing population polices, Smyth (1996) suggests that quality of care is the one area in which governments and donor agencies have recognized the need for a woman-centred approach to service provision. Quality of care is critical for the continued use of contraception (RamaRao et al. 2003). The following sections provide an analysis of the supply-related issues that have a bearing on the decision-making process at the point of service provision. These sections focus on the interactions between choice, quality of contraceptive information provided and the technical issues surrounding service delivery in Edu and Ilorin East LGAs. These sections rely on observational data from two facilities in Ilorin East and extracts from the field diary for Edu.

### **7.3 Choice of method**

The ability to choose is one of the key components of the right to plan one's family as defined in the ICPD Plan of Action in 1994. This concept of choice covers not only individual agency regarding the decision to use contraception but also the method used in achieving an individual's reproductive goals (UN 1994). This section examines the aspect that deals with individual agency in the decision-making



process outside the household. It begins with the premise that service provision plays an important role in the ability of an individual to exercise their right to choose their method, based on past evidence of misuse of contraceptive technology on the bodies of women in developing countries under the rubric of population control (Bandarage 1997; Hartmann 1995; Rao & Sexton 2010; Richey 2008). Choice is examined in this section based on the variety of contraceptive methods available for use and informed contraceptive decision-making, as the presence of a range of methods is necessary if rights to contraceptive freedom are to be truly exercised (Ross *et al.* 2002). Several issues need to be considered when analyzing the variety of methods made available for use by clients. Firstly, the contraceptive methods available must reflect individual need and the needs, rather than the preferences, of the State. Secondly, these methods must be examined contextually within the current status of healthcare service provision nationally and locally within the state.

#### **Box 7.1: Choice of available forms of contraception**

*We do injections, pills and condom but every other method we refer you to PHC (Local pharmacy, Urban: IE).*

*We have the injection, pill, IUCD and then we have condom for male. (Local clinic, Rural: Edu).*

*Here in our pharmacy we have the condoms, pills, and injections (Local pharmacy/PMV, Urban: Edu: Field diary: 20-07-13)*

*We have the hormonal methods, the IUD, barrier methods (condom, diaphragm, and female condom) and injectable. The injectable is of two types: Noristerat (given every 2months) and Depo-Provera (given every 3months). Then we have a new method called implant. This implant is of two types: implanon (3yrs and one rod) and jadellen (5yrs and two rods). The IUD I mentioned the other time is inserted into the uterus and can stay there for 5-10yrs without any problem. The oral pills are of two types: microgynon and xluton. This xluton is given to nursing mothers and the microgynon is given to other people. (Local clinic 2, Urban: IE).*

*We have the condom both male and female condoms. Then we have the cervical cap, diaphragm, foams, and jellies that serve as spermicidal. Under the hormonal we have the oral contraceptive pills and there are of 2 different types: combined oral contraceptive pills and we have the mini pills. Then we have injectable. Under this, we have three types: 1month (norigynol), 2 month (injection Noristerat), and 3 months (Depo-Provera). The implant is another modern method that is very effective. It is long lasting because we have one for 3yrs, which we call implanon and we have one for 5yr, which we call jardelle. Then we have the IUD. (Local Clinic 1, Urban: IE)*

Mbizvo & Phillips (2014) suggest that many developing countries have a limited capacity to provide a full range of contraceptive methods, especially within the public sector. In Chapter Three, this thesis showed that the private medical sector supplies 59.9% of modern contraceptive methods in Nigeria with 38.2% from private chemists, pharmacy and PMVs (NPC and ICF Macro 2014). The commodities supplied by these private facilities are limited to pills (including emergency contraception), injectables, and the male condom, which is also evidenced in some of the quotes in Box 7.1. These methods are also the most commonly known and used methods in the Nigeria (NPC and ICF Macro 2014). The only overly medical and long acting modern method used in Edu is the IUCD. This limitation stems from supply related factors such as the lack of health professionals with qualifications required to provide long acting methods of contraception, frequent commodity stockouts and other infrastructural challenges within public sector facilities in these areas. This situation is not unique to Nigeria as evidence suggests that many other countries in Sub-Saharan Africa face similar constraints in service provision (Ross *et al.* 2002; Cleland *et al.* 2006; Duvall *et al.* 2014).

Equally, the methods provided by public facilities are a reflection of the methods promoted by the state and donor agencies. As can be seen from the data in Box 7.1, these methods are mainly provider-dependent hormonal methods and vary within LGAs in the state. While clinics and hospitals in Ilorin East have a fairly full range of these methods, women in Edu LGA are limited to the pill, injections, condoms and the IUCD. Both observations and informal interviews with service providers suggest that methods like the implants are not made available to their facilities because they lack the professional training required to insert them. Furthermore, as evidenced in Chapter Five there is a lack of awareness about implants among community members in Edu LGA. Provider dependent methods certainly have their appeal to the state and donor agencies.

*We have a goal and that is to get 20 per cent CPR. Definitely what would give us CYP are the long acting methods. (NGO Representative: 19-7-13)*

Whilst these methods are efficient in meeting programme targets (Trussell 2004a), they do not necessarily have enough variety to cater to the reproductive needs of

women, especially in situations where they have been contraindicated for hormonal methods. For example high blood pressure or weight related issues are common factors that serve as a reason to withhold the use of combined hormonal contraceptives or injections like Depo-Provera because of their relationship with the increased risk of cardiovascular complications such as blood clots, strokes and heart attacks (Trussell 2004a; Trussell 2004b). Altering women's bodies is a repetitive process when using short-acting contraceptives, whereas the use of long-acting, reversible methods delivers long-term altered bodies that fit well with the objectives in the terms of development assistance offered and the programme targets. This raises questions about the practicality of the contraceptive technologies made available and women's right to exercise contraceptive freedom when such methods do not meet their contraceptive needs.

**Adanna:** *that IUD I went there to do immediately I started it after like one month abi the two or three month, I started having problem.*

**Interviewer:** *What kind of problem?*

**Adanna:** *I used to bleed. The menstruation starts and it does not stop. Very heavy. I went there to complain. I was given injection and other tablets to stop the bleeding. They encouraged me to continue that it would soon normalize. The next month followed within two weeks plus I started seeing another blood.*

**Emeka:** *that one lasted for about three weeks*

**Adanna:** *they called it spotting.*

**Interviewer:** *Did it mimic your period?*

**Adanna:** *No it was very light but after a while*

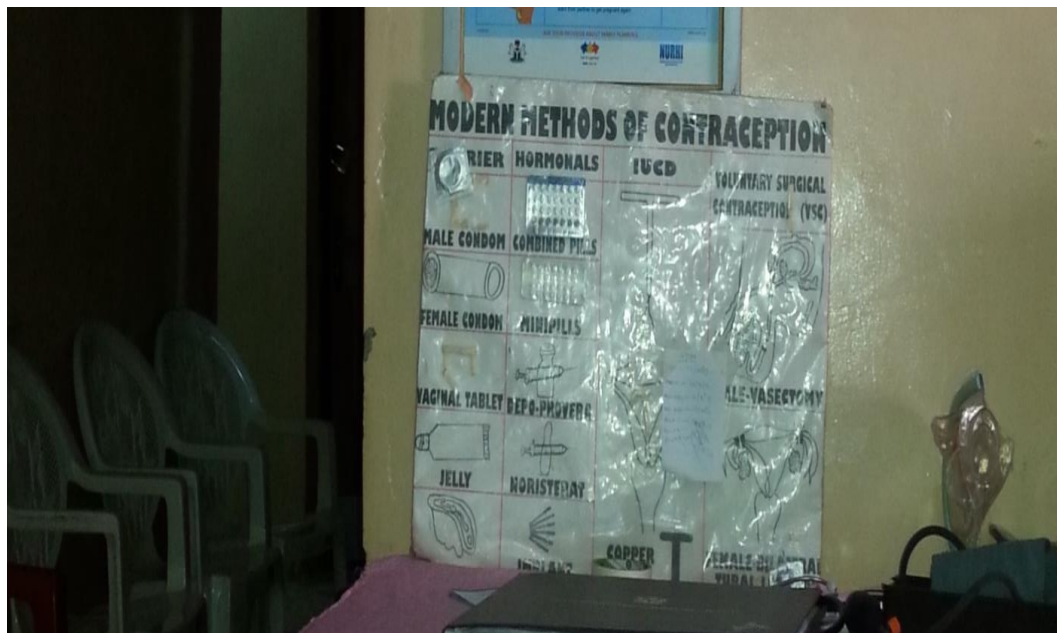
**Emeka:** *it became very heavy*

**Adanna:** *From there I went back again. Like two times. By the time I met you they had removed it. (Couple interview (urban, Ilorin East): Emeka and Adanna)*

For example, Adanna did not meet the eligibility criteria for hormonal forms of contraception because of her weight and blood pressure. Other options included the use of the IUCD with which she experienced severe side effects such as irregular bleeding that led to a discontinuation of the method. Increased bleeding is one of the most common reasons for IUCD removal within the first year of insertion (Hubacher *et al.* 2009, Haddad *et al.* 2013). Regarding the option to use the male condom, Adanna and Emeka reported using the condom around the time of their interview because she (Adanna) had discontinued the use of the IUCD. However, Emeka expressed some pleasure related concerns with using the male condom.

Also, they opted out of using natural methods of family planning because of their previous inconsistent use with the Billings method. Adanna and Emeka’s scenario illustrates some of the difficulties around choosing the method that best fits their reproductive needs. While their ideal method of choice comes with its own complications, it can be argued that the option to use the IUCD might be revisited particularly because they now know what to expect in relation to the side effects of IUCD. User-controlled methods which include the diaphragm, foams, and jelly (see Figure 7.2) are not generally available for clients such as Adanna whose bodies find hormonal methods unacceptable.

**Figure 7.2: An example of a decision-making tool used to illustrate the constellation of contraceptive methods available.**



Source: Researcher’s personal photograph

**Service Provider:** *It’s only female condom and male condom that we have. Any other ones we don’t have them.*

**Interviewer:** Why

**Service Provider:** *We were not supplied. It’s no longer in the market. Like the diaphragm and cervical cap the ones we have are all obsolete. The jelly and foams, the new condoms they are making now contains all these spermicidal so there is no need to use foams and jelly (Local Clinic 1, Urban: IE).*

**Service Provider:** *Because it is not so common now again. The only two (refers to diaphragm) that we have we normally show it to family planning students*

*from school of nursing. So the diaphragm is not available. Even the female condom very few people accept it.*

**Interviewer:** Why

**Service Provider:** *Some say that it is messy. They can't just put something inside their (vagina<sup>11</sup>). The only people that use it would be the students (poly and university) and they are very few (Local Clinic 2, Urban: IE).*

Participant observation in one of the facilities showed visual aids that clearly suggest the availability of several user controlled methods (see Figure 7.3). However, these methods are hardly ever mentioned as fertility management options during counselling sessions and were not made available to Adanna. The situation was not unique to this facility. User-controlled methods are not supplied to other clinics and some of the commodities available are used for teaching purposes only. There are several other factors that influence the use (or non-use) of these methods in the community. User-controlled methods require a personal understanding and exploration of female reproductive parts, parts which many African women find difficult to explore for cultural and social reasons, again highlighting women's bodies as not just physical entities. Research in South Africa reported the difficulty of inserting the female condom because of the perceived fear of the condom 'getting lost inside' as well as a refusal 'to touch themselves' (Mantell *et al.* 2001).

Socio-cultural understanding of the body affects the way knowledge is produced about the acceptable ways in which individuals engage with their bodies. This knowledge influences the ways in which individuals exercise sexual rights, body performance and ownership. In many African settings, these forms of knowledge also affect the way women engage with medical technologies like contraception, especially in situations where they lack control over the possible side effects of such technologies and where these indications intersect with their sexuality (Izugbara & Undie 2008). This emphasizes the notion of insecure bodily boundaries (Longhurst 2001).

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<sup>11</sup> Words that describe reproductive organs are in many cases implied through silence, pauses or phrases like 'you know' for cultural reasons. During the interview, the word *vagina* was implied with a pause and eye contact that suggested a reference to female body parts.

'Messiness' and the inability to explore the boundaries of the female organ illustrate the interference of these actions with sexual pleasure, thus highlighting some of the power dynamics within sexual activity. Here, the sexual body takes precedence over the medicalized body. The sexual body intersects with medicalized and fertile bodies, and while the medicalized body offers a timed alternative to a fertile body, the sexual body and practices inherent in its performance influence the way women engage with activities targeted at improving their reproductive outcomes. Sexual activity and pleasure for most African women is associated with male pleasure, often at the expense of female satisfaction and reproductive well-being. 'Wet' sex, especially that enhanced by lubrication from methods such as condoms and foams, is discouraged because men receive greater pleasure from less lubrication during penetrative sex and this preference for friction is also associated with female virginity and/or fidelity (Montgomery *et al.* 2008; Bagnol & Mariano 2011; Rice *et al.* 2012).

This, combined with programme targets for methods that provide longer CYP, forms the practical context within which contraceptive technology is supplied in the state. The ability to choose is the fundamental element in providing *quality* contraceptive services (Bruce, 1990). Choice is embedded in reproductive rights and freedoms and it lays the foundation for the decision-making process in the public domain. Promoting only certain methods limits the ability of clients to make informed choices about contraception. Notwithstanding this, and given the methods and services available, the following section provides an analysis of the quality of information given to clients.

#### **7.4 Information given to clients**

The quality of contraceptive information given to clients plays a key role in improving continuation rates and better reproductive health outcomes (Glasier *et al.* 2003). As described in Chapter Two, contraceptive information relies heavily on client-provider interactions and focuses on the informational components of choice, effective method know-how and continuity mechanisms, depending on the method used (Bruce 1990). This interaction entails knowledge sharing by both the

client and service provider and the knowledge produced forms part of the information cycle about the effectiveness of contraceptive technology.

The (re)production of knowledge therefore plays an important role in understanding people's experiences of managing their fertility. The language used and the modes of understanding family planning methods are components of how contraceptive knowledge is reproduced in society. However, it is important to stress that the sharing of information discussed in this section is different from the promotion of particular forms of contraceptive method as discussed earlier in this chapter. Here, the focus is on the quality of information provided when accessing contraceptive services.

Service providers, through what Foucault refers to as the 'medical gaze', furnish information about contraception in ways that legitimize their position as professionals (Foucault 1984). This position allows service providers to offer or withhold information according to their own perspectives (Richey 2008), which presents new sets of challenges in actualizing the idea of informed choice. Firstly, clients already have to make decisions based only on those methods provided by the State. Secondly, some of them have to make decisions on their method of choice based on incomplete information. In helping clients make informed choices, public service providers use decision-making tools such as pamphlets that contain information about the different methods available from their service. One example of such a tool is a two-sided card that is designed to help and encourage interactions between clients and service providers. It has been documented as a useful aid in promoting informed choice in family planning clinics after adjustment for clients' personal reproductive histories (Kim *et al.* 2005, 2007).

What was common among the clients was the way in which they described the methods. Phrases such as '*the one they put in the arm*', '*the one they put inside*'<sup>12</sup>, '*they say there is the three-months one, they say there is the two-months one*' describe implants, IUDs, Depo-Provera and Noristerat respectively, based on the site of entry into the body or the duration between each dose of injectable

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<sup>12</sup> 'Inside' means vagina

contraception. Clients may not necessarily understand how these methods work in the body, but they can describe them based on how service providers explained it to them and make decisions about the methods available. The tool presents the methods according to the contraceptive needs of the client (spacing or limiting births). In situations where clients lack English language reading skills, service providers provide the information verbally and ask clients to make decisions based on the information thus conveyed. The tool was commonly used in both facilities in Ilorin East but was less common in Edu where most of the counselling is done verbally without the use of any decision-making tools.

**Service Provider:** *When they come for family planning for the first time we greet them and ask them what brought them to the clinic. When they tell me it's FP I ask them which type maybe they are hearing stories about the FP so I am going to ask them that question which type are you going to do. If they say they just want to do any and that they don't know much about it. I would tell them we have different types. We have the injection, pill, IUCD and then we have condom for male.*

**Interviewer:** *What about spermicide, female condom and co?*

**Service Provider:** *We don't have those one*

**Interviewer:** *Why*

**Service Provider:** *We have not been supplied those ones. It's only Noristerat, depo, IUCD, condom and tablet that we have. So I am going to explain to them how each one is working. After explaining to them I would do the weighting if it's a female and other examination so that I would know which one would fit the body of the client. So after that I would give them their family planning and tell them the side effect of each of them in case anything happen. Because it is a new thing in the body they may see the changes maybe missing the period or spotting which is for the injection so I would explain each side effect of each family planning method. (Local Clinic, Edu: Rural)*

This conversation suggests a procedure and, more importantly, mentions the provision of information about the side effects of contraceptive technology. However, this narrative is not a representation of 'truth' about information sharing during counselling sessions. Whilst it was challenging to secure access for participant observation in facilities in Edu, data from observations in facilities in Ilorin East revealed different aspects of the 'truth'. Firstly, service providers were regularly observed communicating adequate contraceptive information to clients especially for the IUD where, because of its design, women need to have an



awareness of the body and engage in practices of self-care (Foucault 1984; Hayter 2006).

*.....The woman said she wanted the IUD. The nurse asks why. She said that is what she preferred. The nurse begins to tell her more about the IUD. It is inserted in your vagina. You have to be very clean so you would not have infection. You need to feel for the rope every time so that you would know it is still inside you but sometimes you can have heavy and painful periods so you need to be checking for the rope... (Diary extract, 160112)*

With the IUD, as with other forms of contraception, women are taught to be active patients and participate in the process of using the method. Contraception can only go as far as preventing conception; clients have to co-operate with the device and establish a habitual regimen of self-examination (Foucault 1985). Secondly, observational data in both facilities also showed that while clients are taught the art of self-examination, menstrual changes associated with the use of contraception are only mentioned occasionally during counselling sessions. This was one of the challenges faced by Emeka and Adanna when they accessed family-planning services in one of the facilities under observation. Withholding 'privileged' information about the possible side effects of the IUD led to the discontinuation of the method for this couple, as evident in the following exchange:

**Interviewer:** You mean you removed the IUD

**Adanna:** *Yes. They now planned me for other ones. They explained that they would give me the one they insert in the hand. So I was asking them about it because this one they didn't tell me more of the side effects. When I was asking them about the side effects they did not tell me any of that. So I was asking them about the side effects of that one in the hand that they now planned me for. They said that it may cause abi I may not see my menstruation. (Couple interview (urban, Ilorin East): Emeka and Adanna)*

Research suggests that the side effects of contraception are one of the factors that influence the use of contraception (Monjok *et al.* 2010; Abbasi Shavazi & Khademzadeh 2004; Ankomah *et al.* 2013; Imbuki *et al.* 2010) and this can also be extended to a decline in continuation rates, especially in situations where clients were not informed about the possibility of an encounter with side effects for their method. Increased bleeding and menstrual pain are the most common reasons for removing an IUD within the first year of insertion (Hubacher *et al.* 2006). These side effects have been observed to decrease over time and this can be reassuring to

couples, so reducing the rate of premature removal (Hubacher *et al.* 2009). It would clearly have been useful for Adanna had she been provided with such information, and there is obviously a possibility that she would have grown accustomed to the device and developed a more tolerant attitude towards the side effects she experienced. The couple's narrative of the IUD gone wrong is likely to serve as a focal point for the transmission of their experience of using family planning to members of their social group and networks. Diffusion through their immediate social groups and networks (Rogers 1995) forms part of what is known about contraception, and their legitimacy in talking about family planning (how it is known) is based on their experience of using contraceptive technology.

During informal interviews with service providers about the lack of information of possible side effects given during some counselling sessions, they responded that many clients would change their mind about using contraception in totality if some of the side effects associated with certain methods were mentioned. Another service provider suggested that some clients were in the habit of being selective about what they heard during the sessions, and '*would subsequently return to the clinic to complain about experiencing the precise side effect they were told could occur with their method*' (Diary extract, 120413). This is particularly common in situations where the side effect is amenorrhoea, with clients returning to these facilities 'in search of their periods'. Research suggests that service providers underestimate the importance of regular menstruation for clients (Glasier *et al.* 2003), which should not be the case as, more often than not, service providers are also members of the community and thus have a unique appreciation of the implications of a regular menstrual cycle.

Regular menstruation is an important feature in the performance of femininity in Nigeria. In relation to the use of contraception, regular periods are significant in more than one way. Firstly, their presence indicates that women are not pregnant and their contraception is effective. Secondly, their presence is important for women that seek the use of contraception without their husband's knowledge because their absence leads to suspicion and may have a number of consequences for women in the home. In one of the rural communities, a participant revealed

previous use of the pill and the IUD but was currently using injections (Noristerat). When prompted to explain why she changed her method, she reported menstrual irregularities. She experienced amenorrhoea with her injection, a situation that raised questions about her fertility and caused some problems in the home, especially since her husband wanted more children from her and her co-wife and was not aware that she was using contraception. Consequently, many women in similar situations seek methods that do not induce amenorrhoea. During onsite observations at one of the local facilities, a woman was observed negotiating with a matron based on her need for a method that allowed for regular menstruation because she *'heard that there are some that you use that you would not see your menstruation... Matron said if you want to see your period you should take the pill; if not, take the injection'* (Diary extract, 291112). Women are not always docile bodies. They are constantly finding ways to resist or modify practices that involve habitual perceptions of their body, which in this case is the absence of a regimen that normalizes feminine behaviour. In other words, if women were to put their bodies under surveillance, they would do so in terms that they found acceptable.

An important feature of the information given to clients is the cost of contraception. Cost is very important in the decision-making process, especially in developing settings like Nigeria where healthcare provision is fragmented and clients end up paying for the shortcomings of government provision.

*A new couple came in early this morning. Madam is counselling her. Her husband stood outside the clinic. Apparently she just had a C-section and lost the baby. Her husband said (according to her) that she should rest. Resting meant not having a child for like a year and a half. Madam runs through a host of methods from the card and how they worked based on the site of entry. 'Like the injections now. If you take the two-months you would have to come back every two months for another one'. She never mentioned side effects. After what appeared to be 'counselling', the woman is thinking. After a while she said she wanted injections. Madam called the husband in and talked a bit about the method. Now it would seem they came to the clinic without funds. Madam said they would have to do a pregnancy test. The husband explained again what his wife's experience giving birth implying that they have not had sex but madam stressed the legal importance of doing a pregnancy test to be sure. The husband said they would have to come back because they didn't have any money again. She said they would use the injections when*

*they come. The man concurred. Madam did not provide temporary methods just in case. (Diary Extract: 28-11-2012)*

As discussed in Section 7.1, the cost of accessing family planning services is crucial to the use of contraceptives. The cost of contraception includes consumables, pregnancy tests (for new clients) and follow-up, especially for women on the IUD who have to return for the first couple of months for check-ups. The scenario described above further illustrates the impact of cost on the entire decision-making process. Couples may have made the decision to use contraceptive services and - based on promotional messages circulating in the community - access services on the premise of free contraception. However, many costs are not included in the promotional messages that encourage the use of family planning and are only incurred by clients when they visit the facilities. Observational data also revealed clients being turned away because they attempted to access services without funds. On several occasions, empathetic service providers gave free services to clients based on their personal situations.

*'It depends on how much we buy our consumables so the prices fluctuate. If we get our consumables cheap in the market we can give them cheap and if we get them expensive we give them you know'. (Local clinic 1, urban: IE)*

Prices fluctuate depending on the current market price of the consumables. The prices also differ between each facility as methods are typically cheaper at the local government-run clinic (local clinic 2) than at those that simply have directives from the federal government (local clinic 1). Consequently, clients are obliged to make economic decisions regarding their next course of action.

*A few patients came back for their refill injections. Apparently the price of injections has increased. It used to be 300 naira now it is 400 naira. Madam is negotiating with her because it appears that if she paid the new price she would not have enough money to go back home. Madam said she would put it in her card that on her next visit she would pay the balance. (Diary Extract: 281112)*

Sometimes a credit facility is drawn up especially for injections where women pay out of pocket fees based on availability of funds and pay the difference on the next visit. This could be one of the reasons why injections and pills are the most commonly used methods. The pills are given without cost and the injections are cheaper psychologically and 'economically' given that many of the women who use

short acting methods are poorer women who weigh up the options of paying a far more substantial one-off fee (for example 2000 naira for the IUD) for long acting methods like the IUD and the implants. Turning away potential clients has several implications for addressing maternal mortality in Nigeria. Women with an unmet need for family planning are at a higher risk of dying due to pregnancy related complications. If the effects of supply related factors such as the cost of available services are not carefully considered in the provision of family planning services, more unintended pregnancies will continue to contribute to the maternal mortality ratio in Nigeria which have risen from 545,000 women per year in 2009 to 576,000 women per year in 2013 (NPC & ICF Macro 2014).

In terms of the couple described in the scenario above, aside from the cost issues, the service provider missed an opportunity to provide a temporary method of contraception to them. Between the initial visit and the next available opportunity to revisit the clinic, there are possible risks of another pregnancy, a potential abortion and/or maternal mortality. Cost issues identified in the scenarios with the patients and the couple exemplify the realities of the reproductive lives of many people in Nigeria. Government support for reproductive health issues including the use of family planning does not match the already alarming rates of maternal mortality in the country particularly in light of the growing presence of the private sector in health care service delivery in Nigeria as discussed in chapters two and three. Poor and vulnerable women run a higher risk of unplanned pregnancies because of both demand and supply related issues around contraceptive service provision (Mandara 2012). Evidence in three countries including Nigeria suggest that post-partum access to family planning is influenced by socio-economic factors and called for training service providers and the integration of maternal and new born health services (Hounton *et al.* 2015). Whilst integrated services are visible in Nigeria more so in both clinics involved in this research, the cost of family planning services needs to be addressed in order to scale up the use of contraceptives. In addition to this, the cost of services which include the cost of transportation (see scenario above) also influences the use of other maternal health services as reported by (Doctor *et al.* 2012). This raises even more questions about the commitment of the government to reducing already alarming rates of maternal

mortality. This thesis acknowledges the role donor organizations and other funding bodies play in advocating for and supplying contraceptive services in Nigeria. However in light of some of the supply related issues discussed in throughout the thesis, donor agencies need to fully appreciate the working conditions of recipient countries, particularly in relation to infrastructural problems that can affect access to and the sustainability of family planning programs. Representatives of NGOs working in Kwara State have advocated for increased co-operation and funding for family planning programs in the state through the allocation and release of funds by the State for a stand-alone budget for family planning to address programme needs that are beyond NGO capacities.

*With strategic engagement we have been able to advocate for a stand-alone budget for family planning three years ago from the state and the five LGAs. But this year, 2013, we have been able to get some funds released from the LGA including Ilorin East. It actually happened a few weeks ago. The uptake is supposed to be free but the challenge has been the consumables because we don't want them to charge clients. The funds from the LGA are to buy consumables so that there would be zero tolerance as regards to paying for family-planning services. (NGO representative 19-7-13)*

An informal interview with the head of the Department of Health for Ilorin East confirmed the release of funds and procurement of consumables needed to run the clinic. The presence of these consumables was also confirmed upon arrival at the clinic, particularly because clients were observed paying a considerably lesser amount of money for contraceptives. This suggests that while developing countries may receive development assistance from donor agencies, the impetus is on them to make and effect changes in their countries. Continued national and state investments in reproductive health services will make them more than effective in preventing unplanned births and improving the lives of women (Mandara 2012; Bongaarts 2014).

## **7.5 Punitive quality, method procedure and interpersonal relations**

So far, this chapter has explored issues around informed decision making on the choice of contraceptives available in the State. This section takes the challenges of accessing and using family planning methods further by exploring issues around the

technical aspects of service provision and interpersonal relations in resource poor conditions.

### **7.5.1 Punitive quality and ‘implant Thursdays’**

Punitive quality, as defined by Bruce (1990), refers to the inappropriate application of medical standards in providing contraceptive services. These standards are restrictive by nature and include the medicalization of some procedures. One example of such restriction was unique to one of the facilities, where implants could only be administered by certain highly trained personnel leading to what this research termed ‘implant Thursdays’.

*...The couple took a while to make up their mind. She said she wanted the implant. She was told to come on Thursday and she would do some tests when she comes because she is now Doctor’s patient. Madam told her the price and asked about her last period and what she was doing to prevent pregnancy. She said withdrawal method. Madam laughed and said to her it was highly unreliable. She said something about [translated version] all the sperm entering her vagina before he withdraws. Because they had to wait till Thursday the couple thought to use something else. The man was pushing for the IUD. The woman said she didn’t like it more than once. They deliberated for a while and finally they picked the IUD. (Local clinic 1 Urban: IE 121112)*

The scenario described above is an example of a task performed by specific highly trained personnel. The insertion of the implant involves ‘a little anaesthesia work and here (in this clinic) it is a doctor that inserts that one’ (Local Clinic 1, Urban: Ilorin East). The insertion of the implants is limited to one day a week, a day that the doctor in the clinic could make available. In addition, the implants are the most expensive method in this facility and observational data revealed that the majority of clients using them were in a higher income bracket than the women using injections and pills. Clients that access services on any other day and choose the implants are placed on a waiting list and told to re-attend the clinic on a Thursday. This restriction attached to the use of the implant is an unnecessary barrier to the use family planning particularly for women that have to return to the facility in order to access this method of family planning and incur an additional cost of transportation. Women thus have to weigh the option of choosing a different method vs coming back on a different day. In the scenario above, the client eventually chose the very method she did not want to use in the first place. An

informal interview with the service provider revealed certain aspects of hospital politics and hierarchies that limited activities in the clinic. As a nurse, the service provider is well within her professional rights and ability to insert an implant device, just as nurses do in other facilities, including the second clinic under study. However, Shelton (2001) describes a hierarchy of practice with traditional conservative norms impinging on work routines and division of labour. This hierarchy of practice more often arises out of concern about the technicality of the procedure (as insertion requires the use of local anaesthesia) than the gender of the service provider. Nonetheless, this barrier to the insertion of implants is unnecessary and is an example of punitive quality acting on technical supply factors to constrain the use of family planning (Campbell *et al.*, 2006; Prata, 2009).

### **7.5.2 Procedure for providing methods**

The choice of contraception is but one half of the process of accessing contraceptive services. A review of the reproductive and sexual history of a potential client, pregnancy tests, body weight and blood pressure examinations are common forms of medical examination that clients must also undergo before they can use their chosen form of contraception. While the rationale behind weight and blood pressure measurement can be understood for hormonal forms of contraception (see, for example, World Health Organization eligibility criteria for contraceptive use (WHO, 2010)), the issue of pregnancy tests is subject to debate. During observations in both facilities, both prospective clients and clients well past their due date for re-supply of contraception were asked to undergo pregnancy tests. Research (Stanback *et al.* 1999, 2005, 2008) suggests that the use of WHO-recommended checklists and/or job aids are more effective ways of ruling out the possibility of pregnancy, so eliminating the need for pregnancy tests and the costs incurred by the examination. Nevertheless, the current research suggests that using job aids and checklists does not take into account the agency of desperate women.

*...One lady comes in. she is a returning client but missed her date to return back to the clinic by a several weeks. She is asked to do a pregnancy test. The lady says she didn't have money so madam collects 80 naira from her to do the test. Madam tells the other nurse that the lady is pregnant and she lied about her last period. Madam could tell she was scared. Her tests come back*



*positive. She is pregnant and has a ten month old baby. The lady tells them that she used the condom but they didn't use it once. She wanted to use contraception to abort the baby..... (Diary Extract: 160413)*

The example illustrated above was not unique to this facility. Similar examples were observed in the other facility where women go through extreme measures to access family planning in order to induce abortions. Although this does not necessarily validate the pregnancy test requirement, it provides another perspective to issues around the medicalization of contraceptive services. Abortion is part of the larger reproductive health and service provision issues in the country. And, it can be addressed with the more perfect use of contraceptive technology and holistic reproductive health services. However, the subject of abortion is very sensitive in Nigeria and there is a need to reform the country's current abortion laws in order to respond decisively to the associated maternal health issues (Oye-Adeniran *et al.* 2002; Otoide *et al.* 2001; Omideyi *et al.* 2011; Mandara 2012).

As mentioned in earlier sections within this chapter, facilities in the State lacked consumables needed for examinations and the administration of various methods. Service providers often improvised and made necessary adjustments in order to provide services to clients. Gloves, syringes, disinfectant and cotton wool are some of the basic amenities lacking in these facilities. Service providers use revolving funds to purchase consumables which, are then included in the overall cost of the contraceptive method chosen by clients. However, there were some unhygienic practices that were a manifestation of resource shortages. During one clinic observation, service providers gave injections to clients without the use of gloves or any form of privacy for that matter. The injections were given in front of other clients in the waiting area as opposed to it occurring in the insertion room. Gloves were worn only when the service provider had to insert the IUD.

*One of the clients complained about the intrusion but the attending nurse is trying to explain to her the importance of these 'practical sessions'. The women were never consulted before a fleet of students enters the insertion room to 'observe'. They have taken the light so they are using a rechargeable lantern in the insertion room. From where I was sitting I could see the woman's thighs because the students kept opening the doors because of the heat. Another lady beside me commented to the lady beside her about wanting to use the IUD. She is the same woman that expresses her discomfort*

*about the students coming in. She said she would have taken the injections but she didn't like taking injections ... when they were doing inserting her IUD there was no light and madam was chatting with the doctor while doing the insertion. She was explaining the procedure to the students. The lighting was an issue. She kept saying she could not see. They never asked if the client was OK with having people in her insertion room. They are talking over her vagina. (Diary Extract: 221012).*

In the second facility, electricity supply was one of the main shortages that affected the implementation of contraceptive services. Here, service providers would frequently insert an IUD using rechargeable lanterns or torchlight, thus requiring assistance in the form of an extra pair of hands to direct the light towards the woman while insertion took place. There was rarely much privacy as the doors to the insertion room were left open and a thin curtain afforded minimal decency or dignity. Privacy issues are further exacerbated by professional training sessions where trainee service providers walk into the insertion room without informed consent being obtained from clients. In this particular instance, although the client had opted for an IUD because of her discomfort with needles, she would clearly have preferred to have had the IUD inserted privately. This reinforces the notion that if women are determined to manage their fertility, they do so regardless of the quality of services provided (RamaRao *et al.* 2003). Research in Tanzania has documented similar challenges in providing good quality contraceptive services (Richey 2003, 2004, 2008). The majority of these challenges are beyond the control of service providers and reflect structural and organizational supply side factors (Mugisha & Reynolds 2008).

### **7.5.3 'Eyan wa ni': Interpersonal relations and use of family planning**

Knowing someone, having kinship relations with service providers and using patron-client social networks are amongst several features of accessing family-planning services. These human elements based in kinship and/or social networks are essential in advancing individual and collective interests in Nigeria (Daloz & Chabal 1999; Smith 2001, 2004). It has been further suggested that having children is essential for the reproduction of these networks (Smith 2004). Ironically then, these networks (social capital) are now proving useful in accessing family-planning services that now aim, implicitly, to limit their extent through the promotion of

smaller families. Through patron-client relationships, kinship members enter relationships with each other (Bledsoe 1980) that may be useful in accessing various institutions including healthcare facilities. These relationships are also influential in the decision-making process as was made evident in Chapter Five, particularly in relation to enabling the clandestine use of contraception and in Chapter Six through the construction of contraceptive information and encouraging and/or limiting access to contraceptive services.

**Saratu:** *You see the provider is our person (eyan wa ni)*

**Interviewer:** *Ok*

**Saratu:** *So the person works at maternity. I told her that I didn't want to come to the clinic*

**Nda:** *you know we nupe people we don't really understand things*

**Saratu:** *So we are ashamed to use it. The person pities us and comes to give us outside the hospital. (Couple interview (rural): Nda and Saratu)*

*...Two nurses come in to gist<sup>13</sup> with madam. One of the ladies wants to refer a patient to her. She has 6 children and doesn't want more kids. The nurse suggested the IUD and asked madam to fit in such a way that the husband would not feel it. The nurse says she deliberately did not suggest the injection for her because she doesn't want her husband to know. (Diary Extract: 270613)*

Because service providers are also members of the community, they can reach out to 'their fellow women' and advocate the use of family-planning services, especially in situations where there is a lack of support for family planning in the wider community. This 'wealth in people' (Smith 2004) is also evident in medical institutions where having social capital and 'knowing someone' improves access to contraception, especially in situations where there is lack of spousal communication on the current reproductive health needs of the wife. Here, clients can negotiate access based on their needs with kinship members that can ensure that their contraceptive needs are met. The reference to the IUD insertion in the second of the quotations above relates to the odd sensations male partners have reported feeling during intercourse (Imbuki *et al.* 2010). An interview with the service provider at the clinic revealed the view that the sensations were 'more of a psychological thing'. Nonetheless, participant observation revealed that clients who

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<sup>13</sup> The scenario starts with an informal conversation. Often it starts with greetings and mundane chit chat in order to seem like an ordinary interaction. It is usually done to limit eavesdropping.

reported having sexual difficulties because of the length of the string had it trimmed to ensure better sexual experiences and to avoid potential discontinuation of the method.

## **7.6 Conclusion**

This chapter has examined the idea of choice and informed decision-making with regards to the use of contraceptive services. Research findings in this chapter complement the data in Chapters Five and Six to provide a more nuanced understanding of the decision-making process and suggest that the process is scalar and contains many interwoven parts that intersect at different levels to influence the use of contraceptive technology. The outcomes of women's reproductive lives are governed by the state, supporting international and national bodies and organizations, social structures, and the discourses and priorities of development. Although women's agency cannot be denied, the findings in this chapter - as with those in Chapters Five and Six - show that women's agency attached to use of contraception is heavily influenced by fertility preferences proposed by the state and society. In particular, these factors provide a basis for the promotion of contraceptive technology mainly in relation to the changes observed in men and women's practice of post-partum abstinence as discussed in Chapter Six and emphasized by the findings of this chapter. These factors, along with discourses around poverty affect the demand and supply of contraceptive services.

In the face of a 'build it and they will come' paradigm, this chapter stresses the complexities of development assistance in augmenting healthcare provision in an already fractured nation state. Research findings suggest that development funding and assistance in this situation provide prioritized services within serve only as sticking plasters much bigger institutional and infrastructural problems of healthcare provision within the country. However, it does not address the bigger issues around contraceptive service provision within the state, especially when this focuses on urban women's bodies and not women's bodies in totality. Therefore, strengthening the health care system in Nigeria, along with further research and advocacy are simultaneous actions that need to occur in order to address the demand and supply side barriers to the use of family planning.

This chapter highlights some of the challenges in quality of care and its effect on the use of contraceptive technology. It suggests that women's bodies are not the same and should not be classed as such by limiting the variety of methods available to women to exercise contraceptive freedom. Women have different contraceptive needs depending on their fertility preferences. Providing methods that do not completely address this need exposes women to the risk of having unwanted pregnancies, which could lead to induced abortions, pregnancy-related complications or death. On the supply side, the quality of contraceptive information provided was also analyzed along with other issues related to service provision such as interpersonal relations, punitive quality and the over-medicalization of procedures that may act as barriers to the use of contraceptive technology. The research findings suggest that although these factors are indeed barriers to use, a contextual analysis of the situation suggests that service providers may be justified in adopting certain practices and procedures before they supply contraceptive technology.

Chapters Five, Six and Seven of this thesis has provided a multi-leveled argument showing the complexity of contraceptive decision-making. Because of the many interwoven parts that have women's bodies at the center, women's agency with the use of contraception was situated within macro, meso and micro-level structures that influence women's lives. Power diffuses through these multi-level structures and women (and men) have to continuously navigate their fertility preferences and contraceptive desires within these structures.

## CHAPTER 8: CONCLUSION

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### 8.1 Introduction

In this thesis it has been argued that contraceptive decision-making is a multifaceted process that involves many actors and structural forces that intersect to influence the use of contraception. Studies of family planning in Nigeria have emphasised the role of men (Isiugo-Abanihe 1994; Orji, Ojofeitimi & Olanrewaju 2007; Oyediran *et al.* 2002) and the importance of spousal communication (Meekers & Oladosu 1996; Bankole & Singh 1998; Feyisetan 2000; Izugbara *et al.* 2010) in the use of contraceptive technology. This thesis noted the absence of contemporary studies on contraceptive decision making among couples in Nigeria (see Meekers & Oladosu 1996; Bankole & Singh 1998) and addressed this gap by providing an in-depth exploration of decision-making processes in Kwara State at the level of both couples and service provision (see Chapter One).

Specifically, the research set out to explore contraceptive decision making in North-Central Nigeria using Kwara State as a case study. Through close investigation of Edu and Ilorin East LGAs, this thesis addressed the following research objectives:

1. To explore men's and women's experiences of negotiating contraceptive intentions as couples (chapters five and six);
2. To investigate if and how contraceptive intentions are implemented (chapter six);
3. To examine the role of the State in contraceptive service provision (chapter seven).

This chapter, therefore, provides a synthesis of the main research findings of this thesis in Section 8.2, and explores the academic and methodological implications of the research in Section 8.3.

### 8.2 Key Findings

The following section summarises the empirical findings described in Chapters Five, Six and Seven of this thesis. The research question that sought to explore men's and women's experiences of negotiating contraceptive intentions as couples was

addressed in Chapters Five and Six. Therefore, this section will begin with an engagement with the key findings of Chapter Five.

### **8.2.1 To explore men's and women's experiences of negotiating contraceptive intentions as couples**

#### *Couple dynamics and women's agency in the use of contraception*

Chapter Five of this thesis elaborated upon couple dynamics and gendered power relations that influenced the use of contraception. The chapter situated the decision-making process more broadly within the division of labour among men and women in the household and reflected upon how men and women's entitlements were a function of their social organization within the household. Regarding fertility related discussions which include family size formation and future contraceptive use, women navigated hierarchies of governance in the household and had limited opportunities to act on their reproductive agency. These opportunities, limited as they may seem, resulted in women's clandestine use of family planning. These findings emphasize gender as a structural factor that constrains or enables women's agency and call for continued advocacy for family planning programs that eliminate gendered barriers to the use of contraceptive services.

- *Fertility decision-making was often a reflection of the broader decision-making processes in the household.* Men and women occupied different spaces that reflected the gendered division of labour and entitlements within the household. These entitlements are provided by the structures that govern the household and are reinforced by the marriage institution. Gender was a critical component of the social organization among couples and permeated every aspect of their lives. Through the use of gendered scripts, men appeared to dominate the decision-making process and their role was visible in the timing of sex and discussion on family size formation, all of which had a bearing on contraceptive use. The reality of the decision-making process as revealed in this thesis was that women had subtle ways of negotiating their reproductive interests in the relationship, which included the clandestine use of family planning.

- *Gender identity performance was fluid.* The fluidity of gendered identities and performance allowed for the observation of other gender identities that challenged existing ways of being and interactions between couples. This was particularly visible in face of the economic realities of men and women in Edu and Ilorin East LGAs. Although male dominance was highlighted in this chapter, dominance was never complete as both men and women reported the relativity of male control especially when factors such as love, intimacy and type of marriage were taken into account. These factors proved essential in the way couples interacted with each other and was an important element in the way they had conversations and/or made decisions about their fertility.
- *Religion and its sub-institutions such as polygyny are important structures that impact on people's fertility preferences.* Religion had multifaceted effects on fertility in both LGAs. These effects were in evidence in all three empirical chapters of this thesis and, in Chapter Five, were shown to operate in the creation of people's desire for children. The locus of women's desire for children is found in the disciplinary power of religion and culture in creating bodies and identities that are submissive to hierarchies of governance within the household (Foucault 1988; Sawicki 1991). In practice, this was more evident in Edu than in Ilorin East. As discussed in Chapter Four, Islam is the predominant religion practiced among the Nupe people, including those in Edu LGA. As a consequence, their cultural practices are largely governed by Islamic doctrines. The effect of Islam on fertility, particularly in Northern Nigeria, has been documented in research on contraceptive use in Nigeria (Renne 1996; Sule *et al.* 2006; Izugbara & Ezeh 2010; Izugbara *et al.* 2010; Garba *et al.* 2012). The data presented in this study supports such research and contributes further to this knowledge base, specifically through the incorporation of the Nupe people into the understanding of fertility practices in Northern Nigeria.
- *Women also exercised their reproductive agency through the clandestine use of contraception.* Clandestine use of family planning was employed by women who lacked the ability to communicate their fertility preferences



with their husbands and had the need to use family planning. Clandestine use was perceived negatively by men and women and was associated with marital discord, gender based violence, distrust and infidelity. Nevertheless, clandestine use suggested that women were not merely passive agents and there was evidence of women resisting patriarchal control in the household even though it could arouse gender-based violence by way of response as exemplified through Aliya's experience. Also, method related issues including the side effects of contraception contributed to embodying the practice of clandestine use and further complicated women's agency and acts of resistance.

- *Women and their social networks were important features of the clandestine use of contraception.* Friends, family and, by extension, the community were important at all levels in providing a nuanced understanding of the decision-making process and provided the basis for a meso-level analysis within this thesis. This thesis argued — by means of the data presented in Chapters Five, Six and Seven — that the social networks formed through friends, family members and other members of the community influence the decision-making process at the point of knowledge sharing and accessing contraceptive services (Valente *et al.* 1997; Kincaid 2000; Avogo & Agadjanian 2008; Alvergne *et al.* 2011). In Chapter Five, their role emphasised the effect of interpersonal relationships with service providers and patron-client ties in accessing contraceptive technology, which was particularly useful for women who sought to use contraception without their husband's knowledge. The interpersonal relationship with service providers further complicated their role particularly in relation to issues around the growing influence of the private sector in the supply of contraceptive services in Nigeria.

#### *Contraceptive decision-making among couples in Kwara State*

Chapter Six focused on providing a micro-level analysis of contraceptive decision making in Edu and Ilorin East LGAs. This chapter continued from the couple

dynamics discussed in Chapter Five to include an analysis of the effect of spousal communication on the use of contraception. Spousal communication relied on the fluidity of gender relations and the dynamics between couples as established in Chapter Five. The findings in Chapter Six highlighted the complexity in communicating fertility preferences, contraceptive use and effect of contraceptive technologies in altering the timing of child birth as evidenced in narratives provided by Yusuf and Faizal. Spousal communication was thus identified as a series of conversations that occurred at different times in the reproductive life of couples. Although communication was sub-categorised into active or passive, this thesis acknowledged an 'in-betweenness' between these categories through its focus resistance and the clandestine use of family planning discussed in Chapter Five. Similar to the women who engaged in the covert use of family planning, men and women's social capital layered the nature of spousal communication and had various impacts of the reproductive lives of women (for example see Anisa and Jega).

- *Spousal communication is a complex process.* The analysis presented in this thesis emphasised the importance of spousal communication in the use of contraceptive services. The findings support the literature on the positive links between spousal communication and contraceptive use (Ogunjuyigbe *et al.* 2009; Okwor & Olaseha 2010; DeRose & Ezeh 2010). However, this research revealed the complexity of the 'communication' in spousal communication. Because of the gendered ways of being prevailing in the household, it was important to explore the varying degrees to which women were involved in spousal communication. The research contributes to the literature on family planning by opening up spaces in which to explore verbal and non-verbal communication, the timing of communication and the level of inclusion in the communication process. Two categories of inclusion in this process were revealed: active and passive inclusion. The fluidity with which agency is able to move across these categories during the reproductive life course of a couple serves to illustrate the importance of dynamic change in such communication.

Passive inclusion indicated coercion and a relative lack of agency in the decision-making process, and many of the women in Edu LGA could be categorised in this way. Here the religious and cultural landscape, education and income-generating activities intersect to shape the way women exercise their agency in the household. There was evidence of contraceptive use amongst women in this category but passivity was operationalized at the point of discussing fertility preferences and at the point of making informed choices about the method of contraception used. This was a reflection of the disciplinary practices present in religion and culture that allow women's bodies to be acted upon through the control of knowledge and of the methods used. On the other hand, active inclusion involved more attention being paid to the timing of spousal communication and suggested that couples can go through many stages of active inclusion, further complicating the decision-making process. Like passive inclusion, it was largely male-dominated, but showed varying degrees of female involvement at least inasmuch that women could dominate the outcome of a couple's fertility based on the culturally internalized preference for high fertility.

The first stage of active inclusion was observed at the level of courtship and operated at a cognitive level to create a future demand for contraception. While conversations at this stage emphasized love, emotion, socio-economic change and the effects of culture on acceptance of or bargaining for future fertility intentions, they also stressed the transformative effect of polygyny on fertility. This transformative effect was bipolar. Women used their husband's declaration of interest in entering a polygynous union in the future either to lower their own fertility because of the fear of neglect, or to foster high fertility in order to compete for resources in the polygynous household. This finding challenges the predominant research that has linked polygyny only with high fertility among women, particularly in Northern Nigeria (Ezeh 1997; Blanc & Gage 2000; Izugbara & Ezeh 2010).

The second stage of active inclusion relates to sexual intimacy and the prevention of unwanted pregnancies in marriage. At this stage, the cognitive demand for contraception created during courtship is actualized, once again

emphasizing the fluidity of spousal communication. This stage also marked the beginning of contraceptive decision making for other couples, particularly when male sexual agency is challenged by the fear of unwanted pregnancy. The method of contraception used is also important here because of its potential interference with sexual pleasure between partners. Study of this stage permitted a meso-level analysis, which expanded on the effects - discussed in the preceding section - of friends and family on the decision-making process within couples. As pointed out there, the roles of friends and family are visible as sources of contraceptive information and in the validation of contraceptive behaviour in the community. This research aligns with Alvergne *et al.* (2011) who argue that in other rural African settings the effects of socio-demographic characteristics and religion on contraceptive use are more visible than the effects of social networks, but stress that social networks add a layer of resistance to the control of contraceptive information by the State.

The third stage of active inclusion occurred after pregnancy-related complications such as abortions or caesarean births. This stage of inclusion has been linked to the desire of limit childbearing among women (Kodzi *et al.* 2012). Here, women's bodies responded (in part) to continuous reproduction by forcing couples for example, Malik and Inka to actively make contraceptive decisions and stressed the disciplinary power of body and medicine in exerting control over life (Gordon 1991; Rabinow & Rose 2006). This stage has therefore been used by service providers as a point of entry at which women use contraception.

### **8.2.2 To investigate if and how contraceptive intentions are implemented**

Chapter Six also addressed the question that focused on the reasons behind men and women's access to contraceptive services. The chapter explored the triggers, events or underlying factors that influenced contraceptive agency.

- *Economic and sexual triggers motivated couples to access contraceptive services.* The influential factors identified here concerned the economics of raising children (Saavala 2013) and issues around sexuality within couples

(Lawoyin & Larsen 2002; Desgrées-Du-Loû & Brou 2005). These factors were linked to the issues discussed in relation to the second and third stages of active inclusion and serve to emphasize that, while such conversations happened at those levels, factors such as sudden unemployment or explicit denial of sexual relations by wives had a direct effect on the point at which women were granted access to family-planning services. Economics and sexuality play a key role in the promotion of family-planning services in Ilorin East. Economic difficulties in particular had implications for men and women's family building strategies that including the use of postponement and not spacing vs limiting in managing their fertility outcomes (see also Moultrie & Timaeus 2014). Here, service providers in the public sector construct information based on the links between marital fidelity, sexuality and the politics of resource allocation in the household in order to encourage the use of contraceptive technology. Post-partum abstinence and the new identities attached to the decline of the practice (for example, the client in the diary extract 281112) were also important in providing a nuance to the sexuality related triggers. Since many service providers also serve as members of the community, they have a special understanding of the household on the one hand and of State interests on the other (Shelton 2001; Richey 2008). This research acknowledged the conflicting identities of service providers but stressed their importance in encouraging women's agency by providing women with the means to navigate the structures that reinforce their subordination in the household.

### **8.2.3 To examine the role of the State in contraceptive service provision**

Chapter Seven located the decision-making process relative to the point of service provision and addressed the question of the role of the State, supporting NGOs and service providers in actualizing the idea of choice and informed decision making. Acceptance of family planning and the promotion of smaller families by the State provided a macro-level analysis of the trickle-down effects of these promotional messages, campaigns and advocacy on the micro-level of the household. The

chapter built on the results of Chapters Five and Six and further demonstrated the centrality of women's bodies in the decision-making process.

- *Informed contraceptive choice was influenced by the agenda set by the State and supporting NGOs.* For this thesis, 'choice' was embedded in the way the State sought to control women's bodies. Both historically and currently within Kwara State, family-planning programmes have been discursively linked to the construction of women's bodies as a solution for rapid population growth. Although contraceptive use can be polarised in terms of its effectiveness in addressing rapid population growth and women's reproductive health, the priorities for the state lay in the collective control of urban bodies rather than in addressing the poor reproductive health status of women throughout Kwara State (Hartmann 1995; Bandarage 1997). Chapters Five and Six illustrated the effects of this selective control of women's bodies where localised differences between the reproductive lives of women in Edu and Ilorin East were evident. The priority to control urban bodies also reflected the funding interests within the international community, which sets the agenda for development assistance and for programmes that focus on the creation of a different kind of urban woman. The contraceptive methods provided by the State are largely provider-controlled ones that grant greater access to the body for control and regulation. Regulation itself is an important factor in service provision because it acts to monitor women's bodies in order that the objectives and targets of donor funding can be seen to have been fulfilled (Bandarage 1997; Takeshita 2010).
- The sustained influence of the international community in service provision in Nigeria was contextualised within Nigeria's continuous lack of political will and financial commitment to family-planning service provision. Family planning in Nigeria is still a very sensitive issue and the reproductive lives of women in Edu further illustrate this sensitivity. As discussed in Chapter Six and Chapter Seven, women in Edu conform to hierarchies of governance in the household and this situation is exacerbated when cultural and religious

leaders exercise power over women's bodies through the control of information regarding beneficial health promotion strategies that could improve the lives of women.

- *The quality of care provided in state-run healthcare facilities was poor.* Turning now to service provision at government-run facilities in Ilorin East, the inadequate information provided about different methods of contraception created situations in which women lacked a full awareness of the characteristics and consequences of their method of choice. Chapter Seven highlighted some of the challenges in providing a high-quality contraceptive service to women accessing services from these facilities. Counselling sessions provided incomplete information about contraception and women left facilities without a full knowledge of what to expect from, and how to manage, different methods. In terms of the side effects of each method, many women reported inadequacies in the type of information provided, as also evidenced in Chapter Five. Approaches differed between LGAs, with Ilorin East offering more specialised access to trained practitioners and contraceptive commodities. However, such additional expertise also meant that service providers were more likely to alter practices and procedures based on their own personal experiences or interests, and this was demonstrated in the chapter by virtue of the fluctuations observed in the cost of contraception and the use of hierarchies of technical expertise that influenced the use of long-acting reversible contraception such as implants. Knowing people and having familial links to healthcare institutions served as forms of social capital that facilitated access to contraception, further underlining the influence of friends and family at all stages of the decision-making process.

### **8.3 Academic and methodological implications**

The research presented in this thesis has contributed to the academic literature on contraceptive use in Nigeria (Renne 1996; Meekers & Oladosu 1996; Bankole & Singh 1998; Oye-Adeniran *et al.* 2005; Iklaki *et al.* 2005; Oyediran *et al.* 2006; Izugbara *et al.* 2010; Fotso *et al.* 2011; Ankomah *et al.* 2011; Ujuju *et al.* 2014).

Rather than applying a narrow focus to decision-making, this research theorized contraceptive agency within the structures that govern the lives of women. Structure and agency offered a more dynamic framework with which to explore the complexity of contraceptive decision making in Kwara State. This thesis extends our knowledge base by applying this framework to encompass a scalar analysis of decision-making that enabled specific focus to be placed on shifting power relations between couples and also in the public sphere of service provision.

Among couples, some empirical work exists that has examined the role of men in the use of contraception, but research into the contraceptive decision-making process among couples, particularly in Nigeria, is limited. In this context, the academic contribution of the current research lies in its inclusion of a gendered analysis of the dynamics and interactions that occur when men and women negotiate their reproductive interests. In so doing, the research stresses the role of individual agency in resisting institutional norms that structurally reproduce gender inequalities and power asymmetries in marital relationships and consequently, in the household. Using structure and agency also demonstrated the ways women created spaces for resistance and embodied practices associated with women's clandestine use of family planning. A common thread in this thesis is the interlinked role of informal social networks at every level of the decision-making process, extending from the household all the way to the point of service provision. A key strength of this thesis is its analysis of the communication process with what is generally understood as 'spousal communication'. The empirical findings suggest a new understand of how and why men and women communicate and act on their fertility preferences. The contributions highlight the fluidity of gender, spousal communication and other interactions governed by structural forces and created a space to fully understand women's agency and family building practices. This was particularly useful in pulling together the influence of sexuality and post-partum practices including sexual abstinence on the creating awareness and use of contraception. Whilst changes in Post-partum sexual abstinence had been documented especially among the Yoruba ethnic group in Nigeria (see Lesthaeghe *et al.* 1981) and male sexual networking has been documented within this period



(see Ali & Cleland 2001; Lawoyin & Larsen 2002), moving forward more research is needed to understand these changes as universal within this group and not only a consequence of the empirical findings of the thesis.

In studying the public domain of service provision, this research addressed a fundamental element of contraceptive policy and practice in Nigeria. Contraceptive service provision in Nigeria was located within the global debates of sexual and reproductive health and the reliance on international donors and agencies for contraception that has led to a selective response to the wider infrastructural, political and social challenges associated with reproductive health issues. Whilst, this research acknowledges the unique situation in contraceptive service delivery in Kwara State and indeed Nigeria, this research demonstrated that a focus on specific areas and, subsequently, specific women's bodies is an unsatisfactory stopgap when it comes to responding to the need for and use of contraception. What it does instead is to further marginalise women as rural and urban bodies in an already geopolitically divided society.

Methodologically, this research has demonstrated the value of a multi-method approach in exploring the complexity of the decision-making process. Using qualitative research tools to dissect the layers of contraceptive decision making provided an in-depth analysis of the kinds of negotiations that occur within and outside the household. Researching 'home' also opened up the opportunity to engage with positionality and identity politics, which expanded on some of the difficulties of doing research in the global South (Giwa 2015).

This research acknowledges the difficulty of applying a pragmatic approach to the use of family planning in Nigeria. However, moving forward — and particularly in light of recent economic challenges and the growing awareness of Nigeria's potential for gaining a demographic dividend — contraceptive use needs to be operationalized within the framework set out at the ICPD in 1994. Scaling up the use of family planning in Nigeria is critical to, firstly, improving the reproductive lives of women and, secondly, achieving sustainable development. One factor that emerged from this research was the importance of time, particularly the timing at

which spousal communication occurred, and how this could be utilised to scale up the use of contraceptive services. The desired family size of couples' changes over time and conversations about fertility begin to take place at the stage of courtship. Family planning advocacy in Nigeria involves reaching out to religious leaders to support its acceptance and promotion in their communities. Because of the positioning of these leaders and their institutions, particularly their role in promoting family life and providing pre-marital counselling sessions for couples, they can be used as points of access for men and women who are at the stage of forming their fertility desires as a couple. The timescale of spousal communication, however, showed multiple points of possible entry, even within the limits of this research. In order for such intervention opportunities to give rise to interest at a policy level, there is a need for more extensive case studies and longitudinal research to enable further understanding and assessment of timing in relation to spousal communication and the use of contraceptive services.

Several actions therefore need to occur concurrently in order to address the supply and demand for contraception in Kwara State and indeed, Nigeria. These include extensive research as identified above, continuous advocacy for holistic reproductive health services, implementation of context specific programs that address the needs of men and women at all stages of their reproductive lives and strengthening of the health care system.

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## APPENDIX I

Table I.1: Background characteristics of participants recruited for the semi-structured interviews.

SN	Name	LGA/ settlement	Age group (male and female)	Occupation	Religion & Tribe	Education	No. of children	No. of living children	Ideal family size	Reproductive health status
304	YUSSUF & FAIZAL (COUPLE INTERVIEW)	IE/URBAN	50-59 (M) 26-30 (F)	CIVIL SERVANT (M) BUTCHER (F)	MUSLIM (YORUBA)	TERTIARY (M) PRIMARY (F)	4	3	4 (M) 6 (F)	USING CONTRACEPTION (DEPO- PROVERA)
306	ALIYA (SINGLE INTERVIEW)	IE/URBAN	36-40 (F)	BUTCHER	MUSLIM (YORUBA)	PRIMARY SCHOOL	7	5	7	USING CONTRACEPTION (IMPLANTS)
303	MALIK & INKA (COUPLE INTERVIEW)	IE/ URBAN	50-59 (M) 41-45 (F)	SECURITY GUARD (M) PETTY TRADER (F)	MUSLIM (YORUBA)	SECONDARY (M) SECONDARY (F)	4 (5) <sup>14</sup>	4	4	USING CONTRACEPTION (IUCD)
298	YUNUS & UMMI (COUPLE INTERVIEW)	IE/URBAN	50-59 (M) 31-35 (F)	WEAVER (M) FISH MONGER (F)	MUSLIM (YORUBA)	NO FORMAL EDUCATION (BOTH)	4	4	4	USING CONTRACEPTION (IUD)
383	SAMIRA (SINGLE INTERVIEW)	IE/URBAN	31-35 (F)	CIVIL SERVANT	MUSLIM (YORUBA)	TERTIARY	2	2	4	USING CONTRACEPTION (PILLS)
381	SAMSON &	IE/ URBAN	30-39	ENGINEER	CHRISTIAN	SECONDARY	2	2	3	NOT USING

<sup>14</sup> The couple did not mention the loss of a child during the survey. During the interview, they mentioned it when we were discussing their reproductive history.

	LEILA (COUPLE INTERVIEW)		(M) 26-30 (F)	(M) HOUSEWIFE (F)	(YORUBA)	(M) SECONDARY (F)				(PERIODIC ABSTEINECE )
<b>394</b>	ABDUL & HALIMA (COUPLE INTERVIEW)	IE/URBAN	50-59 (M) 41-45 (F)	CIVIL SERVANT (M) PETTY TRADER (F)	MUSLIM (YORUBA)	TERTIARY (M) TERTIARY (F)	4	4	4	NOT USING
<b>385</b>	MAHMUD & HAUWA (COUPLE INTERVIEW)	IE/URBAN	30-39 (M) 31-35 (F)	TAILOR (M) PETTY TRADER (F)	MUSLIM (HAUSA/FULANI)	SECONDARY (M) PRIMARY (F)	3	3	4	USING CONTRACEPTION (PILL)
<b>68</b>	ASAKI & AMINA (COUPLE INTERVIEW)	IE/RURAL	20-29 (M) 26-30 (F)	BLACKSMITH (M) HOUSEWIFE (F)	MUSLIM (YORUBA)	PRIMARY (M) PRIMARY (F)	7 <sup>15</sup> 2	7 2	6 3	USING CONTRACEPTION (NORISTERAT)
<b>80</b>	HAFSAU (SINGLE INTERVIEW)	IE/RURAL	31-35 (F)	HOUSEWIFE	MUSLIM (FULANI)	NO FORMAL EDUCATION	5 <sup>16</sup>	5	5	NOT USING
<b>401<sup>17</sup></b>	EMAKA & ADANNA (COUPLE INTERVIEW)	IE/URBAN	40-49 (M) 31-35 (F)	WRITER (M) BUSINESS WOMAN (F)	IGBO (CHRISTIAN)	TERTIARY (M) TERTIARY (F)	8 8	5 5	3 4	USING CONTRACEPTION (CONDOM & RHYTHM METHOD)

<sup>15</sup> This is a polygamous household. The number of children recorded is a reflection of the number of children Asaki has with both his wives. The first wife was excluded from the interview because firstly, she declined the invitation to take part and secondly, some form of conflict exists between them as a couple.

<sup>16</sup> Hafsau was not using contraception at the time of the study but had previously used Depo-Provera. The reason provided for discontinuing the injection was her experience with the side effects. The number of children provided here was a reflection of the number of living children as she did not reveal the loss of any child until we had the interviews in her home.

<sup>17</sup> This couple was not included in the survey. They were recruited from one of the clinics for observation.

<b>395</b>	COUPLE INTERVIEW	IE/RURAL	30-39 (M) 31-35 (F)	TAILOR (M) PETTY TRADER (F)	YORUBA (MUSLIM)	SECONDARY (M) SECONDARY (F)	3	3	3	USING CONTRACEPTION (DEPO-PROVERA)
<b>162</b>	JEGA & ANISA (COUPLE INTERVIEW)	EDU/URBAN	30-39 (M) 26-30 (F)	CARPENTER (M) HOUSEWIFE (F)	MUSLIM (NUPE)	SECONDRAY (M) PRIMARY (F)	6 6	3 3	40 <sup>18</sup> 3	NOT USING <sup>19</sup>
<b>139</b>	INDA & AFI (COUPLE INTERVIEW)	EDU/URBAN	20-29 (M) 26-30 (F)	UNEMPLOYED (M) FOOD VENDOR (F)	MUSLIM (NUPE)	TERTIARY (M) NO FORMAL EDUCATION (F)	8 8	6 6	40 <sup>20</sup> 12	USING CONTRACEPTION (CONDOM)
<b>141</b>	WALI & KAMI (COUPLE INTERVIEW)	EDU/URBAN	20-29 (M) 21-25 (F)	STUDENT (M) STUDENT (F)	MUSLIM (NUPE)	TERTIARY (M) TERTIARY (F)	1	1	7 4	NOT USING <sup>21</sup>
<b>142</b>	SINGLE INTERVIEW	EDU/URBAN	20-29 (M)	CIVIL SERVANT (M)	MUSLIM (NUPE)	TERTIARY (M)	1	1	4	NOT USING
<b>333</b>	NDA &	EDU/RURAL	20-29	STUDENT (M)	MUSLIM (NUPE)	SECONDARY	2	2	8 <sup>22</sup>	NOT USING <sup>23</sup>

<sup>18</sup> Intends to marry more wives

<sup>19</sup> The couple were not using contraception at the time of the survey. During the interview, Anisa mentioned she started using the pill a few days ago.

<sup>20</sup> Intends to marry more wives

<sup>21</sup> Wali and Kami were currently not using contraception at the time of the survey but were using at the time of the interview

<sup>22</sup> Intends to marry more wives

<sup>23</sup> Nda and Saratu were currently not using contraception at the time of the survey but were using at the time of the interview

	SARATU (COUPLE INTERVIEW)		(M) 21-25 (F)	TAILOR (F)		(M) SECONDARY (F)	2	2	4	
<b>329</b>	ADAM & EVE (SEPARATE COUPLE INTERVIEW)	EDU/RURAL	30-39 (M) 26-30 (F)	TAILOR (M) BUSINESS WOMAN (F)	CHRISTIAN (NUPE)	TERTIARY (M) TERTIARY (F)	1  1	1  1	4  3	NOT USING CONTRACEPTION (PREGNANT)
<b>345</b>	JOHN & MARY (SEPARATE COUPLE INTERVIEW)	EDU/RURAL	30-39 (M) 31-35 (F)	CIVIL SERVANT (M) TEACHER (F)	CHRISTAIN (NUPE)	TERTIARY (M) TERTIARY (F)	4	4	4	USING CONTRACEPTION (PILL)
<b>335</b>	SAMUEL & RUTH (COUPLE INTERVIEW)	EDU/RURAL	30-39 (M) 36-40 (F)	TEACHER (M) PETTY TRADER (F)	CHRISTAIN (NUPE)	TERTIARY (M) SECONDARY (F)	5 5	5 5	6 5	USING CONTRACEPTION (DEPO- PROVERA)
<b>344</b>	PETER & ANITA (COUPLE INTERVIEW)	EDU/RURAL	30-39 (M) 26-30 (F)	CIVIL SERVANT (M) PETTY TRADER (F)	CHRISTIAN (NUPE)	TERTIARY (M) TERTIARY (F)	1	1	4	NOT USING CONTRACEPTION (PREGNANT)
<b>349</b>	COUPLE INTERVIEW	EDU/RURAL	40-49 (M) 31-35 (F)	FARMER (M) TEACHER (F)	CHRISTIAN (NUPE)	TERTIARY (M) TERTIARY (F)	3	3	5	USING CONTRACEPTION (IUD)
<b>316</b>	COUPLE INTERVIEW	EDU/RURAL	30-39 (M) 26-30 (F)	HEALTH WORKER (M) TEACHER (F)	CHRISTIAN (NUPE)	TERTIARY (M) TERTIARY (F)	2	2	4	NOT USING CONTRACEPTION

<b>149</b>	NABILA (SINGLE INTERVIEW)	EDU/URBAN	36-40 (F)	HOUSEWIFE (F)	MUSLIM (NUPE)	SECONDARY (F)	6	6	8	NOT USING <sup>24</sup> CONTRACEPTION
<b>398</b>	AMUDAT	IE/RURAL	36-40(F)	TRADER	MUSLIM (YORUBA)	PRIMARY	6	5	5	INJECTIONS (NORISTERAT)

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<sup>24</sup> This participant was not using contraception at the timing of both stages of the research. However, the participant reported the use of the pill to space all 6 children without her husband's knowledge.