

Child Spacing Attitudes in Northern Nigeria

Part I. Literature Review: Islam and Family Planning with a Special Emphasis on Northern Nigeria.

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Part II. Formative Research: Child Spacing and Family Planning Attitudes of Young Married Men and Women in Selected Areas of North West Nigeria.

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Part I

Literature Review: Islam and Family Planning with a Special Emphasis on Northern Nigeria

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List of Acronyms (PART I and PART II)

AIDS	Acquired Immune Deficiency Syndrome
CBOs	Community Based Organizations
CEDPA	Center for Development and Population Activities
CHEWs	Community Health Extension Workers
COCIN	Church of Christ in Nigeria
CPR	Contraceptive Prevalence Rate
DFID	Department for International Development (UK)
DHS	Demographic and Health Survey
DEFD	Doma Education Development Foundation
ECWA	Evangelical Churches of West Africa
FBO	Faith Based Organization
FCT	Federal Capital Territory
FMOH	Federal Ministry of Health
FOMWAN	Federation of Muslim Women's Association of Nigeria
FOS	Federal Office of Statistics
FP	Family Planning
HIV	Human Immunodeficiency Virus
IUCD	Intrauterine Contraceptive Device
ICPD	International Conference on Population and Development
IET	Islamic Education Trust
IP	Implementing Partner
ISMA	Islamic Medical Association
JICA	Japan International Cooperation Agency
JNI	Jama'atul Nasril Islam
KII	Key Informant Interview
MCH	Maternal and Child Health
MIS	Management Information System
NCWS	National Council of Women Societies
NDHS	Nigerian Demographic and Health Survey
NGO	Nongovernmental Organization
NPC	National Population Policy
NOSOCA	Northern States Old Students Association
PAC	Project Advisory Committee
PARE	Pastoral Resolve
PPFN	Planned Parenthood Federation of Nigeria
RH	Reproductive Health
SAW	Sallahu Alaihi Wassallam
STI	Sexually Transmitted Infection
SWAAN	Society for Women and AIDS in Africa
TFR	Total Fertility Rate
UNICEF	United Nations Children's Education Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VVF	Vesico-vaginal Fistula
WHO	World Health Organization
WIN	Women In Nigeria

Introduction

This document reviews and synthesizes available literature, both published and unpublished, on the following topics:

- 1) Islamic perspectives on family planning
- 2) lessons learned from efforts to introduce and promote modern contraception in majority Islamic communities around the world
- 3) context and history of family planning interventions in North West Nigeria, with a discussion of factors contributing to poor performance
- 4) evidence-based suggestions for promoting acceptance and use of modern contraception in the region

Prepared at the request of the USAID Mission in Nigeria to inform its strategy for improving contraceptive use in the largely Muslim North and North West regions of Nigeria, this international literature review by consultant Aisha Abubakar incorporates a desk review of experience with family planning in that region. **Section A** provides relevant background on Islam and its teachings and summarizes arguments frequently cited both in support of and in opposition to modern contraception. **Section B** offers overviews of experience with FP in selected Islamic settings, highlighting factors that appear to have either facilitated or hindered the success of those efforts. **Section C** offers background and reviews experience with FP in Northern and North West Nigeria, along with brief summaries of lessons from specific programmatic interventions in the region and other relevant settings. **Section D** synthesizes global and regional experiences into lessons and recommendations that might prove useful in developing health-care delivery and other programs to more effectively promote FP in North West Nigeria.

A. Overview of Islam and Islamic Views on Family Planning

Overview of Islam

Islam, the youngest of the major religions, counts among its followers about one-fifth of the world's population, or 1.5 billion people. Great cultural, ethnic, linguistic and political diversity characterizes the nearly 50 countries with majority Muslim populations, the largest of which are India and Indonesia (Roudi-Fahimi, 2004). All those nations are united, however, in adherence to the teachings of the Prophet Mohammed, who lived in the late sixth and early seventh century A.D. in the area corresponding to modern-day Saudi Arabia.

Islam is considered not only a religion but also a way of life or a code for living. The main sources of Islamic guidance, collectively referred to as *Shari'a*, are:

1. its holy book, the Koran (alternatively spelled "Qur'an"), believed to have been revealed to Mohammed directly by Allah (God) over more than two decades
2. the *Sunnah*, practices and examples established by the Prophet
3. *the Hadith*, the collected sayings of the Prophet
4. *Ijtihad*, religious scholars' interpretations of the *Sunnah* and *Hadith*, based on analogy. In light of Islam's lack of a central religious authority, this element of guidance -- while not carrying the same weight as the Koran, the *Sunnah* and *Hadith* -- is particularly important in matters such as FP that receive little, if any, direct mention in the other sources. (Akbar, n.d.; Boonstra, 2001; Roudi-Fahimi, 2004)

With guidance from these sources, Muslims believe, every human act can be classified as commanded, recommended, left legally indifferent, discouraged or positively forbidden (Anonymous C, 1979). An important general principle is that that which is not expressly forbidden is permitted (Roudi-Fahimi, 2004). Indeed, Islamic scripture includes many recommendations and/or prohibitions qualified by the phrase "unless necessary," leaving broad leeway for individual responsibility and judgment and for

interpretation by religious leaders. Some scholars emphasize Islam's flexibility and adaptability to the changing needs of its followers.

Among core principles of Islamic thought and life relevant to the debate over FP and reproductive health are:

- identification of the family as the fundamental unit of society
- its view of children as a gift from God, "the decoration of life"
- compassion, including acknowledgment of human weakness and the belief that Allah wants His followers to be free from hardship and undue burdens
- concern for the promotion of the family's and society's well-being
- value placed on the acquisition and application of knowledge and wealth for the betterment of family and society
- the sacred nature of marriage and the identification of tranquility as marriage's primary character, purpose and benefit (Anonymous B, 1979; Anonymous C, 1979; Omran, 1984; Roudi-Fahimi, 2004)

Also relevant to discussion of FP in Muslim contexts are Islamic teachings regarding the status and roles of women. Some scholars observe that practices such as *pardah* -- the physical segregation of men and women, symbolized by the head covering worn by some Muslim women -- which Westerners may view as oppressive are prescribed more by culture and tradition than by religion. In fact, Islamic scripture emphasizes justice and the equality of men and women before God, without denying their differences. In the *Hadith*, the Prophet stressed that Muslim men and women were both obligated to seek knowledge and that men who have more than one wife must care for them equally. Several authors suggest that, over time, the conflation of culture and tradition with religion, among both believers and some Muslim leaders, has contributed to the perpetuation of practices and beliefs that deny women's equality on a practical basis. (Anonymous B, 1979; Jacobson, 1994)

Islamic views on family planning

Historical texts indicate Muslims' awareness and use of various methods to prevent pregnancy since ancient times. Leading Arabic medical texts, which were extremely influential in the medieval world, contain many references, recipes and advice for contraception and abortion (Musallam, 1983).

Discussion of contraception in Islamic religious texts is fairly sparse, however. The Koran does not mention it at all. Several passages in the *Sunnah* and *Hadith* report on the Prophet's knowledge and approval of his companions' use of *azi*, whose literal meaning is "isolation" or "separation" but which has long been understood as *coitus interruptus*, or the withdrawal method. In several accounts, Mohammed's companions ask him directly if the Koran forbids the practice, and he replies that it is permitted as long as it does no harm and there is good reason to avoid pregnancy. The principal rationale reportedly used by the Prophet to explain his view was predestination -- that God has foreordained what will be created and that nothing man does can change that. The scripture also indicates that the *azi* is permissible only with the wife's consent, a condition that some scholars suggest reflects the need not to deprive her of either the opportunity to bear children or to experience sexual pleasure.

While Islamic religious sources include relatively few direct references to contraception, they are replete with principles and concepts that can be and frequently are used to support contraceptive use. As discussed below, however, also notably present are concepts -- sometimes the very ones cited in support of contraception -- used in both ancient and modern times to bolster arguments against it. This document's later examination of specific Muslim contexts in which FP has been introduced aims in part to shed light on factors that may influence whether religious leaders and their followers tend toward progressive/permmissive or conservative interpretations of these texts.

Arguments supporting family planning: Many Islamic scholars have stated publicly, including by issuing *fatwa*, or religious/legal rulings, that the Prophet's approval of *azi* in the circumstances noted above implies approval of many contraceptive methods that did not exist in the Prophet's lifetime (see Appendix 1). In the same way that Muslims are not confined to wear the same clothing or to eat the same food as those who lived in Mohammed's day, but instead are free and, in fact, encouraged to take advantage of modern inventions and knowledge in pursuit of Islamic ideals, they are permitted, in the right circumstances, to employ modern methods of contraception.

Supporters of family planning draw on a number of key arguments and teachings to back up their position, including:

- the Koran's clear recommendation to breastfeed children during their first two years in order to protect mothers' and children's health
- the Prophet's cautions against women becoming pregnant while they are breastfeeding which many view as endorsement of birth spacing
- the permissibility of contraception during this period on the grounds that sexual abstinence for so long would constitute hardship
- passages in the Koran advising Muslim men not to have more children than they can care for
- the desirability of avoiding making a slave woman pregnant, presumably in order not to have a child born into slavery and to ensure the woman's continued ability to work. (Omran, 1984; Roudi-Fahimi, 2004)

In addition, Omran asserts that through the years, Islamic theologians have identified a number of acceptable reasons for practicing contraception, including:

- to avoid transmission of congenital diseases to offspring
- to protect women from the stresses and ill health effects of pregnancies that are too close together
- to better enable a man to meet his financial obligation to support his family support and to avoid his pursuit of ill-advised activities in order to do so
- to protect women's beauty and physical fitness, ensuring husbands' continuing enjoyment and happy married life
- to allow for the education, proper rearing, and religious training of children, which is easier with fewer children
- to allow for separate sleeping arrangements for brothers and sisters after puberty. (Alyssa, 1996; Omran, 1984; Roudi-Fahimi 2004).

Drawing on these and other arguments, many Islamic leaders have condoned use of modern contraceptive methods within marriage, with both partners' consent, and as long as it risks no harm to the woman's health. Such approval is commonly limited, however, to temporary methods, since permanent alteration of the body is considered tampering with Allah's will and thus is forbidden. Accordingly, many scholars have disapproved of both male and female sterilization, although that view has softened along with medical advances that increasingly have made these procedures reversible (Boonstra, 2001). Another important qualification commonly placed on Muslims' permission to practice contraception is that it be only for "good" reasons; the wish to avoid having female children is specifically excluded.

Arguments opposing family planning. Several authors indicate that, in general, approval of contraception is now more common among Muslim scholars than disapproval. It remains true, however, that many Islamic scholars' interpretations of the Koran, *Sunnah* and *Hadith* do not support, and in some cases adamantly oppose, contraception. Religious ideas and precepts commonly cited in denouncing or discouraging Muslims' use of contraception include the following:

- the prohibition on interfering with God’s will (note that “Islam” means “submission [to the will of God]”)
- the assertion that using contraception implies distrust that God will provide for all, as the scripture affirms
- scriptural passages calling on Muslims to multiply and expand their numbers
- the admonition against taking the life of one’s children
- specific and generally unyielding opposition to permanent methods, based on the Koran’s prohibition of castration and the avoidance of harm
- fear of promoting promiscuity (Omran, 1984)

Another argument sometimes raised is the Koran’s prohibition of infanticide, which some have interpreted as extending to include contraception. One *Hadith* used to support this view appears to contradict others indicating the Prophet’s approval of *azi*. In it, *azi* is equated with infanticide. However, many scholars believe that scriptural references to infanticide refer to the previously relatively common practice of burying newborn children, especially girls, and that the extension to contraception is not relevant.

Other objections to FP raised by Muslims seem to have political rather than religious origins (or at least overtones) and are similar to those heard in other, not-necessarily-Muslim, contexts. For example, many opponents charge that FP is a Western invention that contradicts and undermines traditional values and that it is motivated at best by imperialist ambitions and at worst by racism and a desire to eliminate or dominate Muslim (or other) peoples. Similarly, some opponents cite the political imperative for high fertility, in order to build the ranks of Muslims and thus their ability to withstand such incursions. In addition, even many supporters of FP oppose efforts on the part of any government to impose family-size restrictions, seeing such moves as undue intrusions on both personal lives and religious affairs. Thus, opposition may be raised in some settings to governmental FP targets and programs rather than to FP itself.

In summary, the very nature of Islam, including the absence of a central religious authority, creates fertile ground for diverse interpretation and practice in matters relating to FP and many other aspects of modern life. Historically and today, there are strong currents of both support for and opposition to FP among Muslim religious leaders and communities. The next section of this literature review examines how such differences have played out and affected efforts to promote FP in selected Muslim countries.

B. Global Experience with Family Planning in Muslim Settings

Selected country programs and their impact

In the last several decades, FP programs have been introduced in numerous countries with large Muslim populations, with varying degrees of success. Although almost half of Africa’s population is Muslim (Omran, 1984), literature is unfortunately scant on related experiences in African Muslim communities and countries (especially Sahel countries). The following overviews of efforts to introduce FP in Muslim settings in different parts of the world (presented in alphabetical order) may, however, suggest some approaches that could be successfully adapted for use in North West Nigeria, since those settings share some cultural, religious and other features with that region.

Bangladesh

With strong support from a secular government and the international donor community, Bangladesh has experienced dramatic declines in fertility and increases in contraceptive prevalence in the last three decades. National demographic and health surveys reported the total fertility rate (TFR) as 6.3 in 1975

and as 3.0 in 2004, albeit with substantial differences between urban, educated and rural, less educated women. The most recent DHS report indicates that married women's use of any method of contraception has increased sevenfold in the last thirty years, from 8 to 58 percent, with use of modern methods having increased by almost ten times – from 5 to 47 percent. Notably, short-term methods are becoming more popular as they have been made more available to Bangladeshi women. (NIPORT, 2005)

Governmental initiatives to reduce population growth began as early as the 1950s, when Bangladesh was still part of Pakistan, and have remained a top priority across sectors, although their character has undergone many changes through the years. In the 1970s, the government deployed full-time, community-based Family Welfare Assistants (FWAs) to provide FP information and methods door-to-door, supported by a social marketing program (NIPORT, 2005). The effort was particularly effective in reaching the large number of Bangladeshi women in *purdah*, since it enabled them to obtain services without leaving their homes (Boonstra, 2001).

Especially since the 1994 International Conference on Population and Development, programs and policies related to FP have stressed integration of services with other family health services delivered at clinics, as well as greater attention to the quality of care and to responding to clients' individual needs and concerns (NIPORT, 2005; Population Council, 2004a). The literature also includes descriptions of successful efforts to integrate services for men into previously female-focused services (Population Council, 2004b), as well as other steps to increase men's involvement in reproductive health.

Another hallmark of government and NGO programs has been outreach to clerics, including educating them about the health benefits of FP and effectively enlisting them as advocates. For example, Pathfinder International recently funded training for several thousand imams whose support for FP has extended to their allowing use of mosque loudspeakers to broadcast information about services (Burket, 2006). However, some observers are concerned that religious support may recede as FP efforts more and more are integrated with initiatives such as micro-lending that have the effect of increasing women's involvement in the public sphere (Boonstra, 2001).

The most recent DHS report identifies the following factors as key contributors to increased contraceptive use in Bangladesh over the last two decades:

- consistent political commitment
- multi-sectoral promotion of the small-family norm
- a strong system of decentralized health service delivery, down to the village level
- the active, coordinated involvement of NGOs
- flexibility in adjusting policies and programs to respond to emerging needs, and
- strong donor support. (NIPORT, 2005)

Nevertheless, considerable challenges remain, including the country's unparalleled population density, still high levels of desperate poverty, the large proportion of young people, and women's persistently low social status.

Egypt

Egyptian social scientists grew concerned about the negative impact of rapid population growth as early as the mid-1930s, but that concern did not motivate the country's leaders to action until the 1960s, when they initiated a FP program. The program made only slow gains in its first two decades, hampered by undue emphasis on quotas and provider incentives, and inadequate attention to training and to women's perspectives. According to the 2006 PRB World Data Sheet, the total fertility rate for Egypt was 3.1 with a contraceptive prevalence rate of 59 percent for all methods and 57 percent for modern methods.

The country's early experience with oral contraceptives and injectable methods taught program managers important lessons about the need to educate providers to effectively screen clients, give clients information about correct use, and monitor their contraceptive use. Introduction of Norplant was more successful because more attention was paid to results of acceptability studies, to training providers, to establishing policy guidelines, and to collecting data to support client follow-up.

Support from religious leaders has always been an important ingredient of the Egyptian FP program's success. Al Azhar Mosque and Al Azhar University, highly respected centers of Islamic learning in Cairo, have provided leadership in promoting FP, including by regularly issuing favorable *fatwas*, which the government has actively disseminated and promoted (Roudi-Fahimi, 2004). Research has underscored the negative impact of religious leaders who are uneducated about the benefits of FP. Programmatic efforts, notably those supported by Pathfinder International, have addressed this by educating both Christian and Muslim leaders about the risks of early marriage and childbearing, women's rights, and other aspects of reproductive health (Burket, 2006).

In recent years, the government program has worked more closely with civil-society organizations, which have encouraged greater emphasis on quality of care. Improvements include strengthening providers' skills in counseling women about methods' proper usage and side effects, expanding the range of methods available, building evaluation capacity, making services more available in underserved rural areas, and involving men in responsible reproductive-health decision-making.

The overall impact of Egypt's FP efforts has been notable, including significant declines in total fertility and increases in contraceptive awareness and use (contraceptive prevalence more than doubled between 1980 and 2005 alone, from 24 percent to 59 percent of married women) (El-Zanaty and Way, 2005). Use of public-sector FP services shows signs of increasing; previously, most Egyptian women obtained FP from private services (Eltigani, 2000).

The program still faces challenges, including disparities in contraceptive acceptance by educational level and geographic region, with the least change having occurred in poor, rural, low-literacy areas. High rates of method discontinuation indicate a continuing need to strengthen information, education and communication efforts, including counseling. (Eltigani, 2000)

Ghana

Less than a fifth of Ghana's population is Muslim but we have included Ghana because of a successful project in the region where its Muslim population resides. Ghana's leaders were among the first in Africa to recognize the implications of population pressures, co-sponsoring a 1962 resolution at the United Nations General Assembly on the relationship between population growth and economic development. Despite a population policy and a public education campaign on the benefits of FP as early as 1969, however, no significant change in attitudes, practices or fertility occurred in Ghana until the mid-1980s (GSS, 2004). Reasons postulated for this early failure include lack of a strategic plan for implementing the population-reduction/FP initiative and lack of grassroots involvement in developing it. (Solo et al., 2005)

A revitalized education campaign in the late 1980s heralded a new era in FP in Ghana, strengthened by creation of a new population/reproductive health policy in 1994. Fertility has fallen and contraceptive prevalence has increased rapidly since the mid-80s with the current total fertility rate of 4.4 one of the lowest in sub-Saharan Africa. The 2006 contraceptive prevalence rate was 25 percent (19 percent for modern methods) (PRB, 2006). Ghana has achieved nearly universal knowledge of FP, thanks at least partially to extensive and strategic use of mass media.

The literature identifies other elements that have been key to the revised program's success, including:

- integration of reproductive health, population and development concerns
- improvements in health infrastructure and service availability, including the hours of FP service provision
- improvements in client satisfaction related to enhanced privacy and reduced waiting times
- increase in female education
- advocacy at (and by) the highest levels of government and among the public about the broad benefits of FP
- development and dissemination of reproductive health service guidelines, which have helped reduce provider biases in method distribution and other barriers to women receiving needed services
- investment in training health-care providers
- attention to strengthening private-sector FP services and to social marketing, to complement public-sector services
- instilling ownership in FP efforts at all levels
- building local health services' capacity for enhancing program sustainability, and
- greater attention to counseling. (GSS, 2004; Solo et al, 2005)

About 16 percent of Ghana's population – mostly people living in or from the country's northern, Sahelian region -- are Muslim. That region is home to a shining light of Ghana's FP experience, an innovative program launched by the Navrongo Health Research Centre. The Community Health and FP Project tested different ways of delivering health-care services in a poor rural community, concluding that the most effective strategy was community mobilization (including involving traditional leaders and men) complemented by community-based deployment of nurses.

That approach's strong positive impact – increasing contraceptive prevalence from 3 percent to 20 percent, reducing fertility by nearly one birth, and reducing childhood mortality by 40 percent, for instance (Solo et al., 2005) – led the Ministry of Health to expand use of the model to other settings. With careful attention to principles such as services and program activities being demand-driven and phased in gradually, after demonstration of community commitment, the model has been successfully adapted in other settings and is now seen as an important guide for decentralizing FP and other primary health-care services. **Of the literature reviewed, the experiences in Navrongo may offer the most relevant guidance for child spacing programming in northern Nigeria; in-depth study of the initiative and subsequent replication and scaling-up efforts is recommended.**

A bibliography of related materials from the Population Council is available at www.popcouncil.org/projects/SS_GhanaNavrongoCHFP_RI.html.

Continuing challenges for Ghana's FP program include a sharp rural/urban disparity in contraceptive acceptance and use; high unmet need for FP; high rates of unplanned pregnancy and rising percentages of unwanted births; inconsistent availability of essential equipment and supplies, including contraceptive methods; inadequate information, education and communication; need for greater attention in counseling to addressing women's fears of side effects; better links with HIV/AIDS programs; and competing priorities, including achievement of the Millennium Development Goals. (GSS, 2004; Solo et al., 2005)

Indonesia

Indonesia is home to the world's largest Muslim population and to a FP program widely recognized as a resounding success. According to the 2006 Population Reference Bureau World Data Sheet, the total fertility rate for Indonesia was 2.4 with 57 percent of married women 15-49 using modern methods. The government began its FP work in 1967, motivated by health and economic considerations. The United States government began supporting its efforts soon thereafter. (Mize and Robey, 2006)

The literature on FP experience in Indonesia underscores the importance of strong, consistent support from the government, collaboration with nongovernmental organizations, and the private sector. Major strategic innovations identified in a recent review of USAID's 35-year partnership with Indonesia's National FP Coordinating Board (BKKBN) include:

- reaching rural areas with grassroots participation, including training community members as counselors
- promoting smaller-family norms, using large-scale behavior-change communication programs that have achieved almost universal awareness of FP
- building private-sector self-reliance, including through use of marketing initiatives and enhancing the role of private midwives, and
- improving quality of care, emphasizing responsiveness to clients' needs and facilitating decentralized health-system decision-making. (Mize and Robey, 2006)

Other key strategies, according to the review, included making substantial investments in training and education for BKKBN professional staff and government colleagues, as well as for health-service providers.

Involving religious leaders was also critical. Related activities included private meetings aimed at creating consensus on population and FP priorities, incorporating FP issues into curricula of religious schools, and creating newsletters and other informational materials especially for religious leaders and for use in religious activities. These and other efforts resulted in numerous declarations by Islamic leaders highlighting FP's benefits and congruence with Islam.

As a result of these and other strategies, in only about four decades, married Indonesian women's use of modern contraceptives rose from less than 5 percent to almost 60 percent (for all methods). The total fertility rate was more than halved, from more than six children per woman to only 2.4, and substantial improvements in both child and maternal health have been reported. The consequent slowing in population growth has been clearly associated with a reduction in poverty and higher rates of education, especially for girls. (Boonstra, 2001; Mize and Robey, 2006)

Iran

Iran currently has a TFR of 2.0 and a contraceptive prevalence of 74 percent for all methods and 56 percent for modern methods. (PRB, 2006). But the path to achieving these statistics has been circuitous. The secular government of Shah Reza Pahlavi established Iran's first FP program in 1967, with the aims of promoting the physical, mental and social welfare of the family and decreasing population growth. Part of a broader push to modernize Iranian society, the program focused on urban, middle-class couples in the context of other efforts to promote women's status.

The fact that the Shah's reforms mostly benefited the elite and the perception that they disrespected traditional values helped to create social and political opposition that led to the 1979 revolution and the establishment of the Islamic Republic of Iran. Although the Ayatollah Khomeini issued a *fatwa* stating that Islam permitted FP as long as it brought no harm to mother or child, as part of its wholesale repudiation of the previous regime and perceived Western imperialism, the new government dismantled the FP program, failed to replenish contraceptive supplies, and outlawed abortion and surgical sterilization (Aghajanian, 1994). Women had been actively recruited as participants in the revolution, but new government "reforms" included many setbacks for women's rights and status, and reaffirmed high fertility and early marriage as national values (Makhlouf-Obermeyer, 1994; Shadpour 1999).

The government's view changed dramatically in the wake of the country's 1980-1988 war with Iraq. The war's heavy toll (more than half a million Iranians were injured or killed) initially reinforced its

pronatalism. But once it had ended, skyrocketing population growth severely depleted government coffers. The prospect of not being able to provide basic necessities caused leaders to view the benefits of FP, for both individuals and society, in a new light. The government's Office of Budget and Planning led strategic, nationwide discussions of links between population and development, drawing on global experience. This strategy, which emphasized national development rather than population reduction, involved and ultimately built strong support among all sectors of government, religious scholars and the public, culminating in a new birth control policy in 1989 (Hoodfar and Assadpour, 2000).

Considering that the new policy represented a complete reversal of the government's previous position, its creation and implementation -- without undermining the government's credibility and support -- was a remarkable achievement. Scholars agree that both the media and religious leaders played critical roles in facilitating public acceptance of the program and its services. Newspapers and television were employed as forums for open debate of the issues, and technical experts were careful to yield to religious leaders on matters of morality and ethics. FP proponents educated religious leaders about its benefits and its congruence with Islamic principles and values, seeking and obtaining *fatwa* to address concerns about contraception overall and about specific methods. The new program received the full sanction of the country's High Judicial Council, which declared that Islam contained no barriers to use of FP, and religious leaders incorporated related themes into their routine activities, including Friday sermons and marriage ceremonies. (Shadpour, 1999)

Features of service delivery under the new program included:

- a strong system for delivery of rural health care, including FP;
- consistent availability of all modern contraceptive methods (including sterilization) at no charge to clients;
- strong emphasis on voluntarism;
- focus on quality of care to build clients' trust; and
- a strong information, education and communication (IEC) component, including open sharing of information about methods' side effects.

The government's financial and political commitment to the program -- extending across numerous sectors, including education -- has grown in intervening years. Widely considered a model program, Iran's FP efforts are credited with helping to decrease population growth, reduce infant, child and maternal mortality, and boost contraceptive prevalence among married women from 37 percent in 1976 to 74 percent in 2006. (Aghajanian, 1994; Boonstra, 2001; Makhoul-Obermeyer, 1994; Roudi-Fahimi, 2002; Shadpour, 1999) It is interesting to note that this success occurred without external donor assistance.

Pakistan

Although Pakistan shares much history and many characteristics with Bangladesh, to which it was once joined, the country has not achieved similar success with FP. Very densely populated and largely rural, Pakistan is a conservative Islamic state where FP -- though established as a government service in the 1960s -- has received inconsistent governmental and social support, reflecting both political upheaval and a very conservative social/religious environment.

About 97 percent of Pakistan's population is Muslim. Poverty rates are high; literacy rates are low, especially among women; and the practice of *pardah* is widespread. These and other factors -- notably the persistent belief among many Pakistanis that contraception is un-Islamic -- have long challenged efforts to promote FP, despite longstanding governmental interest in reducing population growth. Efforts to promote FP had little influence on contraceptive use or fertility for more than two decades, a failure attributed to weaknesses in the health-system infrastructure, poor quality of care and conservative

religious beliefs, among other factors (Mahmood, 2005; National Institute of Population Studies, 1992; Stephenson, 2004).

Improvements in the 1990s, including the introduction of social marketing, instituting a Village-Based FP Workers Program, increased promotion through mass media, community-based outreach, greater involvement of NGOs and the private sector, and other factors have substantially increased knowledge, and in some instances use, of contraception (Guttmacher, 2005; Hamid and Stephenson, 2006). Additionally, evidence indicates an increase in Pakistani women's desire for smaller families, perhaps in response to harsh economic realities (National Institute of Population Studies, 1992). Contraceptive use has begun to increase slowly: The most recent estimates of contraceptive prevalence among married women are 28 percent for all methods (PRB, 2006) compared to 12 percent for all methods in 1990-1991 (National Institute of Population Studies, 1992). Fertility has begun to decline, too: The Population Reference Bureau's 2006 World Data Sheet reports a TFR of 4.6, representing a reduction from more than 6 in the 1970s and 1980s.

But the unmet need for FP remains high at about 25 percent of currently married women -- a finding underscored by the sharp contrast between usage and high reported levels of knowledge of contraception. One important factor in this discrepancy appears to be poor coverage by the national FP program: Government FP services are estimated to reach as little as 10 percent and no more than 25-30 percent of the population (National Institute of Population Studies, 1992).

The National Institute of Population Studies' 1992 report on the Demographic and Health Survey completed in 1990 and 1991 (a subsequent survey was conducted in 2006; data are still being analyzed) notes numerous financial, operational and social obstacles that historically have impeded FP progress in Pakistan, including:

- over-concentration of FP services in urban areas
- widespread son preference
- women's low socioeconomic status
- prevailing religious conservatism and fatalism
- inconsistent supply of contraceptive methods.

Factors cited by other authors include poor health infrastructure, with very limited access to health facilities in many rural areas; poor quality of health services; and poor integration of FP with other basic health services (Hamid and Stephenson, 2006; Stephenson, 2004). Notably, the government appears to be more actively addressing the strong influence of religious conservatism, including through efforts to promote understanding among religious leaders of the congruence of FP with Islam (IRIN News, 2006).

Tunisia

Tunisia was the first African and Arab country to adopt an explicit population policy. The influence of the traditional kinship system had already begun to wane in Tunisia in the late 1950s, when the country's first president, Habib Bourguiba, introduced gradual modernizing reforms including egalitarian marriage and divorce laws, prohibition of polygamy, and FP.

A key element of the public's acceptance of the reforms was that they were introduced in the context of both national development and Islamic tradition, although by a secular government. As in Iran, religious leaders were persuaded to issue edicts supporting contraception and to incorporate reproductive health and development themes into their sermons and other activities (Naik, 2003). A strong women's movement, nurtured in the years leading to independence, also played a role in creating unprecedented educational and employment opportunities for women, which helped motivate FP acceptance. (Gates, 1981; Jacobson, 1994; Makhoul-Obermeyer, 1994)

Legal reforms related to FP included a 1961 law authorizing the importation of contraceptive methods and liberalization of the law governing abortion in 1965 and even further in 1973. Initially, some critics say, the government's population-control ambitions led to some coercive practices and an over-emphasis on provider-controlled methods (Woodrow Wilson International Center for Scholars, 2005). With those problems corrected, delivery of FP services has been integrated into maternal/child health care and effected through a network of primary-care clinics and mobile health teams. Recently, government health services have stepped up efforts to educate men about FP. (Naik, 2003)

Results of the spectrum of reforms that included FP are very evident in Tunisia. Female literacy and employment rates have both increased dramatically. The most recent data available indicate that more than half of married women use modern contraceptive methods and that the TFR has fallen remarkably quickly, from 7.2 in the 1960s to 2.0 now – the lowest in Africa. (PRB, 2006)

Selected programs and research of possible relevance to northern Nigeria

In addition to accounts and analyses of national FP efforts such as those described above, the literature includes descriptions of several research studies and programmatic interventions in Muslim settings that may be of interest and provide useful guidance in developing strategies for northern Nigeria. Following are brief summaries of a few such initiatives, organized by region or country.

Central Asian Republics

Focus group discussions in Kazakhstan, Kyrgyzstan, Turkmenistan and Uzbekistan shed light on reproductive health attitudes, beliefs and practices in these Central Asian Republics, to inform health communication and health promotion programs in the region. While revealing cultural and traditional distinctions among the countries studied, research findings also uncovered a number of common beliefs and attitudes, including:

- persistent misconceptions about modern contraceptive methods, including fears about their side effects
- changing preferences regarding age at first marriage and ideal family size, influenced by changing educational levels and economic realities
- attitudes toward FP influenced by religious beliefs, kinship traditions, cultural values, family pressures, and negative experiences with health services
- lack of communication about FP between spouses, with the result that responsibility for contraceptive decisions is most often left to women but the expectation that women will seek their husbands' approval to use FP
- lack of reliable information on FP. (Storey et al., 1997)

Egypt

Underwood et al. describe the impact of a serial television drama addressing FP themes in Egypt. The 17-episode "edutainment" program, titled *And the Nile Flows On*, aired in December 1992. Researchers administered a pre- and post-test sample survey to gauge the program's effect on FP awareness, attitudes and practices. They found that program viewers reported reduced fears of side effects of modern contraception, improved knowledge of the reproductive process, a more positive view of contraceptive users and providers, and increased intention to visit a FP clinic. They concluded that the program demonstrated the potential impact of edutainment in influencing individuals' knowledge and attitudes and underscored viewers' strong affinity with religious leaders and the influence of their words and opinions. (Underwood et al., 1994)

Storey et al. report on a three-year program focused on training doctors and clinic assistants in FP technologies and service-delivery skills, and supported by a nationwide, multimedia public-education campaign. The program's goals included promoting the concept of physicians specializing in FP, encouraging women to consult doctors on reproductive health matters, and making the names and addresses of such physicians known. It was found to be especially effective among urban residents, who reported increased intent to visit a FP clinic and to use contraception. Physicians reported strong support for the project as well as an increase in the monthly average of new FP acceptors. (Storey et al., 1994)

Sudan

El Tom and colleagues describe a successful pilot project to recruit and train village midwives and other paramedics as a new cadre of community health workers. Recruits were trained to provide FP information and to distribute oral contraceptives along with other services such as oral rehydration and vaccination. Lessons learned during the project's first phase, which led to revisions in the project design, included the need to use a team approach consistent with existing authority roles, to involve midwives in a broader range of activities than just maternal and child health care, to implement phased and decentralized training, and to emphasize community participation. Elements of community participation included weeklong seminars for religious leaders, where a leading Islamic scholar dispelled misconceptions and fears about FP being anti-Islamic. Further acknowledgment of the important influence of Islamic beliefs came in the form of opening and closing all training workshops with Islamic prayers and presenting new information in an Islamic context. (El Tom et al., 1984 and 1989)

A 1985 survey of men in urban Khartoum found that men dominated decisions about FP use and were responsible for obtaining contraceptives when FP was practiced. Survey results also underscored the existence of widespread misconceptions about vasectomy and an association of education with the belief that Islam views FP favorably. Researchers emphasized the value of involving men in FP programs to encourage acceptance. (Khalifa, 1988)

Tanzania

Focus group discussions were conducted to identify cultural barriers to contraceptive use in a village where women had good access to contraceptive information and methods but where only 2 percent participated in the FP program. The FGDs identified strong Muslim beliefs, male dominance and limited exposure to modern ideas (as assessed by employment, travel and access to media) as key obstacles to FP acceptance and use. Researchers noted that village women were mostly illiterate and therefore relied on vague knowledge of religious edicts, most often citing their husbands' beliefs rather than scripture itself. They recommended integrating modern ideas about contraception into the area's traditional religious, political, and cultural beliefs – rather than trying to supplant them – in order to promote FP and concluded that appealing to modernism may not always be a good strategy. (Keele et al., 2005)

Tunisia

An innovation by staff of the postpartum program at the Maternal and Neonatal Hospital in Sfax improved the rate of new mothers returning for well-baby care and to adopt a FP method. Elements key to this improvement included linking infant and mother health and scheduling a visit to a separate mother-and-baby clinic on the fortieth day after birth -- a date with special meaning in Islamic tradition. The initiative dramatically increased returns for follow-up and FP acceptance. (PRB, 1993)

C. Northern Nigerian Context (with emphasis on the North West)

Population and culture

Estimated at 64,430,000, northern Nigeria's population accounts for 53 percent of the national total but is much less densely concentrated than in the south. The region occupies fully three-quarters of the country

and is made up of three geo-political zones (North Central, North East and North West) bound together by Islam (the prevalent religion), Hausa (the dominant language), low population density, a communally organized civil society, and a predominantly rural nature. Despite these similarities, significant religious, cultural, gender-relation, and language differences exist among the zones (Ejembi, et al., 2003).

North West Nigeria has a population of about 35 million and an annual growth rate of 2.9 percent (PRB, 2004). This high rate of population growth, if sustained, will result in a doubling of the population over 24 years, jeopardizing the zone's infrastructure and quality of life in general. Three-quarters of the people in this predominantly Islamic zone live in rural areas; most are peasant farmers. Literacy is 55.7 percent among men and 20.9 percent among women (NDHS, 2003). Among factors potentially hampering acceptance and use of FP in the North West region are cultural norms and traditions supporting early marriage, valuation of women only for their ability to reproduce, polygamy, and male control of women's reproductive capabilities. Most women in the region are uneducated and neither socially nor economically empowered.

Early marriage, especially of girls, remains common because parents fear that children might initiate sexual activity, risking pregnancy, before marriage and because girls' education is not highly valued. Ages of first marriage in North West Nigeria are 13 years for girls and 21 years for men. Risks associated with early marriage include early pregnancy and childbirth, which can jeopardize both maternal and child health.

Valuation of women mainly for their reproductive functions – and for the *number* of children they bear – means in practice that men are excluded from matters related to pregnancy and childbirth and have little understanding of or investment in them. Polygamy, a common practice in the region, reinforces the valuation of women primarily for reproduction. Wives may compete to bear the most children in order to inherit a larger share of the husband's property. Because sons are preferred, women often continue reproducing to please their husbands and their husbands' families with male offspring.

The cultural norm that places women's reproductive capacities under strict control of men leaves women highly dependent on their husbands and restricts their movements outside the home. For example, a woman must ask for and gain her husband's permission to access health-care services, including FP services. She is also expected to defer to her husband on other decisions, including whether and when to have sexual intercourse.

Reproductive health indicators and family planning knowledge, attitudes and practices

According to the 2003 Nigeria Demographic and Health Survey, the TFR for Nigeria is 5.7 births per woman. This figure represents a reduction from 6.7, which was reported for 1988-1999. (Note: The 2006 PRB Data sheet cites Nigeria's TFR as 5.9.) Fertility is significantly higher among rural women than urban women. Age-specific fertility rates (ASFRs) for rural women rose sharply from 15-19 years to 20-24 years, peaked at 25-29 years, and then declined. The urban ASFRs showed a more gradual pattern, indicating delayed marriage and some deliberate attempt to postpone or terminate births. Considerable variation exists across the country's six geo-political zones, with the lowest TFR of 4.1 in the southwest and South East. Rates for North West and North East Nigeria are significantly higher: 6.7 and 7.0, respectively.

Nigeria's maternal mortality ratio of 740/100,000 live births is among the highest in the world. Maternal mortality in North West Nigeria is even higher -- 1,025/100,000 live births, about six times the ratio in the southwest zone (Ejembi, et al., 2003). Similarly, the child mortality rate of about 5 percent in North West Nigeria is almost twice that of the southwest, and the infant mortality ratio of 114/1,000 births in the North West is about 2½ times that of the southwest (UNICEF MICS, 1999).

Notable regional variations exist in FP knowledge, attitudes and practices in Nigeria. Knowledge among currently married women of any method of contraception ranges from a low of 63.5 percent in the North East to a high of 97 percent in southwest Nigeria. In North West Nigeria, 75.1 percent of currently married women report knowing about any FP method, according to the most recent DHS (NDHS 2003). Knowledge of any *modern* FP method is 71.8 percent for women in North West Nigeria and 60.8 percent in North East Nigeria.

Several studies confirm high levels of knowledge about various contraceptive methods in northern Nigeria. For example, a 2003 evaluation report for the Center for Development and Population Activities (CEDPA)/Packard's reproductive health/FP project in Kano notes that more than nine of 10 survey respondents – both men and women -- knew of at least one method. Women's knowledge of at least one method was lower than men's but still relatively high at 86 percent. Both men and women were more likely to know about female than male sterilization.

Major sources of information about FP in Nigeria include electronic media (radio and television), print media (newspaper, magazines, posters, and leaflets), and traditional folk media (town criers and mobile public announcements). Radio is the primary source, and television the second. Table 1 shows women's sources of information on FP across the zones, with those for North West Nigeria highlighted.

Region	Radio	Television	Newspaper/ Magazines	Posters/Leaflets/ Brochures	Traditional	None Specified
North-central	26.3%	14.4%	9.7%	14.4%	7.7%	69.7%
North-east	20.8%	7.6%	5.7%	9.7%	3.9%	76.6%
North-west	39.3%	10.8%	4.6%	5.4%	2.7%	60.4%
South-east	53.6%	27.5%	18.4%	14.9%	10.2%	41.4%
South-south	49.1%	36.2%	23.1%	28.1%	20.9%	44.7%
South-west	63.8%	47.1%	20.9%	23.8%	8.0%	30.1%

Source: NDHS 2003.

Results of the 2003 NDHS indicate marked regional differences in attitudes toward FP with approval higher in the south than in the north. For example, 61 percent and 51 percent of married women in the southwest and South East, respectively, said that both they and their husbands approved of FP. In contrast, more than half of women in the North West said that both they and their husbands disapproved. Table 2 presents percentage distributions of currently married women who know of FP, by approval of FP and perception of husband's attitude toward FP.

Region	Woman Approves of FP			Woman Disapproves of FP			Woman Unsure
	Husband Approves	Husband Disapproves	Husband's Attitude Unknown	Husband Approves	Husband Disapproves	Husband's Attitude Unknown	
North-central	40.6%	11.0%	15.8%	1.8%	16.6%	6.3%	8.1%
North East	18.0%	11.4%	11.9%	2.8%	38.7%	9.3%	7.9%
North West	17.4%	7.5%	8.1%	1.8%	51.6%	6.6%	7.0%
South East	50.7%	9.1%	6.2%	2.9%	22.4%	3.5%	5.2%
South-south	47.4%	17.8%	9.5%	2.1%	13.8%	3.8%	5.5%
South-west	60.6%	11.5%	12.8%	0.7%	8.2%	1.8%	4.5%

Source: NDHS 2003.

As for FP use, the Population Reference Bureau estimates current contraceptive prevalence for Nigeria as 12 percent for all methods and 8 percent for modern methods (PRB 2006). The 2003 NDHS reports that 29 percent of all women, 31 percent of currently married women, and 65 percent of sexually active, unmarried women reported ever having used any FP method. The male condom was the most common ever-used modern method both among all women (10 percent) and among sexually active married women

(46 percent). The condom and the pill are the most common ever-used modern method among currently married women (8 percent each). Approximately, one-third of married men and one-fourth of sexually active, unmarried men reported ever use of methods that required their active participation -- for example, male sterilization, male condom, periodic abstinence, and withdrawal. The common use of periodic abstinence and withdrawal by sexually active, unmarried men is of concern because these methods do not prevent transmission of sexually transmitted infections.

Current use of contraceptive methods varies substantially by area of residence, religion, educational level and background, number of living children, and household economic status. Married women in urban areas are twice as likely to currently use any FP method as women in rural areas (20 percent versus 9 percent). The same pattern exists for current use of any *modern* method (14 percent urban versus 6 percent rural). **Contraceptive use** also varies by region: Current use of any method is 32.7 percent in southwest Nigeria but **only 4.9 percent in North West Nigeria**. Current use of any *modern* contraceptive method is 23.1 percent for southwest Nigeria but only 3.3 percent for North West Nigeria.

In North West Nigeria, despite a high level of reported knowledge about contraception (75.1 percent for women, 95.2 percent for men), current use of any contraceptive method by currently married women ages 15-49 years is as low as 5 percent (NDHS 2003). In cities in Sokoto and Kebbi states, contraceptive uptake has improved somewhat recently. However, almost no records of contraceptive acceptance exist in most remote local government areas (LGAs). For instance, of the 23 LGAs in Sokoto state, only one (Gwadabawa) reports consistently. The situation is similar in other states in the region; only in Kano and Kaduna states are there better records of FP acceptance. (Personal communication, Abubakar, 2006)

Regional experience with family planning

Traditional methods of birth control have been practiced in northern Nigeria – and particularly North West Nigeria – from time immemorial. Traditionally, Nigerians have recognized the need for spacing births. Abstinence while breastfeeding is still widely practiced across northern Nigeria as a method of child spacing.

Nevertheless, discussing or practicing FP *per se* was once generally taboo in Nigeria, particularly in the North West. Children were seen as gifts from God, and any use of modern birth control was considered sinful. Introduction of modern contraception to the region in the 1960s and early 1970s met almost universal resistance; initially, acceptance was virtually zero. Various, primarily donor-driven interventions undertaken over the years have failed to substantially increase use of FP methods, which remains low relative to southern Nigeria. Opinion appears to have changed in favor of FP, however. As suggested by key informants' responses during interviews conducted for this review (see Appendix 2), young adults in particular are now discussing FP publicly and beginning to embrace the practice.

These changes are largely attributable to events related to introduction of FP over the last 40 years. As in many other countries, the U.S. Agency for International Development (USAID) introduced modern contraception in Nigeria about four decades ago. USAID and other external influences, particularly funding and technical assistance, have played a significant role in development of the country's reproductive health program. Other donor and technical assistance agencies that have provided such assistance include the United Nations Population Fund (UNFPA), the British Department for International Development (DFID), the World Health Organization (WHO), the Japan International Cooperation Agency (JICA), the World Bank, the Ford Foundation, the David and Lucile Packard Foundation, and the MacArthur Foundation. These donors have funded projects with governments, nongovernmental organizations (NGOs), civil society organizations, faith-based organizations (FBOs), community-based organizations (CBOs), and other stakeholders.

In 1964, the FP Council of Nigeria was established in response to unintended pregnancies, child dumping, illegally induced abortions, and high rates of maternal and child morbidity and mortality. The Council's successor, the Planned Parenthood Federation of Nigeria (PPFN), was by 2001 operating a network of 73 clinics in 36 states; providing support services to other NGOs and private-sector clinics; and implementing projects focused on sexuality and RH services, removal of socio-cultural barriers, and institutional capacity building. As of 2002, PPFN had over 4,000 adult and 1,000 youth volunteers, and a staff of 180 (PPFN Annual Report, 2001/2002). Staff strength has increased to 256, but the network of clinics has been reduced to 46 due to lack of adequate funding and the merger of some clinics.

USAID refocused its efforts in northern Nigeria in 1993 when its Mission Director convened a meeting of NGOs in Katsina. The meeting was informed, in part, by a USAID policy shift from working with government to working with civil society, after the Abacha military regime halted the country's transition to democracy. The meeting identified issues unique to the north, such as high rates of maternal, child, and infant mortality and low uptake of FP, and developed strategies for working with NGOs in the region.

Today, FP services are provided in the region in public health center, by NGOs such as PPFN, and in private hospitals, with support from donor organizations such as Packard, UNFPA, and Pathfinder International, working with the private-sector FP initiative.

Brief descriptions of government, civil society and internationally supported FP efforts follow.

Government efforts

Government initiatives in FP and reproductive health have been largely donor-driven. An assessment report on Social Sector Development in Northern Nigeria indicated that:

- The past First Lady's initiative dedicated to children and women's development programs was not carried out in northern Nigeria
- No state governments in the north have been proactive in initiating intervention programs on reproductive health/FP. It appears that the only area in which those governments have acted is vesicovaginal fistula, VVF – perhaps the only reproductive health topic on which governments in the north have taken the lead in the country.
- Although the Kano State government has endeavored to provide free services ranging from antenatal care to post-abortion care for women in public health facilities, these programs are limited to urban health facilities.

However, FP services are provided in almost all public-sector hospitals and clinics in the North West states of Nigeria. According to records at the FP coordination centers in Sokoto, Kebbi, Zamfara, and Kano states, commodities are sufficient but more service providers are needed. Similarly, more and continuous training on the various contraceptive methods is needed to improve provider performance. (Personal communication, Abubakar, 2006)

Civil society response

Civil society groups are actively working in northern Nigeria on child survival, FP, HIV/AIDS, and reproductive health programming. Such groups include multi-focus NGOs working in the area of literacy, vocational skills, micro-finance and faith-based activities, which often combine reproductive health interventions (such as sexuality education for adolescents, counseling or referral services) with other activities.

Branches of networks and umbrella organizations such as Planned Parenthood Federation of Nigeria (PPFN), Society for Women and AIDS in Africa (SWAAN), Women in Nigeria (WIN), and the National

Council of Women's of Women's Societies (NCWS) provide health-based support. NGOs representing nomadic people -- such as the Pastoral development Initiative and the Pastoral Resolve – also exist.

Both Christian and Muslim faith-based NGOs also have been carrying out reproductive health projects in the north. Most of their activities focus on information and awareness-creation, with clients needing services being referred to either private- or public-sector facilities offering FP. Evangelical Church of West Africa (ECWA) and Church of Christ in Nigeria (COCIN) are the dominant faith-based Christian organizations that have been carrying out reproductive health interventions, such as providing FP services in clinics. The Federation of Muslim Women Association of Nigeria (FOMWAN) has been running FP/birth spacing clinics in the northern States of Kaduna, Plateau, and Bauchi. The Islamic Health Workers Association operates in Kebbi State, and the Islamic Medical Association (ISMA) has branches throughout the North.

Youth groups in the north have been engaged by international organizations to provide reproductive health services. Most focus on adolescents and are made up of young people who are either students or graduates. Groups of medical students or graduated health workers are also very active in the states of Borno, Katsina, Kaduna, Taraba, and Kano. Trade unions and professional associations such as nurses and midwives associations, the National Union of Road Transport Workers, the Nigerian Medical Association, and the Association of Resident Doctors have been engaged by international organizations to reach out to their members to update their knowledge on current reproductive health issues and best practices.

Media associations such as the Nigerian Association of Women Journalists (NAWOJ) have highlighted women's reproductive health issues, including the plight of VVF patients, the problems of early marriage, the absence of emergency obstetric care, and harmful traditional practices.

Donor and international NGO activities

Along with USAID, the David and Lucile Packard Foundation has been at the forefront of reproductive health support in northern Nigeria. The main difference between Packard's approach and that of USAID is that the latter tends to emphasize FP, while Packard views reproductive health more broadly. Packard has also focused on creating a critical mass of leaders in reproductive health/FP in northern Nigeria through fellowships and its mid-career emerging leadership program. Appendix 3 includes descriptions of Packard-supported work carried out by implementing partners (CEDPA, Pathfinder) as well as other initiatives supported by international organizations and donors.

Selected additional research and programs of interest

To supplement the review of different organizations' programs in Appendix 3, we briefly describe other selected research and programs documented in the literature that may offer useful guidance in designing and implementing programs in northern Nigeria:

Key informant interviews. In a dozen in-depth interviews with gatekeepers and opinion leaders in North West Nigeria, consultant Aisha Abubakar found strong support for the idea that FP is consistent with Islamic belief and that FP is necessary within marriage. Most respondents also agreed, however, that women must submit sexually to their husbands and can refuse sex only when sick. Their overall impression was that FP acceptance had increased rapidly, perhaps in reaction to the country's poverty. (See Appendix 4.)

Why Nigerian adolescents seek abortion rather than contraception. Focus group discussions in Benin City, Nigeria explored adolescents' perceptions concerning risks associated with contraceptive use versus induced abortion. Researchers identified fear of future infertility as a powerful disincentive to contraceptive use, along with lack of understanding of the risks associated with unsafe abortion.

Although Benin City is in the southern, largely Christian region of Nigeria, there may be similarities in adolescents' levels of knowledge and sources of information about modern contraception among regions. Authors Otoide, Oronsaye and Okonofua call for a comprehensive policy on contraceptive marketing and distribution to adolescents, as well as documentation and better understanding of informal contraceptive delivery points, notably patent medicine dealers. (Otoide et al., 2001)

Integrating FP with post-abortion care. Studying a semi-urban town of Western Nigeria, Fasubaa and Ojo found that counseling on contraceptive use and behavior change for women who had undergone abortion resulted in significant increases in contraceptive use and decreases in the number of women with multiple sexual partners. Counseling methods used included a behavioral contract technique, assertiveness training, traditional psychological counseling, and provision of contraceptive information. (Fasubaa and Ojo, 2004)

In Kano, Sokoto, Kebbi and Borno states, IPAS and in-country colleagues trained 57 nurse-midwives at health facilities offering post-abortion care in post-abortion FP counseling and method provision, provided seed stocks of FP commodities, facilitated re-supply, and furnished other support to enhance recordkeeping and supervision. After the training intervention, 100 percent of post-abortion patients received FP counseling, compared to 54 percent previously, and 52 percent received methods, compared to zero previously. It was also found that women who are not abortion patients now seek FP services at the post-abortion care sites, which have gained a reputation for convenience and quality of care. (Oji, 2006)

Lessons from regional experience with family planning

Despite its slow pace, progress has been made in Northern Nigeria as a result of the interventions described briefly above and in more detail in Appendix 3. Overall achievements include:

- Increased awareness among reproductive-age women and men of FP services and where to access them. This was achieved through the use of the mass media, especially the radio, to disseminate information about FP.
- Successful integration of FP into public-sector maternal and child health facilities. Although acceptance has been very slow, FP services are now routinely offered in many such facilities.
- Successful use of professional associations and umbrella organizations to directly implement FP programs at the grassroots.
- Flexibility in project design so as to allow for cultural and religious sensitivities that can be stumbling blocks to successful programming.
- Involvement of religious leaders in FP program activities.
- Involvement (by some programs) of communities from the planning stage, so as to ensure community ownership and sustainability.
- Support of local partners to form networks and coalitions, which can foster a cordial relationship between NGOs and CBOs working at the grass-root levels and give them ownership of the project.
- Increasingly effective monitoring and evaluation of program activities.
- Provision of technical assistance throughout each project's lifespan.
- Programmatic involvement of men, including training them as community male motivators.

These and other achievements can serve as building blocks for future FP efforts in Northern Nigeria. Local programs can also be enhanced by lessons gleaned from both successes and failures in other parts of the Muslim world.

D. Synthesis, Lessons Learned, and Recommendations

The preceding review of global and regional experience introducing FP in Muslim settings provides a number of insights regarding factors, conditions and approaches that can either facilitate or hinder such efforts' success. Elements that seem to contribute to the likelihood of successful FP interventions in such settings fall into several categories, including some that are beyond the control of researchers and program managers. The presence or absence of those factors in a given locale may indicate the likelihood of success in introducing or expanding FP services. The facilitating and impeding factors noted below or organized by social, political and health-system characteristics.

Facilitating factors

Social

- existing demand for lower fertility due to socioeconomic, educational motivations
- public awareness and participation
- integration of FP efforts into valued existing programs, including health, education, and others
- public interest in and appreciation of social and economic development goals
- social momentum to improve women's status
- environment conducive to female empowerment (including related to education, workforce, decision-making power in the family)
- good access to mass media, for incorporation into appropriate communication and advocacy strategies
- donors committed for the long haul
- working with and building capacities of NGOs
- respect for and alignment with religious tradition, including:
 - involving and getting the support of religious leaders
 - incorporating FP messages into routine religious activities

Political

- committed government, including sustained financial support
- interest, commitment and involvement across all sectors of government, not just health
- program objectives and activities need to be aligned with government priorities

Health system

- promotion and delivery of FP services in a reproductive health framework (including integration with other RH services)
- emphasis in IEC on FP's personal and public advantages and its congruence with Islamic values
- sensitive, responsive IEC materials, including frank and accurate information on methods, side effects and mechanisms of action
- providing a full range of methods so couples have the broadest possible choice
- careful introduction, including acceptability trials
- attention to quality and client-centered services, including multiple aspects of accessibility
- involving men in design and delivery of services, in recognition of their important role in reproductive health decision-making
- decentralized service-delivery system with strong system for informing clients of availability of services
- strong supply, re-supply and distribution system for contraceptive methods
- strong data collection to measure and demonstrate need, impact
- involving community in design and implementation of health services
- collaboration with NGOs and private sector where opportunities exist

- effective management and supervision of health services

Impeding factors

Social

- low literacy, low educational levels
- strong influence of kinship traditions
- high fertility valued / desire for large families
- limited exposure to modern ideas (for example, through mass media)
- male dominance in family decision-making
- men's lack of knowledge of and opposition to FP
- perception that FP threatens male authority
- polygyny (sometimes wrongly seen as religious imperative; can create childbearing competition)
- suspicion of Western imperialism, especially population control motivation
- fear of / opposition to government intrusion in personal or religious affairs
- fear that FP will lead to promiscuity
- paucity of good data regarding the need for FP and its impact
- conviction that FP is anti-Islamic
- fears and misconceptions of modern methods, including fears of side effects
- confusion between religion and tradition

Political

- governmental opposition to or ambivalence about FP
- lack of support across government functions
- over-dependence on external funding; government failure to sustain its own investment in FP
- lack of appreciation of links between FP and development

Health system

- culturally inappropriate or insufficient IEC
- inadequate availability and accessibility of counseling and methods
- inadequate access to health services
- inadequate attention to quality of care, including factors such as negative provider attitudes which can undermine clients' trust
- poor contraceptive supply and distribution systems
- inadequate investment in training and supervising health personnel
- inadequate or inconsistent financial support

Bearing these observations in mind, we make the following recommendations for improving FP programs implementation in the region. All program activities should be targeted at behavior change and designed and implemented using a multi-sectoral approach.

Recommendations for service planning and delivery

1. *Involve opinion leaders and community gatekeepers in planning and implementation of FP programs (avoid pre-packaged programs).* Obtaining community support from the earliest stages of a program is critical to understanding and meeting community needs and to gain program acceptance.
2. *Make a special effort to involve in- and out-of school youth, men and other key populations in RH program planning and implementation to ensure their effective involvement and understanding and attention to their needs.*

3. *Integrate FP into all maternal and child health clinics and other service delivery points, and make it a routine part of services.*
4. *Create sustainable mechanisms for training health-care providers in technical aspects of FP services and in elements related to quality of care, including counseling and respectful treatment of clients.*
5. *Consider emulating the ELICO mapping program used in Indonesia and making use of trained Community Health Extension Workers who are available and unemployed all over the region.*
6. *Consider adapting the Navrongo Community-based Health Planning and Services (CHPS) initiative combining community engagement with deployment of community-based nurses for the northern Nigerian context.*
7. *Provide door-to-door FP services to women in purdah and down to the grassroots. To learn more about the Indonesian and Bangladesh approaches, key Nigerian leaders could participate in study tours.*
8. *Integrate FP services into other health and development programs, including those that address Safe Motherhood.*
9. *Implement programs using both the private and the public sectors. Allocate more funds to the private sector.*
10. *Ensure that program activities are effectively monitored from all levels. Results should be documented and circulated as encouragement to program implementers and community members as evidence of their positive impact.*
11. *Create and/or support effective systems for distribution and resupply of contraceptive methods.*
12. *Support the effective decentralization of FP services, including availability of a broad range of methods down to the primary care level.*

Recommendations for Information, Education and Communication

1. *Produce IEC/BCC materials in local languages, making them culturally and religiously sensitive. Focus groups made up of intended beneficiaries as well as community and opinion leaders should be conducted to uncover prevalent beliefs, misunderstandings, concerns and other factors that will need to be addressed.*
2. *Emphasize audience participation and intensive social mobilization and advocacy.*
3. *Conduct special outreach for religious leaders. Select an appropriate entry point for reaching out to them, facilitate discussions among them about FP and Islam, and encourage (and assist) them to incorporate messages about FP into their routine activities. Seek and publicize religious rulings in favor of FP.*
4. *Refer to examples of Islamic scholars' and leaders' participation in FP activities in other countries and adopt practices that have been successful there. Publicize favorable statements on FP by prominent religious leaders in such settings.*
5. *Work with the education sector to include FP in secondary-school curricula, so that students learn reproductive physiology and understand the connections between good reproductive health and social and economic well-being.*
6. *Educate local, state and national legislators about FP and seek to develop them as advocates.*

Appendix 1

Summary of key informant interviews on family planning conducted for desk review

Consultant Aisha Abubakar conducted twelve in-depth interviews with gatekeepers and opinion leaders in selected communities in order to better understand the community's beliefs about, perspectives regarding, and experiences with, FP in North West Nigeria. The interviews also sought to better understand individuals' perceptions of FP and services being provided, and to solicit ideas for promoting FP in the region. Respondents were selected through contact persons residing within the communities who could identify opinion leaders and gatekeepers. The key informant interviews were conducted using a guide designed for the interview (see below). Twelve respondents (see Appendix 2) were interviewed: three religious leaders, three married men, three married women, and three unmarried youths. The interviews were conducted in Zamfara, Sokoto, Kebbi, and Kano states. Highlights of respondents' comments on key topics follow:

- Rapid population growth: Eight of the 12 respondents saw population growth as a serious problem; however, four saw it as a blessing. One said, *“This is just American propaganda to reduce the population of Moslems in the world so that they can conquer the world, but with God, that will never happen.”*
- Desire for more children: When asked whether men or women want more children, two respondents said that both parents do. However, 10 respondents insisted that women often desire more children because of competition among women in polygamous homes (the case for many families in the zone). Having many children meant that they would inherit more of the husband's wealth.

Ten respondents said that the desire for more children is seldom discussed openly because children are believed to be gifts from God and their numbers are for God to decide. Two respondents said men have the authority to decide how many children the family will have.

- Number of children: Nine respondents said that Islam did not specify the number of children a couple should have, but that it clearly stressed that children – regardless of numbers -- should be adequately cared for and raised to become responsible citizens. In addition, Islam holds every parent responsible for the development of their children, they said. (The remaining three respondents did not respond to the question.)
- Whether FP is necessary: Ten respondents said they believed that FP is necessary and should be compulsory for the married, particularly considering the population's poverty and the consequences of such poverty. However, they felt that FP is not necessary for the unmarried because the Islamic religion prohibits pre-marital sex. Providing FP services to the unmarried will encourage them to engage in this forbidden practice. (The remaining three respondents did not respond to the question.)
- How spousal communication affects FP: Half of the respondents said that community norms are for a wife to inform and seek permission from her husband for everything she does. Thus, it would be wrong for a woman to use FP without her husband's knowledge or consent. The remaining six respondents said that a woman may use any contraceptive method without her husband's consent as long as she is using the method for her health and that of her children. Of the respondents, the religious leaders gave more conservative responses regarding the need for a woman to inform and seek permission from her husband.

- Whether Islam permits FP: Eight respondents said that Islam permits FP as long as it is not practiced as a state policy but, rather, to enhance health by allowing for the spacing of pregnancies and births.

Some respondents referred to the fact that Islam has clearly stated that each parent is responsible on the final judgment day for the upbringing of his or her children. One respondent said, *“This is basically saying why should anybody give birth to children he/she cannot train and bring up in the Islamic way?”* Another respondent added, *“The people claiming that Islam forbids FP are simply ignorant of the Islamic facts about FP.”*

On the other hand, four respondents (of whom two were religious leaders) condemned FP, insisting that it is not permissible in Islam and should not be practiced by any true Moslem. They pointed to the saying of the Prophet to his followers: *“Get married and multiply in number so that I will be proud of you on the last day.”* Therefore, these respondents said, a woman should never refuse her husband sex and, if she does, God will be unhappy with her.

- Can a woman refuse her husband sex? *“God has placed men on top of women, the man has total control over the entire household,”* a religious leader said in response to the question of “to what extent do married women have control over their bodies and can a woman refuse her husband sex?” Most respondents agreed that a woman has no control over her body and can refuse sexual relations with her husband only when she is sick.
- How to promote FP: The majority of respondents suggested that FP could be promoted via campaigns to create awareness; sensitization activities for opinion/religious leaders, and intensified media programs on FP. Other suggested activities were community activities through role plays and local dramas. Some respondents recommended male involvement in FP programs so that men would be more likely to support women’s desires to contracept. Suggestions for improving FP programs/services included the provision of FP services to grassroots and remote areas.

Respondents could not recall any FP promotion activity that had failed, and they felt that FP and related issues had been widely discussed by the media, particularly on the radio. Although international donors might feel that FP is progressing very slowly in the region, some respondents said, acceptance of FP had increased, judging from numbers of people seeking services at FP service outlets. “To us in the communities,” said one respondent, “we know that the increase in acceptance of FP is rapid, since you now see even young girls with first birth going to the clinic to access FP service while, in the past, this was not the case.” Respondents thought that increased support for FP was a reaction to the country’s poverty.

Key informant discussion guide

Good Morning my name is Aisha Abubakar and I am conducting an inquiry into previous data and documentation on the factors that contribute to low performance and uptake of FP in the North Western region. I am inviting you to discuss this issue with me as you have been identified as someone who may have information to share. As I raise the issue I would like us to discuss it frankly. There is no ‘right’ or ‘wrong’ answer. We just want to understand the community’s beliefs and perspectives on the issue. Please I request that you feel free to talk and express your feelings. Please permit me to use this tape recorder because I want to get all you say correctly in order so as not to quote you wrongly. Thank you for accepting to participate. Let us start by an introduction. Tell me your name, what you do for a living, and what experiences you have had with FP in North West Nigeria.

1. General question: There has been a lot of concern about the problems of rapid population increase and high fertility in Northern Nigeria. What are your views about this? (*probe for; the nature of the problem, what are responsible, what should be done etc*)
2. With respect to the home front and based on cultural and religious perspectives, in your experience who desires more children: men or women? Please explain why you believe this is so.
3. If a husband or wife desires more children and the other spouse doesn't, are there ways the issue has been tackled from the community perspective? What about through religion?
4. In considering the number of children to have, what do you think the Islamic point of view is?
5. What is the preferred sex of a child? Why do people prefer male/female children? Are there any religious/cultural reasons?
6. What do people in this community say/think about FP for married people? For unmarried people?
7. Some people believe a woman should practice FP without her husband's consent and others believe a woman should have right over her body. What are the issues around the need for secrecy in this society?
8. What are this community's views about making FP services available to young men and young girls? (Let's talk about this further).
9. What are some of the issues people in this community have about FP in Islam?
10. To what extent do you think married women have control over their bodies in this community? Can a woman say "no" when her husband wants to make love to her? (PROBE) What reasons could make a woman refuse her husband sex?
11. In your experience, what have been/what would be the most effective ways to promote FP in these communities?
12. Can you think of any examples where a FP promotion was tried, but was not successful? Why do you think it wasn't successful?

List of key informants

Names	Address	Sex	Venue
Ustaz Ibrahim Sani Gusau	Central Mosque, Gusau.	M	Gusau
Mallam Usman Garba	Kofar Gari, Sokoto	M	Sokoto
Mallam Abubakar Umar	Sabon Gari Market Kano	M	At market
Hadiza Bako	Kofar Kudu, Gusau	F	Gusau
Hafsat Dayyabu Danja	Maryam Abacha Hospital Sokoto.	F	Sokoto
Zuwaira Dahiru	Birnin Kebbi Central Motor Park.	F	Birnin Kebbi
Abbas Yakubu	Sokoto, Central Market	M	At market
Hadiza Garba	Nurul Islam School Sokoto	F	At school
Danazumi Iro	Sokoto Health Project	M	At home
Jamila Mohammed	Kofar Fada Birnin Kebbi	F	At home
Abdallah Yahaya	BUK Road Plaza Kano	M	In shop
Rukayya Yusu Aliyu	University of Sokoto	F	At school

Appendix 2

Current and recent donor-supported FP interventions in Northern Nigeria

Community Participation of Action in the Social Sector (COMPASS): COMPASS is a USAID-funded organization implemented by nine partner organizations: Adolescent Health and Information Project (AHIP), Creative Associates International Inc. (CAII), Civil Society Action Coalition on Education For All (CSACEFA), Federation of Muslim Women's Associations of Nigeria (FOMWAN), Futures Group, Johns Hopkins University/Center for Communication Programs (JHU/CCP), Nigerian Medical Association and Management Sciences for Health), under the leadership of Pathfinder International. The organization represents a partnership between the Nigerian government and USAID with the aim of laying the foundation for sustainable improvements in reproductive health/FP, child survival, and basic education. COMPASS operates in nine states of the nation, three of which (Kano, Bauchi, and Nassarawa) are in the North.

Activities carried out by COMPASS in the North include:

- training of Islamic school teachers
- training providers of FP services, traditional barbers, TBAs, community health extension workers (CHEWs), community health volunteers, and patent medicine vendors to provide non-prescriptive methods of contraception, counseling, and referrals, and to link with service delivery points for commodity supplies using CBD vouchers.

In Kano, the organization has recorded improved quality of social sector services defined as the number of community-based and facility-based service providers adhering to basic quality standards when delivering services. More health providers and supervisors have been trained to meet national standards, and the capacity of NGO advocacy networks and policy champions to advocate for improved health policies has increased (COMPASS RH/FP quarterly narrative report, April-June 2006).

In Bauchi State, COMPASS supported the recent passage of a bill by the State House of Assembly that stipulates that one million women in the state will be entitled to receive free antenatal care. So far, COMPASS has trained 250 service providers in the state, specifically focusing on antenatal care. The project also works with community Quality Improvement Teams to renovate health facilities and supply equipment for antenatal care and delivery.

Center for Development and Population Activities (CEDPA): CEDPA has worked in Northern Nigeria since 1983, initially providing technical support to women's organizations to build their capacity to access reproductive health services. In 1993, CEDPA/Nigeria launched the USAID-funded ACCESS project to promote the empowerment of women through integrated quality FP and reproductive health services. ACCESS was succeeded by the ENABLE project, which seeks to strengthen women's capacity to make informed and autonomous decisions to prevent unintended pregnancy.

Since 2001, the David and Lucile Packard Foundation has supported CEDPA's work to increase access to FP and reproductive health services in Northern Nigeria. In two phases (October 2001-March 2004 and May 2004-April 2006), CEDPA worked with local NGOs and FBOs to provide home visits, community education, and advocacy to local leaders in order to increase contraceptive use in peri-urban areas of Bauchi, Kano, and Plateau states.

As a result, many new contraceptive users and continuing users were reached; even more people were reached with information. The projects successfully linked clients to clinical services. The process of

using home visits to generate interest in FP/RH and to link clients to existing clinical services is effective and can lead to sustained contraceptive use.

Service statistic data for the period of April 2002 through September 2003 show that 31,436 new clients were recruited and 76,250 continuing clients were served with various modern FP methods at both clinic and community levels; oral pills and injectables were most commonly used (CEDPA report on the evaluation of the CEDPA/Packard RH/FP project in Northern Nigeria). Meanwhile, according to the report, project staff felt that the project identified several successful strategies, including:

- *Use of male motivators as service providers.* Two major problems for women and youth in the project areas of Kano are lack of information on sexual and reproductive health and lack of easy access to facilities providing FP services. As a result, the project trained male motivators who conducted and provided information during community sessions; conducted community sensitization rallies; provided house-to-house information and services; and distributed culturally appropriate IEC materials that assisted in reinforcing learning.
- *Eligible Individual and Couples (ELICO) Initiative.* This initiative used maps to improve planning, recruit eligible individuals and couples for provision of FP services, and follow-up clients. Project staff reported that regular follow-up and revisits by CHEWs helped dramatically to reduce client drop outs. The maps helped the CHEWs recruit new clients since eligible individuals and couples changed as people left or moved into the project communities.
- *Workplace initiatives.* These have included monthly visits to factories by project staff to provide health talks and create awareness on FP as well as HIV/AIDS issues. In addition, every quarter, the CHEWS lecture on the human reproductive system, FP methods and practice, and HIV/AIDS prevention and control messages. Lectures targeting factory employees, managers, and union leaders are blended with role plays, video shows, and distribution of print and other IEC materials. The subject of HIV/AIDS was a launching point for providing FP information; i.e., promoting condom use for dual protection. Voluntary counseling and testing was explained and promoted. During such meetings, CHEWS provided FP commodities and made referrals for long-term contraceptive methods. The project also worked with factory clinics to provide long-term methods to workers and their spouses. Employees of factories without such clinics were linked up to referral clinics for follow-up services.

Despite the successes recorded by the CEDPA/Packard project, the evaluation report shows that acceptance and use of FP and reproductive health services in Northern Nigeria remains low. Among the most important factors CEDPA has identified as contributing to low acceptance of FP are cultural norms that devalue women; a perceived social need for women's reproductive capacity to be under strict male control; practices which restrict women's access to medical care; low levels of female literacy; and early marriage.

Pathfinder International: Pathfinder International has worked extensively in Northern Nigeria. Pathfinder's Packard-supported project from October 2000 to September 2003 aimed to increase access of underserved populations there to FP/reproductive health information and services through a network of private sector service providers. The project worked in the states of Borno, Katsina, Kaduna, Kano, Niger, and Sokoto to strengthen the capacities of private-sector providers by providing grants to Nigerian NGOs. Project goals were to:

- Establish a network of stakeholders and groups in the private commercial and NGO sectors

- Conduct six international study tours for Nigerian professionals to identify issues, challenges, and opportunities in the private sector, and to share lessons learned and best practices for service delivery and advocacy
- Conduct annual site-specific cluster evaluations and six semi-annual stakeholder meetings to share lessons learned and best practices
- Create an enabling environment for reproductive health organizations to provide services through intensive advocacy activities with religious, traditional, and political leaders.

Throughout the project, Pathfinder was challenged by poor capacity of the Northern Nigerian NGOs and found it difficult to find credible NGOs and community-based organizations (CBOs) working at the grassroots levels for project implementation and management. In general, grantees had weak and fragile organizational structures requiring aggressive and intensive technical assistance and capacity building. Also hampering implementation of the project was poor access to project sites, which made project monitoring challenging and resource intensive. Use of professional associations and umbrella organizations (for example, consortia of private clinics) has proved clearly advantageous, but, in some instances, personal interests and rivalries in these organizations have hindered progress.

Incorporating non-profit making activities into a profit-oriented practice also was difficult. For the most part, the project found, private practitioners remain well-to-do clients' first-choice providers, but the public-sector facilities are the first and only choice for lower-income target groups. The private-sector facilities provide quality service in terms of convenience, time saving and confidentiality. However, the public sector is still highly relevant for clinical services not offered through private practitioners and for those who cannot afford private services.

Other contributions by Pathfinder include introducing to Northern Nigeria "Future Search," a program review tool that has proved useful in building consensus among various stakeholders on ways to address RH challenges in the region (for more information see <http://www.futuresearch.net>) and supporting dialogue among religious leaders. The latter effort recently led to publication of religious leaders' statements on Islam and FP, a process Pathfinder facilitated but did not direct, thus increasing its credibility. (Burket, 2006)

Engender Health (VISION Project): The VISION Project aimed to establish scalable models of high-impact, high-performance FP/ reproductive health service delivery networks built upon public-private partnerships in selected LGAs. The project worked only in Bauchi State in Northern Nigeria.

VISION was a partnership project involving Johns Hopkins University (JHU), Engender Health, Society for Family Health and IntraHealth International. Each implementing partner focused on different aspects of the program, which includes child spacing, safe motherhood, sexually transmitted infections, HIV/AIDS, adolescent reproductive health, child survival, and client-provider interaction. The project's programmatic strategies were:

- Creating demand through awareness creation, using IEC materials and advocacy
- Improving supply of services through increased service provision outlets
- Capacity-building through training of health-care providers, strengthening of facilities, and provision of commodities
- Enhancing quality of care through training in infection prevention and provision of infection prevention equipment

Department for International Development (DfID): DfID's main FP/reproductive health program is the Partnership for Transforming Health Systems (PATHS), which covers the Northern Nigerian states of

Kano, Kaduna, and Jigawa. PATHS' objectives include reducing maternal mortality, increasing access to reproductive health services, and achieving sustainable benefits for the poor by helping them get basic health systems that function effectively and are universally accessible. Underpinning this program is commitment to strong partnership with stakeholders for full local ownership and sustainability.

Community and stakeholders are encouraged to define program content in the focal states. DfID's programmatic approach involves program diagnosis, solution seeking, and community planning for and implementation of programs. DfID provides both technical assistance and funds for implementation.

Appendix 3

Conferences of Muslim leaders that have issued statements supportive of FP

1971 -- Rabat Conference on Islam and FP

Statement endorsed use of contraception to protect health and in social and economic circumstances not conducive to a child's or family's welfare

1979 -- Banjul conference

Statement emphasized that FP is not new in Africa or Islam, citing longstanding tradition, encouragement of birth spacing. Endorsed FP and defined it as promoting responsible parenthood.

1982 – Dakar

Statement endorsed FP but opposed imposition of national programs.

1990 – National Conference on Islam and Child Spacing in Somalia

1994 – International Conference on Population and Development

Called for universal access to a full range of safe and reliable FP information and services; Islamic countries generally endorsed the conference's program of action, while reserving the right to national sovereignty in its interpretation and application.]

1995 – Conference on Women, Islam and FP in Niger

Statement noted “confusion between religious precepts and tradition” and affirmed that the Koran and *Hadith* do not prohibit contraception.

1998 -- Al Azhar International Conference on Population and Reproductive Health in the Muslim World

Part II

Formative Research: Child Spacing and Family Planning Attitudes of Young Married Men and Women in Selected Areas of North West Nigeria

Sharon Tsui and Nancy E. Williamson

With field support from
development Research and Projects Centre (dRPC)

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In Kano:

Dr. Yashua Alkali Hamza
Hajiya Saa' Tijjani Hashim
Hajiya Aisha Abba Ahmed
Hajiya Amina Usman
Hajiya Aisha Abdullahi Bichi
Hajiya Amina Aliyu
Hajiya Hauwa
Alhaji Yahaya El Yaqub
Alhaji Ibarhim Magashi
Alhaji Mohammed Tijjani
Alhaji Sani Ahmed
Alhaji Abubarkar Mohammed

In Zamfara:

Alhaji Lawal Sule Gusau
Alhaji Aliyu Abdullahi
Alhaji Arzika Abubakar
Hajiya Shafa Abubakar
Hajiya Safiya Mohammed
Hajiya Hauwa Kulu Dantake

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Executive Summary

Recent demographic data show that women living in North West Nigeria have some of the highest total fertility rates (TFR), high ideal family sizes, and lowest contraceptive use in the country. The study described here sought to understand barriers and facilitators to FP and child spacing among young married men and women, aged 15-30 years, in Kano and Zamfara States of Nigeria. Qualitative methods, such as Participatory Learning and Action methods, in-depth interviews, and focus group discussions, were used to generate information from young married people, community members, and key stakeholders, such as TBAs, barbers, religious leaders, and reproductive health professionals. Study participants came from both rural and urban areas and from areas with and without FP services.

This final report is comprehensive and emphasizes the respondents' own words, quoting extensively from 35 Participatory Learning and Action (PLA) exercises with young men and young women (19 PLAs with men, 16 with women), 43 in-depth interviews with adult stakeholders and 20 focus group discussions with adults in the communities (12 FGDs with women and 8 with men). This summary of the major findings is organized under **seven** topics below:

Fertility Norms

Fertility norms of young married men and women were examined by exploring their perceptions of family size, such as what is meant by a “large”, “medium”, and “small” family and what is an ideal family size. The data suggest that young married men and women had a wide range of perceptions on family size, making it difficult to clearly distinguish patterns of large, medium, and small families across states, study sites, rural and urban areas, and communities with and without exposure to FP programs. However, several general trends by gender and urban vs. rural areas were identified:

- Young married men's perceptions of typical family sizes were larger than young married women's. Young married men also had larger ideal family sizes than young married women.
- Young married men living in urban areas had a smaller ideal family sizes than young married men living in rural areas. Unlike young married men, young married women shared similar concepts of ideal family size across rural and urban areas. Young married men living in urban areas were more likely to report a smaller ideal family size than their counterparts living in rural areas. Even in urban areas without exposure to FP interventions, young married men were more likely to report a smaller ideal family size than their counterparts from rural areas.
- No apparent differences were found in perceptions of large, medium, small, and ideal family sizes between young married men and women from communities with and without exposure to FP programs.
- No apparent differences were found in perceptions of large, medium, small, and ideal family sizes between young married men and women from Kano versus Zamfara.

Respondents were also asked to identify advantages and disadvantages associated with large, medium, and small family sizes in order to better understand young married men's and women's ideal family sizes. Economic and social gains were the main advantages associated with having a large family. According to the majority of young married men and women, children were an important source of security for parents in their old age and provided help to the parents at home and on the farm.

Socially, many young married men said they would gain respect in the community by having a large family. Also, some older married women (stakeholders interviewed outside the 15-30 age group) explained that co-wives would be better positioned if they had more children than the others. In addition to economic and social gains, many young married men and women felt religiously compelled to have many children. They cited the Prophet Mohammed, who they said, told Muslim believers to produce as many children as possible in order to make the Prophet proud of them on the Day of Judgment.

Although there were many advantages associated with a large family, many young married men and women expressed concerns over the practical aspects of raising a large family. For example, many young married men pointed to current economic hardships in Kano and Zamfara as deterrents to having a large family, including low income, poor employment opportunities, and the high cost of living. These respondents said they had inadequate financial resources to support many children with education, health care, clothing, and food. Furthermore, young married men and women noted the challenges of providing a good moral upbringing and running a large household, respectively, as disincentives to having a large family. For these reasons, many young married men and women felt that it would be more manageable to raise a small- or medium-sized family.

Perceptions of Family Planning and Child Spacing

In general, the majority of young married men and women held positive attitudes towards family planning (FP) because they understood it to contribute to child spacing. They perceived spacing to be beneficial for maternal and child health, particularly to avoid “kwanika” – a situation where a woman becomes pregnant before she has finished weaning her child. Spacing allows a mother time to rest and enables the infant to grow up strong and healthy before another child is born. Also, some respondents believed that spacing enabled parents to better care for their children, having sufficient resources to pay for the children’s education and health care needs, as well as time to pay attention to the children’s moral upbringing. Furthermore, many respondents felt that spacing was preferable to limiting because they believe that spacing is clearly permitted by Islam.

However, some young married men and women held negative attitudes toward FP for religious or cultural reasons. Some respondents saw FP to be for limiting of family size, which they said was unacceptable in Islam: one should not decide on having an exact number of children as children are blessings from God and limitation challenges God’s will. Furthermore, some respondents felt that one should not practice FP in order to avoid economic hardship. Instead, one should have faith in God to provide all that is needed. In addition to religious reasons, some young married men and male community members felt that FP was a subversive Western policy for population control of Muslim and/or African populations.

Key Sources of Information on Family Planning and Child Spacing

Young married men and women were asked to identify key sources of information contributing to their understanding of FP and child spacing. In general, the majority of young married men and women identified the radio, peers, health talks, and modern health care providers as key sources of information. Young married men and women had mixed feelings on the role of their parents as a source of information on FP and child spacing. Notably, many respondents felt they could not communicate with their parents or elders on such a private and modern issue as FP. Finally, many young married men and women perceived religious leaders to promote negative attitudes towards FP.

The majority of young married men and women living in both Kano and Zamfara said they were first exposed to FP and child spacing messages through the radio. Some of the respondents said they learned about the benefits of spacing, the dangers of “kwanika”, and places to access FP methods from radio programs such as BBC World Service, Voice of America, and Radio Kano. Most of these respondents felt these radio program messages were credible and trustworthy. However, the main drawback to the radio as identified by young married women and female community members was that it lacked personal dialogue and a forum to ask questions.

Other major sources of information for young married men and women on FP and child spacing were peers and health talks at the clinic. Both young married men and women said they sought FP information from their friends because they felt comfortable talking about it with their peers. Some young married people explained that only their peers could understand and give them support on this “modern issue”.

Notably, many young married men said they would consult their male friends on FP and child spacing practices even before consulting their wives. Health talks at the clinic were also a key source of FP information for young married women attending antenatal care and well-child visits. For their part, health care providers believed health talks were an effective way of raising awareness on FP and child spacing in the context of maternal and child health care.

Modern health care providers were an important source of information for young married couples in Kano. Many young married men and women said they would directly seek advice on FP and child spacing from hospital providers. Some explained a need for couples to be proactive in dealing with “kwanika;” others felt that only health care providers were in the position to offer them sound advice on modern FP methods; and some felt that providers would maintain confidentiality on such a private issue as FP.

Although some young married people identified parents as a source of information on FP and child spacing, many young people felt that they could not openly communicate with their parents and elders on this issue. Many young married people, especially those in Kano, said it was not in keeping with Hausa culture for FP matters to be discussed with parents and elders. They felt such an issue was too private and should only be discussed between husband and wife. Some young people also felt that a couple’s relationship could be harmed if parents were involved. Furthermore, many young married men and women perceived their parent’s attitudes towards FP to be negative and felt their parents would not understand nor support their decision to practice FP. Also, in general, many young married men and women perceived religious leaders to be against FP.

Communication on Family Planning and Child Spacing Practice

Either young married men or women may initiate communication on FP and child spacing practice. The data suggest that young married women were more likely than young married men to initiate this communication. Usually, a young married woman would suggest FP or child spacing to her husband by gauging his mood, speaking to him in a “kind” and “obedient” manner, and appealing to his understanding with her needs. Sometimes, a young married man initiates communication on FP or child spacing when he observes that his wife is suffering from frequent childbirth. In general, both young married men and women express anxiety about their partner’s reaction to the suggestion of FP or child spacing. Particularly, young married women were worried that their husbands would feel rejected – interpreting the mention of FP or child spacing to imply refusal to comply with a husband’s sexual demands – which would cause serious strife in their relationship. In many cases, young married women perceived their husbands’ attitudes to be negative so they did not talk to their husbands about practicing FP or child spacing.

A mediator is sometimes used in instances when a young married person feels he or she cannot communicate directly with a spouse. Usually, the mediator is a family member, such as a parent or an older sibling. In Zamfara, several young married men said they asked their mother to first talk with their wives on FP use. In Kano, young married men and women said parents and siblings are involved when the couple cannot resolve a problem between themselves. For example, a young married woman may rely on her parents to convince her husband that she needs to practice child spacing.

Decision-Making on Family Planning and Child Spacing

Although some young married women were able to initiate communication on FP, the husband was the main decision-maker on FP and child spacing practice. The majority of young married men and women in Kano and Zamfara believed the husband had the most influence on a couple’s decision to practice FP. They explained that the husband is the head of the household. The majority of women believed it was their duty to obey their husbands and that they could not practice FP without the permission and support of their husbands.

Several young married men from rural and urban Kano believed that a husband and wife should make a joint decision to practice FP and child spacing. These young married men explained that a joint decision was necessary because it was the woman who was most affected by the need for FP. Also, some young married men felt a joint decision was important to avoid any misunderstanding between the couple, which could cause strife in their relationship.

None of the young married women felt they could make a decision about FP and child spacing practice on their own. However, a few young married men believed the wife, ultimately, had the most influence on FP and child spacing practice because she could practice it, or not use it, secretly without the knowledge of her partner.

Knowledge and Attitudes toward Family Planning/Child Spacing Methods

Young married men and women identified the following FP methods:

- Natural: breastfeeding, periodic abstinence, and withdrawal (azi)
- Traditional: guru, karhu, laya, rubutu, local herbs and seeds, goyon ciki
- Modern: oral contraceptive pills, injectables, and male condoms

Of all the methods listed, breastfeeding was the most commonly identified and practiced child spacing method among young married men and women in Kano and Zamfara. Other well-known and practiced methods were guru, karhu, and laya, which are traditional talismans and amulets worn by women to prevent pregnancy. Finally, the majority of young married men and women knew of at least one modern FP method, typically, oral contraceptive pills or injectables.

Young married men and women had mixed attitudes towards natural, traditional, and modern FP methods regarding their efficacy, ease of use, accessibility, and cultural and religious acceptability:

- **Perceived efficacy:** In general, natural and traditional FP methods were perceived as unreliable in preventing pregnancy. Many respondents attributed the inconsistent effectiveness of these methods to God's will, saying that it was part of God's timing for a woman to be pregnant again. For this reason, some respondents said they preferred modern FP methods because they could be sure that they would work. The majority of young married men and women viewed modern methods to be very effective in pregnancy prevention.
- **Perceived safety:** Several young married men and women expressed concerns that modern methods were too potent, fearing that they would damage the womb and cause permanent infertility.
- **Perceived ease of use:** The majority of young married women perceived modern methods to be easier to use because they had a specific dosage, directions for use, and health care providers would help them troubleshoot any problems associated with the method. Many young married women felt that they did not know how to use traditional methods effectively because no one knew how much to take.
- **Perceived accessibility:** Many young married men and women, especially those living in rural areas, felt that traditional methods were cheaper and more convenient than modern methods. They said that traditional FP methods were more easily accessed within the community, whereas modern methods were accessible only at certain clinics outside of the community. Young married men pointed to the costs of transportation and services as deterrents to using a modern FP method.

- **Perceived cultural and religious acceptability:** In general, many young married men and women felt that it was acceptable to practice modern FP because it was part of living in the modern times. However, they also felt that modern FP was not accepted within the wider community, particularly by their parents, elders, and religious leaders. Some young married men pointed to the stigma of FP use, saying that if it was known among the community, then it would negatively affect their chances of marrying another wife. Further, some young married men felt uncertain about the religious acceptability of using FP. They wanted guidance from religious leaders, especially on the use of FP in the current context of economic hardship.

Health Care Providers' Attitudes on Family Planning Service Delivery

Although the majority of health care providers perceived FP to be beneficial to maternal and child health, several health care providers expressed personal ambivalence about delivering FP services. Some providers felt that FP was not justified under Islam if the intention of use was for people to avoid economic hardship; they felt that FP should be used only for health reasons. Some providers felt that FP use facilitated immorality among young married women by allowing them to live promiscuously without the worry of pregnancy as a consequence.

Notably, several female health care providers were unwilling to provide services to women who sought FP alone. A woman had to provide evidence of her husband's permission to use FP before she was given services.

I. INTRODUCTION

A. Background

Northern Nigeria, particularly the North West region, is characterized by high fertility, high ideal family size, and low use of family planning. The total fertility rate (TFR) for women ages 15-49 in the North West ranked second highest of all regions in Nigeria with 6.7 births per woman (NDHS 2003). A comparison of the TFR and cumulative fertility, which is an indication of fertility over time, suggests that fertility is declining for women in all regions of Nigeria---except for the North West. The North West also has the highest proportion of adolescent mothers: 45.2% of women age 15-19 have begun childbearing (NDHS 2003).

High ideal family size parallels the high fertility. Men and women from the North West have the highest mean ideal number of children (12.8 children) in contrast to Nigeria as a whole (8.6 children) (NDHS 2003). There is low uptake of FP practices in the North West, despite a relatively high level of awareness of contraceptive methods. The majority of women ages 15-49 reported knowing at least one contraceptive method (75.1%) and at least one modern method (71.8%). However, only 5% of these women were currently using contraception: 3.3% used a modern method and 1.6% used a traditional method (NDHS 2003).

Table 1 provides NDHS data for women in the two states, Kano and Zamfara, where this new study was conducted.

Table 1 Summary of key fertility desires and contraceptive characteristics of women, age 15-49, in Kano and Zamfara State (NDHS 2003)

Fertility Desires and Contraceptive Characteristics:	Kano (N* = 426)	Zamfara (N* =154)
Median Age at First Marriage (years)	14 (N = 366)	14 (N = 150)
Men's Ideal No. of Children (mean)	95 (N = 55)	30 (N = 27)
Women's Ideal No. of Children (mean)	12 (N = 423)	10 (N = 154)
Did not know any FP Method (%)	27	15
Knew at least one Modern FP Method (%)	73	79
Knew at least one Traditional FP Method (%)	0.2	6
Never used any contraceptive method (%)	82	77
Ever used at least one Modern FP Method (%)	16	7
Ever used at least one Traditional FP Method (%)	1	15

*N = Total sample size for women

B. Study Objectives

The purpose of this study was to explore barriers and facilitators to FP among young married people in North West Nigeria. The study explored:

- fertility norms of young married men and women;
- young married men's and women's perceptions of FP and child spacing;
- ways in which young married men and women communicate and make decisions on FP and child spacing practice;
- current FP and child spacing practices among young married men and women;
- acceptability of FP methods;
- health care providers' attitudes towards delivery of FP services; and
- young married people, community, and key stakeholders recommendations for increasing FP uptake among young married people.

C. Research Organizations

This qualitative study was conducted by Family Health International (FHI) in collaboration with the development Research and Projects Centre (dRPC). FHI's Behavioral and Biomedical Research department drafted the study protocol, provided technical assistance on using the Participatory Learning and Action (PLA) methods, analyzed the qualitative data, and drafted the final report with input from dRPC. The Reproductive Health Unit of the Global HIV/AIDS Initiative Nigeria (GHAIN), the FHI country office in Nigeria, coordinated and facilitated the study, including communication with the USAID Mission, budget preparation and monitoring. dRPC coordinated and led the stakeholder workshops, collected the data, and transcribed the data. All partner organizations were involved in review of the final report.

FHI is a not-for-profit organization dedicated to improve lives worldwide through research, education, and services in family health. FHI works in the research and program areas of HIV/AIDS; reproductive health and FP; and health of women and children in resource constrained settings. dRPC is a non-profit organization based in North West Nigeria with a mission to build capacity for participatory development among direct implementers of development programs and projects. dRPC works in the program areas of HIV/AIDS, reproductive health including FP, early childhood development and poverty alleviation.

D. Study Sites

With input from the USAID Mission, Kano and Zamfara States were chosen as study sites to represent North West Nigeria (**Figure 1**). Kano and Zamfara are both located in the North West region of Nigeria. Kano has an estimated population of 9,383,682¹ while Zamfara's is 3,602, 356². In both Kano and Zamfara States, Hausa is the predominant ethnicity and Islam is the major religion. **Table 2** highlights selected welfare indicators for Kano and Zamfara³:

¹ 2006 Census

² 2005 estimates based on 1991 Census

³ 2006 Core Welfare Indicators Questionnaire (CWIQ) Survey conducted by the National Bureau of Statistics (NBS)

Table 2 Selected indicators from the 2006 Core Welfare Indications Questionnaire (CWIQ)

Core Welfare Indicators:	Kano State	Zamfara State
Households self-classified as poor (%)	61	39
Household economic situation compared to one year ago (%)		
Worse now	30	6
Better now	45	80
Household infrastructure (%)		
Safe water source	40	48
Safe sanitation	4	60
Has electricity	52	19
Employment (%)		
Unemployed (age 15-24)	3	0.9
Unemployed (age 15 and above)	2	0.3
Underemployed (age 15 and above)	13	31
Education (%)		
Adult literacy rate, any language	58	53
Male	67	66
Female	48	42
Youth literacy rate, any language (age 15-24)	63	60
Male	66	72
Female	59	48
Access to medical services (%)	59	43
Children under 5 fully vaccinated (%)	14	2



Figure 1 Map of Nigeria (NDHS 2003)

To narrow down to specific study sites within Kano and Zamfara States, dRPC conducted mapping exercises in Kano and Zamfara to identify a selection of communities that could better represent the wider North West region of Nigeria. Six local government areas (LGAs) were selected according to rural and urban residence. Two communities within each LGA were selected according to whether they had a history of FP services or not (**Table 2**). See **Figures 2** and **3** for the specific locations of LGAs within the Kano and Zamfara States, respectively (NBS 2007).

Table 3 Summary of study site characteristics

State	LGA	Description	Intervention	Non-Intervention
Kano	Minjibir	Rural with remote communities	Kunya	Agarandawa
Kano	Kura	Rural with several peri-urban wards	Kurunsumau	Dinka
Kano	Fagge	Urban with major markets and transport for all of Nigeria	Fagge Central	Yanmata Gabas
Kano	Gwale	Urban with prominent educational institutions	Dorayi	Sabon Gida Jaen
Zamfara	Zurmi	Rural border with Niger and few peri-urban locations	Unguwa Sarki or Zurmi Town	Gurbin Bore
Zamfara	Gusau	Urban with several rural locations	Tudun Wada	Wonaka

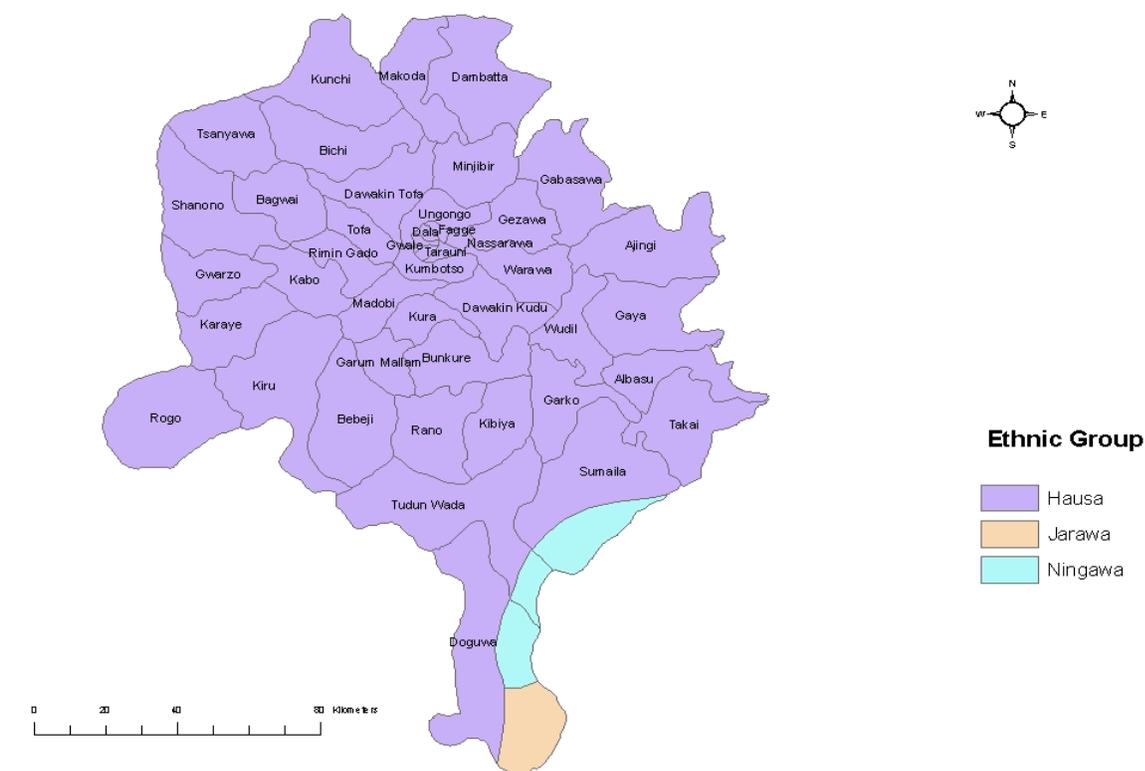


Figure 2 Ethnic Group Map of Kano State by Local Government Area (NBS, 2007)

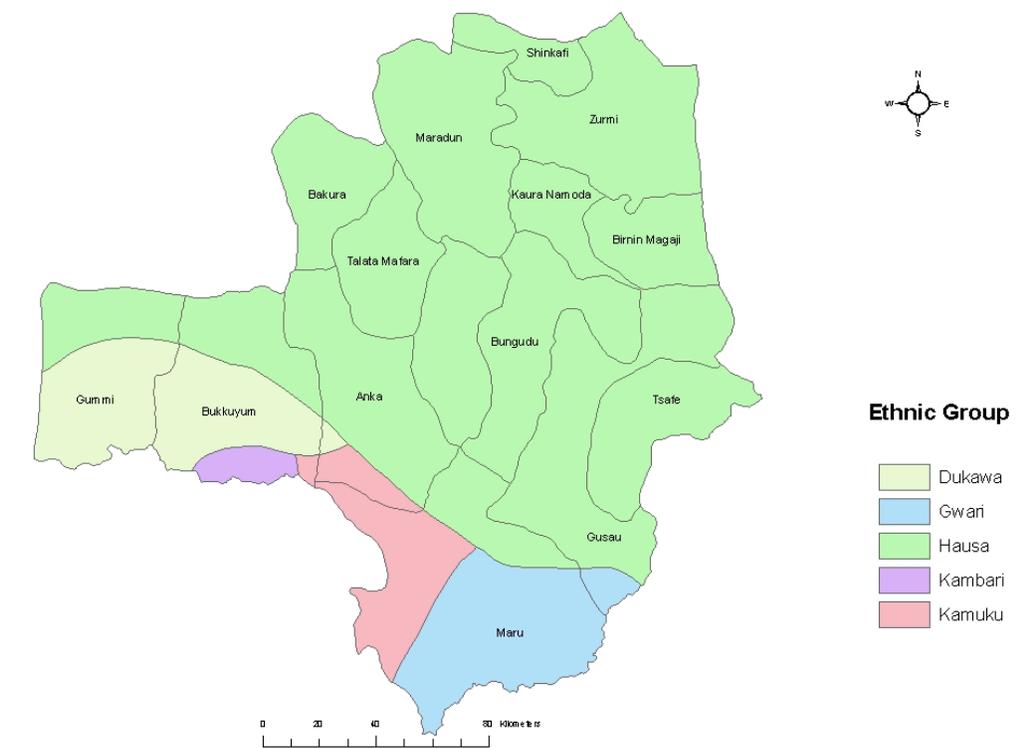


Figure 3 Ethnic Group Map of Zamfara State by Local Government Areas (NBS, 2007)

E. Study Participants

Rationales for focusing on young married women and men (ages 15-30) were the following: (1) We wanted to avoid the sensitivity of studying the unmarried in North West Nigeria and thus focused on the married. (2) We wanted to see if changes were occurring among young people who were starting their families so we limited ourselves to those 15-30 years of age. The lower limit reflects the low median age of marriage for women in these states: age 14. The upper limit takes into account the fact that men marry later than women and are typically older than their wives. (3) Since this tends to be a male-dominated society, we felt that it was essential to include men as well as women. (4) Although we wanted to study both young men and young women, we thought it might be too challenging to interview couples either separately or together. So we do not have a sample of couples.

While this study is focused on young married people, adult community members and key stakeholders in the field of reproductive health were also included to provide a wider, contextual understanding of young married people’s attitudes towards child spacing and FP.

Study participants were purposefully selected according to these criteria:

- **Young married men and women:** ages 15-30 years
- **Community members:** adult residents of the area in which PLA was implemented, including influential adults such as parents, in-laws, and teachers
- **Key stakeholders:** adult FP/RH service providers, religious leaders and scholars, teachers of Islamiya schools, traditional barbers, and TBAs

The process of recruiting participants into the study was based on practices that have been tested and found effective in previous PLA studies in the Northern Nigeria research environment. The process was a

formal one which entailed securing permission to recruit participants for the study from both the modern (the Ministry of Health and the Ministry of Local Government) and traditional authority structures of the research sites.

The grounds of requesting permission were laid when key stakeholders from both the modern and traditional authority structures were sensitized to the research objectives during the stakeholder workshop. This was later followed up when they were asked to lend their support to the formal letters requesting permission. Once permission was obtained, both the local government and traditional authority structures were asked to provide a representative to accompany the research team into the field. The representatives' presence facilitated community acceptance and assisted the research team to identify and recruit specified numbers of sample populations of young married men and women, community members and key stakeholders.

Together with representatives, the research teams first mapped designated sites to identify locations where the sample populations could be found and arrangements were made for PLAs, FGDs, and IDIs to be conducted. In some cases, it was necessary to verify ages and marital status with the representatives before participants could be included in the research. In most cases, houses of the traditional leader in the community were used as the site for PLAs and key stakeholder interviews, while interviews were conducted within houses of the TBAs and in health facilities of the providers. Interviews with male community and PLAs with married male participants were held in open air locations such as markets and in schools late in the evenings. In all cases, participants were taken through the informed consent protocol by the researchers in the local language in order to obtain their permission before any research instrument was administered.

II. RESEARCH METHODS

A. Data Collection Methods

Participatory Learning and Action: Participatory Learning and Action (PLA), an approach that uses interactive visual aides to facilitate group discussions, was used to generate discussion on study topics with young married men and young married women. Researchers used at least three different types of PLA exercises with young married people in each community. These exercises include Community Mapping, My Family, Story Telling, and My Universe with young married people:

- **Community Mapping:** study participants work as a group to draw a map of their community, showing the different places that are important to them. This tool helps participants to reflect on community-related factors that affect sexual and reproductive health, including access to health services.
- **My Family:** study participants draw a family portrait on flipchart paper. This tool helps participants identify how family members can help or hinder individual members have good sexual and reproductive health.
- **Story Telling:** study participants are given a scenario, such as “kwanika” (pregnancy occurring while breastfeeding), and are asked to tell a story surrounding that scenario. This tool helps participants to identify causes leading up to the scenario (i.e. why does “kwanika” happen?) or discuss consequences as a result of that scenario (i.e. what happens to the mother and child if she has “kwanika”?)
- **My Universe:** study participants are given colored paper cut out in different shapes and sizes. The participant places his or herself at the centre of the universe and arranges the colored shapes

around his or herself to represent the different important people in his or her life. This tool helps the participant to identify important people in their lives, to think about the relationships they have with them, and to think about how these people affect their decision-making in relation to child spacing and FP.

Thirty-five PLA activities were conducted in Kano and Zamfara: 19 with young married men and 16 with young married women. Each PLA session, involving at least 3 different PLA activities, lasted from 45 minutes to 1 hour and 30 minutes. Approximately 8-12 young married people were involved in each PLA activity.

In-Depth Interviews: Researchers conducted 43 one-on-one in-depth interviews (IDI) with key stakeholders such as TBAs (11), traditional barbers (4), local imams (11), religious scholars (2), community leaders (2), Islamiya teachers (4) and health care providers (9). The in-depth interviews were typically conducted privately at the respondent's home and lasted from 45 minutes to 1 hour and 30 minutes

Focus Group Discussions: Researchers conducted same-sex focus group discussions with adult male and female community members. The focus groups typically had at least eight participants and were held at the community leader's home and lasted approximately one hour. There were 20 focus group discussions: 12 with female community members and 8 with male community members.

B. Informed Consent and Data Collection Procedures

Data collectors were trained on the principles of research ethics using FHI's "Research Ethics Training Curriculum for Community Representatives." Data collectors obtained verbal informed consent to ensure that participants understood the risks and benefits to joining in the research study.

Data collection in Kano and Zamfara took place from March 19 – April 6, 2007. There were six research teams in total: two female and two male teams in Kano and one female and one male team in Zamfara. Each team consisted of three people: one person was the facilitator who led the community members through PLA exercises and interviewed respondents using the approved in-depth interview and focus group discussion guides; one person was the note-taker who documented the PLA exercises and interviews; and one person was the observer who aided the facilitator and note-taker as needed.

C. Data Management

Interviews (in-depth interviews and focus groups) were taped, transcribed and translated from Hausa into English. Text data from the interviews were coded using NVivo 7.0.

D. Data Analysis

An iterative process of reading, coding, displaying, and reducing the data was used to analyze the qualitative data. All transcripts were read initially for content (topics that did or did not appear), quality (how well the questions were asked, how deep were the responses), and patterns (emerging themes, contradictions, and gaps). Following the initial read, the technical monitor (Tsui) developed a coding tree to capture major concepts and its nuances found in the text. These codes were then applied to the text through NVivo 7.0. After coding, the technical monitor re-read the coded text to write detailed memos discussing the context, emerging themes, contradictions and questions raised. Finally, the technical monitor generated matrices to look for larger cross-cutting themes across state (Kano vs. Zamfara), residence (urban vs. rural), gender (male vs. female), and degree of community exposure to FP programs (FP services vs. no services).

E. Study Limitations

There were several significant study limitations. First, this study was conducted during the run-up to the general elections and many study participants were reluctant to cooperate (speak freely), suspecting researchers of being politicians. Although researchers approached study participants with a community-broker, such as a Local Government Area representative or a traditional leader, researchers had to spend a substantial amount of time going through the informed consent process in order to convince and assure potential study participants about the study objectives.

Second, we were unable to draw strong comparisons from the different study groups, such as Kano versus Zamfara, urban versus rural areas, and intervention versus non-intervention areas, in part because of the study design. The qualitative study design involved a purposeful selection of study participants which yielded rich qualitative data. And data saturation was reached among these study participants. However, due to the small sample sizes of each study group, we did not find a diverse range of responses in which to compare the different study groups.

Third, comparisons across study sites were also difficult because some of the research questions were not systematically asked, probed, or answered. This was because the researchers found the study instruments to have too many questions during data collection at the first study sites, and there was confusion on which questions to prioritize. Due to the limited budget, researchers were not able to repeat data collection in the first sites completed.

Fourth, many of the PLA and FGD transcripts were summarized and did not indicate individual respondents (e.g., respondent A, respondent B, etc.), making it difficult to quantify frequency of responses and to make empirical comparisons. Data was summarized at the field level because researchers did not have cassettes to record the interviews as a result of delayed disbursement of funding to dRPC. For this reason, this report describes frequency of responses qualitatively: “few” refers to two similar responses; “several” refers to three to four similar responses; “some” refers to five to ten similar responses; and “many” refers to more than ten similar responses.

Finally, this qualitative study was conducted among a purposeful selection of Local Government Areas within Kano and Zamfara States. Readers are cautioned about generalizing the study findings to all of Northern Nigeria.

III. FINDINGS

A. Fertility Norms

Definitions of family sizes

Wide variation on perception of family size: Young married men and women and community members were asked to define a “large,” “medium,” and “small” family size (**Table 4**). The data indicate that their definitions varied widely across study sites. In general, rural men’s perceptions of “large”, “medium”, and “small” family in both Kano and Zamfara were larger than urban men’s perception of “large”, “medium”, and “small” family. Unlike men, women from rural and urban areas shared similar notions of “large”, “medium”, and “small” families. No differences were found between respondents living in areas that have and do not have FP programs. Finally, the data suggest that definitions of family sizes varied between men and women. In general, women’s notions of a “large” and “medium” family were smaller than men’s notion of a “large” and “medium” family. Both men and women shared a similar understanding of a “small” family size.

Table 4 Summary of large, medium, and small family sizes by study sites and sex

Study Sites (+ exposure to FP program; - no exposure to FP program; U- urban; R- rural)	Male			Female		
	Large	Medium	Small	Large	Medium	Small
Kano State						
Kunya, Minjibir (+, R)	40	10-20	2-7	12-15	NA	NA
Agarandawa, Minjibir (-, R)	12-13	5-9	1-3	7-10	4-5	3-4
Kurunsumau, Kura (+, R)	6-40	NA	3	7-10	4-5	2-3
Dinka, Kura (-, R)	15-30	10-12	1-15	NA	NA	NA.
Fagge Central, Fagge (+, U)	20	5-15	2-5	8-12	1-2	0-1
Yanmata Gabas, Fagge (-, U)	10-20	2-3	0	12-20	4-6	3-4
Dorayi, Gwale (+,U)	20	10	2-4	12-15	6-10	2-4
Sabon Gida Jaen, Gwale (-, U)	NA	NA.	NA	15-20	10-12	3-4
Kunya, Minjibir (+, R)	40	10-20	2-7	12-15	NA	NA
Zamfara State						
Unguwa Sarki/ Zurmi Town, Zurmi (+,R)	30-35	15-18	2-10	20-30	13-14	2
Gurbin Bore, Zurmi (-, R)	NA	NA	NA	20-30	15	10
Tundun Wada, Gusau (+, U)	NA	NA	NA	NA	NA	NA
Wonaka, Gusau (-, U)	20-30	10-15	5-10	20-30	13-14	2+

* NA = Not Available; questions defining “large”, “medium”, and “small” family size were not asked, probed, or answered.

Ideal family sizes

Young married people’s ideal family sizes are listed in **Table 5**. In general, respondents living in areas with exposure to FP programs had smaller ideal family sizes than respondents living in areas without exposure to a FP program. In general, men reported larger ideal family sizes than women. Patterns of differences between respondents living in rural and urban areas were more complex: men shared similar ideal family sizes across rural and urban areas, but women from rural areas reported larger ideal family sizes than women from urban areas. In general, respondents from Zamfara had larger ideal family sizes than those from Kano.

Table 5 Summary of ideal family size by study sites and sex

Study Sites (+ exposure to FP program; - no exposure to FP program; U – urban; R – rural)	Male	Female
Kano State		
Kunya, Minjibir (+, R)	10-11	4-5
Agarandawa, Minjibir (-, R)	20	4-13
Kurunsumau, Kura (+, R)	2-3	2-20
Dinka, Kura (-, R)	14	3-10
Fagge Central, Fagge (+, U)	5-10	3-10
Yanmata Gabas, Fagge (-, U)	15-20	No ideal family size

Dorayi, Gwale (+,U)	No data	5-6
Sabon Gida Jaen, Gwale (-, U)	3-20	4-13
Zamfara State		
Unguwa Sarki/ Zurmi Town, Zurmi (+, R)	3-50	20
Gurbin Bore, Zurmi (-, R)	15-17	12-13
Tundun Wada, Gusau (+, U)	4-14	6
Wonaka, Gusau (-, U)	20-30	4-12

* “No data” means the question on ideal family size was not asked, probed, or answered.

Questioning the concept of “ideal family size”

Several young married people and many community members (including TBAs and traditional barbers) felt that there was no such thing as an ideal family size. Many of these respondents were hesitant to specify a particular family size because they believed family size, the number of children per family and the number of wives in a family, was ordained by God. A TBA explained, “The ideal family size, well, this is only known to God. Who, apart from God, no one else can say this is the ideal family size.” (K1R2_TBA)⁴ Other respondents felt that family size did not matter as long as children were spaced so there would not be any problems with the mother or child. A young married woman from urban Kano said, “Honestly, I haven’t decided on having an exact number of children because if there is spacing between each birth I give, then there will be no problem.” (K4U1_YMW)

Advantages of a large family

Young married men and women identified many advantages to having a large family, including:

- children are a source of security for parents in their old age
- children can assist with farming in rural, agricultural communities
- sons can represent the father in different roles
- a large family is respected in the community
- having many children helps a co-wife in the competition for inheritance
- young married people are compelled by their faith to have many children
- Caveat: parents must be able to support their children

Children are a source of security for parents in their old age: The foremost advantage to having a large family is that children provide a safety net for parents in their old age. A young married woman from rural Kano said, “I want to have many children because in the future, they will look after me.” (K1R1_YMW) Many young married women emphasized the importance of having many children because it is not known which child will eventually benefit the parent. For example, a female community member from urban Kano explained, “If you have ten children or twenty, each one will be different. Even if it is just one child that God gives you, you can get one that will take care of you. If it is ten children, among them you will find different personalities where one will be said to take after his father and another will take after the mother and so on. One will take you to Mecca; another will build you a house. You just put up your feet and rest. If you have many children, if one does not take care of you, another will.” (K3U2_FC)

⁴ This is an archival name used to protect the identity of the respondent and to manage qualitative transcripts. “K1R2” refers to the location of the respondent interviewed and “TBA” refers to the respondent category, i.e. Traditional Birth Attendant.

Children can assist with farming in rural, agricultural communities and by representing the father:

Another benefit to having a large family is that children can provide labor. In rural agricultural communities, many young married men felt children could assist the family in farming and provide free labor. A young married man from rural Kano explained, “When you don’t have a large family, you will have to pay for labor. If you have them [children] in abundance, [then] they will have a big job in no time and you don’t have to pay for labor from outside. They can even help others.” (K1R1_YMM) Similarly, in both rural and urban areas, male community members felt that their male children could represent the father on occasions. A male community leader from rural Kano said, “A man with a large family would find this useful during [the] farming season. They will assist in work at home when he’s not around. Also, he could be represented by any of his sons during occasions.” (K1R2_MCL)

A large family is respected in the community: In addition to the practical aspects of having many children, young married people identified cultural and religious reasons for having a large family. Some young married men felt they would have the respect of the community if they had a large family. A young married man said, “I even want my children to reach about forty in number. I want to see that in this community, I am the one with the highest number of children... The main reason why I want to have many children is because whomever God has given many children then that person is the wealthiest person in the world.” (K2R2_YMM) A male community member explained it was part of the Hausa culture to respect a large family whose members are known throughout the community. He said, “A person with a large family is given great respect in the community, and every member of the community would know his children because they are from a large family.” (K3U1_MC)

Inheritance competition by co-wives: Inheritance competition among co-wives, particularly with the ideal of having many sons, is a reason why some women bear many children. A matron from urban Kano explained, “You know our people sometimes they prefer to see their children scattered around them in every corner, more especially if your husband has another wife, then there will be competition because of inheritance. That is all – people are reaching for more, especially if there is another wife. But if she is the only one, she will not bother herself.” (K4U1_FHP) Having many children, especially many sons, in order to better compete for inheritance was mainly expressed by older women, such as female community members and TBAs. It is unclear whether this cultural reason is a motivating factor for today’s young married women to have many children.

Young married people are encouraged by their faith to have many children: Finally, many young married men and women felt compelled to have many children as part of practicing religion and being a “good believer” of Islam. A male community member said, “The Prophet (SAW) said he will be proud of the number of his followers on the Day of Judgment. So why would we not want to have a large family? We follow our religion, not our culture.” (Z5R2_MC) Similarly, a matron said, “Religiously, you know that the Prophet said that we should give birth to as many children so that he will be proud of us in the hereafter. That is what our women capitalize on.” (K4U1_FHP) Many of the respondents referenced an injunction by Prophet Mohammed (SAW⁵), which directed believers to marry and reproduce to make the Prophet proud of them. “O ye who believe, marry to reproduce so that I will be proud of you in the Day of Judgment.” (K4U1_RS) Some respondents explained that it was important to follow the injunction in order to increase the number of believers in Islam. For example, “Religiously it is very important to have many children so that Islam will have many followers.” (K4U1_FC)

Caveat: Parents must be able to support their children: While many young married people felt compelled by faith to have a large family, some respondents emphasized the importance of being able to take care of the family. They felt that children should be “well behaved” and “properly trained” in order

⁵ SAW: acronym for Arabic "Salla Allahu alaihi Wa Sallam". It means "peace be upon him", but it is used when referring to the Prophet.

to truly contribute to Islam. For example, a male community member from urban Kano said, “One said Islam said we should produce as many children as we can (saying of the Prophet). But we should remember that there is a condition for producing those children. We should be able to give them quality education and take good care of them.” (K3U1_MC) Similarly, a male community member from rural Zamfara explained, “Religiously, it is stated that we should marry and produce children as much as possible. On the other hand, it is also religiously stated if you cannot take care of all their responsibilities, you need to have as small a family as possible.” (Z6U2_MC)

Disadvantages of a large family

Young married men and women identified three major disadvantages of having a large family:

- financial hardship in raising many children
- difficulty in giving a good moral upbringing to many children
- physical difficulty in raising many children.

Financial hardship in raising many children: The majority of young married people felt that financial hardship was the key disadvantage to having a large family. Many respondents felt that they did not have adequate financial resources to provide many children with education, health care, clothing, and food. A matron from urban Kano explained, “To say the truth, family size is very important due to the situation we are in now. If you say you are going to have [a] large family, you are going to suffer. Everything is costly now--- not like before... So you have to plan your family and take the size you can afford, not the heavy size that you cannot manage.” (K4U1_FHP)

Many respondents in Kano emphasized the cost of education as a major financial burden. For example, a male community member from rural Kano said, “Even though [a] large family has its advantages, it has lots of disadvantages, especially if you want to bring them up properly with good education, Islamic and Western education.” (K2R2_MC) Similarly, another respondent from urban Kano said, “Even education is costs something. If you say you are going to enroll your children in a government school, you will not get what you want. If you say you are going to enroll them into private school, you have to pay fifteen thousand in some schools per term and that is even the cheaper one.” (K4U1_FHP)

Some of the young married men and women said they preferred to have few children in order to adequately provide for the children. A young married man from rural Kano explained using an analogy of raising cattle: “The way the person with four children will train his children will definitely differ from me that have ten children. This is very obvious. The man that rears just three cattle cannot be compared to the one that rears a whole lot of cattle. The one with few cattle will have well-fed cattle than the one with many cattle. It is difficult to cater for a large family. It is not that we are against it.” (K1R1_YMM)

Difficulty in giving a good moral upbringing to many children: Besides financial hardship, many young married men were concerned about the father’s capacity to discipline and give a good moral upbringing if there are many children in the household. Children from a large household are at risk of becoming social delinquents because they lacked sufficient supervision from their father. For example, a male community member said, “The father’s ability to bring up the children to become responsible citizens able to practice their religion would guide the children to become responsible adults. If, however, children are left to roam about, it will be difficult to instill discipline in them. Such children often succumb to bad influence from friends.” (K1R1_MC) Similarly, a male health care provider said, “Such children, if they are many, will become thugs and the females may become [a] social nuisance. Even the parents will lose respect for the family since the children cannot cater for them.” (K2R1_MHP)

Several young married men disagreed that a father could not give a good moral upbringing if he has many children. These respondents felt that a child’s moral outcome ultimately depended on God’s will. For

example, a young married man said, “In terms of moral upbringing, it has a lot to do with the parents, but the ultimate is with God. He (God) only guides whoever He wants. I don’t believe it is right for you to say because you have a large family, you won’t be able to take care of them because you can only do your best. You can spend a lifetime training your children but it is only when God permits that they grow up with good morality.” (K1R1_YMM)

Physical difficulty of raising many children: Several young married women mentioned the physical difficulty in raising many children and running a large household. They said a woman would not be able to be calm or maintain herself, especially if she takes care of the household without her husband’s support. A young married woman said, “When you have too many children, you won’t get enough for yourself and you’ll always be reprimanding. There’ll be too much fighting. Don’t do this, leave that, this one beats that one, you’ll never be calm.” (K1R1_YMW) Another young married woman expressed similar sentiments, “Honestly, if you have many children, you will befall with different problems – some husbands care for their family while some don’t. So if you are the type whose husband is careless about his family, this will make you not like to have children. If you have many children and your husband is not helping you, this will be a real problem to you. Honestly, it is hardship that makes people not like having children because if a woman has many children and she is the one responsible feeding and clothing, then definitely she will not like to have many children – she will feel that few children are enough for her. Although it is God that gives you the children, you will be thinking about different things which are making you not like having children.” (K2R2_YMW)

Advantages of a medium-sized family

Young married men and women identified very similar advantages of having a medium-sized family to advantages of having a large family. For example, children can provide for elderly parents and children can assist the family with the farm or represent the father on family business. A distinctive advantage to having a medium family as compared to a large family is that the family size is more manageable.

Manageable family size: The majority of young married men and women felt a medium-sized family was advantageous because parents could adequately provide for the children without going beyond their means. “A person will not have difficulty in managing them [the children]. He and his family will both live comfortably.” (Z5R1_MHP) A young married man from urban Kano explained further, “They would not have the problem of feeding, they would have good food, provide good health and shelter unlike if one has 30 children, and the children will have [a] good upbringing.” (K3U1_YMM)

Disadvantages of a medium-sized family

Not enough children to assist family: According to the young married men and women, the only disadvantage associated with a medium family size is that there may not be enough children to assist the family. For example, a trader may not have enough sons to represent his business, or a farmer may not have enough children to help him with the farm. “If a family is not large, it brings about some problems. [For] example in the case of traders, if a person cannot go to his shop due to some circumstances, if his children are not many, [then] he may not be able to get someone that will represent him. So this is a problem. Also, if a person happens to be a farmer, he will not have children who will help him with his farm work.” (K3U1_FHP)

Advantages of a small family

Small family is very easy to manage: The major advantage to having a small family is that the parents will find it “very easy” to take care of the children and the household. Many respondents, such as young married people and community members, felt that parents could be at ease knowing that they were

financially able to raise a small family. A male community member from rural Zamfara said, “Their advantage is they are not beyond your [financial] control. You will not have much problem. Whatever you get will be sufficient for them. You will be able to satisfy all their needs like training, educating, feeding, clothing – without much difficulty to you and them.” (Z5R2_MC) Similarly, a female Islamiya teacher from urban Kano said, “A small family size will be easier to manage and train. He [the father] will enjoy taking care of the family.” (K4U1_FIT) Notably, a religious leader from Kano felt that a small family was advantageous because the parents could be accountable to the children’s upbringing in accordance to the Islamic faith. He said, “In my view, this is one of the reasons why people should have a small family size which they can manage within their income, looking after the health and the moral upbringing of the children. We are responsible for the good upbringing of our children and we will be asked to account for this in the hereafter.” (K2R1_RL)

Disadvantages of a small family

Young married men and women noted two disadvantages in having a small family:

- there are few children to take care of parents in old age
- the uncertainty of child survival

Few children to take care of parents in old age: According to young married men and women, having few children to take care of parents in old age is the key disadvantage of having a small family. “The disadvantage of having a small family is that the man will not have children to assist him in his day-to-day activities because the family members are few.” (K3U1_FHP) Many respondents felt that having a large family could ensure some of the many children would take care of parents in old age. For example, a male community member from rural Zamfara said, “If you have a small family, there is the danger that they will turn out to be bad. But if there are many of them, if one does not take care of you or help you, another will. But if your family is small and they are all bad, it is a big problem.” (Z5R2_MC)

Uncertainty of child survival: Another disadvantage associated with having a small family is the uncertainty of child survival. Young married men and women felt that they might risk losing all of their children by having a small family. A young married man spoke about his friend who regretted having a small family because two of his three children died, “There is a friend of mine. He had only three children – two boys and a girl. Now all the boys are dead. It now remains only the girl and he is now regretting about deciding to have only three children.” (K2R1_YMM)

This concern with child survival was expressed mainly by respondents living in rural areas where there is higher infant mortality and/or incidence of disease outbreaks. For instance, a young married woman spoke about her experience of high infant mortality: “We don’t have many children here. You keep giving birth but the children do not survive. This is a village. If you say that is the way you feel [about family size], you will be called an ignorant woman here. We do not have many children here. They die. They die a lot. They die a day or two after birth. A woman can give birth to over ten but will lose about seven. I have ten but only three are alive now.” (K1R2_YMW) A male health care provider from rural Zamfara explained, “The disadvantage of a small family is that in case of something like an outbreak of disease, they may all die, but if they are many, there will be some that will remain.” (Z5R2_MHP)

B. Attitudes toward Family Planning

Young married men and women shared varying attitudes toward FP. In general, young married men and women held a positive attitude toward FP because they understood it to be child spacing. They believed child spacing was beneficial for maternal and child health. However, there were also young married men and women and many community members who felt FP was unacceptable. Some felt that FP practice

challenged God's will for one's life. Others understood FP to be limiting, which was against Islam. And for some, it was perceived as a Western policy for population control of Muslims and/or Africans.

Family planning facilitates child spacing

The majority of young married men and women and community members held a positive attitude toward FP because they said it would facilitate child spacing. For example, a young married man from urban Zamfara defined FP as “methods which make people arrange their family set up and provide a space between each birth.” (Z6U1_YMM) Similarly, a male community member from rural Kano said, “[Modern contraception] is not to stop giving birth but to facilitate spacing of children, that's what it means.” (K1R2_MC) These respondents gave the following reasons why FP and/or child spacing were acceptable:

- spacing is permitted under Islam
- spacing benefits maternal and child health
- spacing helps avoid economic hardship
- spacing allows parents to pay attention to children's moral development.

Spacing is permitted under Islam: The majority of respondents, including all of the religious leaders and scholars interviewed, believed that child spacing was acceptable under Islam when the intention is to protect the health of the mother and child. A male community member from urban Kano explained why child spacing is permitted under Islam. He said, “Islam is a simple religion. Islam teaches us to take good care of our family.” (K3U2_MC) Unlike child limitation, respondents said child spacing was the “most viable” option to allowing the mother a chance to rest and the child to grow strong and healthy before another child “without crossing the boundaries of religion.” (K3U1_YMM)

Spacing benefits maternal and child health: The foremost reason why young married men and women valued child spacing was because they believed it was beneficial for maternal and child health. Child spacing was beneficial to a mother's health by giving a woman time to rest between pregnancies. It was beneficial to child's health by allowing a child to grow up “strong and healthy” – to breastfeed fully – before another infant comes along.

Notably, respondents discussed the benefits of spacing for maternal and child health in terms of the concept of “**kwanika**” – a situation whereby a breastfeeding woman becomes pregnant. Many young married men expressed “pity” for a woman experiencing “kwanika” because she would not be able to care for herself and the baby, nor would she be able to manage her household activities. (K2R1_YMM; K1R2_YMM; K4U1_YMM) Similarly, some young married women felt a woman with “kwanika” would be the subject of gossip in her community since she would not be able to keep up with herself and her children. (K3U1_YMW) A young married woman explained, “When you have too many children, you won't get enough for yourself. You'll always be reprimanding. There'll be too much fighting. Don't do this, leave that, this one beat that one, you will never be calm. You see a situation like that warrants a woman to space so that she will stop giving birth consecutively.” (K1R1_YMW)

Many of the respondents believed a child's health is negatively impacted if his/her mother has “kwanika”. Some young married men believed children born too closely together would not be well-looked-after by their mother. A young married man said of children who were not spaced “are looking pale and surely this is nothing other than starvation.” (K2R1_YMM) Similarly, another young married man said, “You know socially, it is a pity to see a young child who cannot even sit to have a younger sister or brother. The older baby would definitely not be adequately taken care of.” (K4U1_YMM)

Also, some young married women believed that the breast milk of a pregnant woman contains “infection” and can cause sickness in the suckling infant. Therefore, it was important to completely wean a child

before a woman becomes pregnant. A young married woman described, “Why you go for child spacing is because of the child. You have a child of four months old and then become pregnant. When you become pregnant, then your child will be sick even if you take him to the hospital for medication. God will protect him but he will lose weight because of the breast milk. He sucks infection from the breast. That is why we want to be given injection for FP so that you wean your child before God gives you another one.” (K3U1_YMW)

Spacing helps avoid economic hardship: Many young married people and community members felt that spacing was beneficial to avoid economic hardship. According to these respondents, spacing was acceptable to prevent “frequent” or “consecutive” births in order for the family to live within their financial means. For example, a young married man said, “It is better to space between each birth because it will be comfortable for both the husband and wife. If you have less income and your wife happens to be giving birth very frequently, you will start complaining of hardships.” (K2R1_YMM) Community members also expressed similar sentiments. A female community member from rural Kano said, “It is acceptable for a woman to do it [child spacing] if she is not well-off – if she gives birth continuously and sees that she is poor and the children are getting too many for her to handle.” (K1R2_FC)

Notably, respondents from both Kano and Zamfara spoke about child spacing as a necessity given the country’s poor economic circumstances. In urban Zamfara, a male community member said, “Economy is the backbone of my reason why I decided to start practicing FP method because the little I am getting now cannot enable to feed, dress, and educate many children.” (Z6U2_MC) Similarly, a female health care provider observed that poor economic circumstances are leading people to practice child spacing. She said, “With us in Zamfara State, we believe that child spacing is very good. We can see that our own women come here everyday to seek child spacing services. What can I say about what is responsible for these changes? The answer for me is the economy of the country. It is going down so everyone wants to space the children. If you are not wealthy, it may be difficult to provide for your children in terms of food, education, and hospital care.” (Z6U1_FHP) Respondents in Kano also expressed similar sentiments that child spacing is a necessity in today’s poor economic circumstances. For example, a religious leader from rural Kano explained why people in his community practiced child spacing, “because of the standard of living, presently people with no good economic power or income and with family will not find things easy. If you don’t have money, you can’t send your children to school.” (K1R1_RL)

Spacing allows parents to pay attention to children’s moral development: Islamiya teachers and religious leaders valued child spacing because it allows parents time to pay attention to their children’s moral upbringing. For example, a religious leader felt that a three-year spacing interval would allow a child to receive “proper care” and “good moral upbringing,” resulting in a “well-nurtured child.” (K2R1_RL)

Family planning challenges God’s will

Some young married men and women felt they could not practice FP because it was challenging or interfering with God’s will in their lives. Male community members from urban Kano described one who practices FP as “one who has his own ideology”, “religiously that person is challenging the will of God,” and “the concern here is like running away from what God [has] ordained”. (K3U1_MC; K3U2_MC) Young married people explained why they thought FP challenged God’s will, saying:

- children are given by God
- one should have faith in God despite economic hardship

Children are given by God: Just as Section 2.1.2 highlighted how many young married people felt compelled by faith to have many children, many respondents believed that it was unacceptable to practice FP because children are given by God. “For children you cannot plan. It is from God so it all depends on how many children God gives you. Nobody gives children except God and nobody can deny somebody except [for] Allah. So in terms of children, it only depends on what God gives you.” (K2R2_MCL) Many young married women also felt they could not use FP to space their children because the time to rest from child birth can only be determined by God. “Under no circumstances should a woman use FP methods. When God destines for her to rest, then she will. When God wills it, it will be as if it rained and it suddenly stopped.... In a situation where a woman needs to rest, you just pray to God.” (K2R2_FC) A young married woman described FP use akin to “playing tricks on God” and added “surely that can never be possible.” (K2R1_YMW)

One should have faith in God despite economic hardship: Some young married respondents felt it was unacceptable to use FP to avoid poverty. These respondents regarded economic hardship as a “test of faith.” They believed that one should trust in God who will provide for His creation. For example, a young married man from rural Kano said, “Even in the face of difficulty, we must resist such advice [to use FP] because Almighty God who gave me will also provide the solution to my problem and even send someone to help me.” (K1R1_YMM) Several religious leaders also discouraged FP when the intention was to avoid economic hardship. A religious leader from urban Kano said, “We view or look at FP as not to produce more children in order to avoid the problem associated with having many children. And in most cases, in our communities when someone is practicing FP, we said that person is ‘dan-boko’ (Western educated), because he doesn’t want to have many children. He wants his salary or income to tally with the few numbers of children he would have.” The religious leader continued, “God says in the Quran ‘don’t kill your children because you are afraid of poverty’... Don’t do that [FP or abortion]. He that gives you the children would provide them with what to eat. Killing these children is a great mistake said Allah (SWT).” (K3U2_RL)

Limiting family size is against Islam

Some young married men viewed FP to be family limitation – for one to stop giving birth in order to reach a particular family size. A young married man described, “Limiting is actually saying to yourself that this is the amount of children that you are going to have”. (K3U1_YMM) Respondents believed limiting was unacceptable because:

- Islam does not condone limiting
- limiting family size is a subversive Western policy to control Muslim and/or black populations
- Islamic leaders tend to disapprove of FP

Islam does not condone limiting: Many respondents said limiting was an unacceptable practice under Islam because one should not decide an exact family size for him/herself. For example, a female Islamiya teacher explained, “FP means deciding on having an exact number of children and Islam doesn’t allow one to decide on having an exact number of children.” (K2R1_FIT) Similarly, a male health care provider from Zamfara said the community was discouraged from FP practice because religious leaders said Islam does not permit one to decide on his/her family size. “They [religious leaders] inform people that it is unlawful for a person to decide on an exact number of children because it is God that provides everything to every[one] which He has created.” (Z5R1_MHP)

Limiting family size is a subversive Western policy to control Muslim and/or black populations: Many respondents, particularly young married men, male community members, and several religious leaders, expressed mistrust in the West. They saw FP as a subversive Western policy to control the Muslim and/or black populations. For example, a male community member from rural Kano said, “When we first heard of the term FP over the radio, we saw it coming from the United States of America to

reduce the Muslim population.” (K1R2_MC) Another male community member from urban Kano said, “Many Hausa man and woman have heard of a foreign policy of the Western people to avoid us from producing more children. They have a hidden agenda.” (K3U2_MC)

Islamic leaders tend to disapprove of FP: Several respondents said religious leaders have influenced their perception of FP. A male community member from rural Kano said, “Basically, our people are suspicious of all things that come from the Western world. It is viewed with suspicion as nothing good could be expected from them towards us. When FP devices were first introduced, a large number of Islamic scholars strongly opposed it and warned people against its use. This opposition was expressed for many years and it has gained popularity with people.” The respondent continued, “Someone attended an Islamic teaching in the Emir palace where a teacher condemned the polio vaccine and linked it to FP of the West to reduce the population of black or Islamic people.” (K1R1_MC)

One of the religious leaders interviewed expressed suspicion of FP, seeing it a Western means of reducing the Muslim population. He said, “I do not like the modern methods. What is their business as white people that they do not want us to have a lot of children? They do not like Islam and anything that will increase the size of Muslims worldwide. They do not like it. They do not want to leave us alone. These are ways of declaring war on Muslims so we have to be careful about what we hear and do when it comes to child spacing and FP.” (K2R2_RL)

C. Attitudes towards Child Spacing

Ideal child spacing interval

According to young married men and women in this study, the ideal child spacing interval ranged from two to seven years. Most young married women said two to three years is the typical child spacing interval – a period of time from the start of breastfeeding to the time when the child is weaned. (K1R1_YMW, K1R2_YMW, K2R2_YMW) Many young married men and women felt that an interval of two to three years would enable a mother to have “enough rest” and the child to be “strong and healthy.” One of the respondent felt that an interval of seven years would be a long enough time for the first child to grow up and take care of the newborn infant. She said, “Because [at] that time, the child is old enough to take care of the new baby.” (K3U1_YMW)

Acceptable circumstances for child spacing practice

In general, respondents believed that it was acceptable for a young married woman to practice child spacing if she had past experiences of health problems associated with pregnancy and labor. For example, a TBA from rural Kano said, “When a woman is suffering at childbirth, this encourages her to practice child spacing.” (K2R2_TBA). Similarly, young married women felt that a husband would encourage child spacing practice if he “observes that his wife is really suffering from pregnancy or at childbirth.” (K2R1_YMW) Particularly, respondents emphasized the need for women who experience “kwanika” to practice child spacing because it negatively impacts a woman and a child’s health.

In addition, some respondents believed that child spacing practice was acceptable and a necessity if they experience economic hardship. A religious leader in rural Kano acknowledged the reality of poverty as a reason why some people have started practicing child spacing. He said, “[Child spacing] is about having some relief from the burden of childbirth, but also the suffering of everyday life. It is not strictly a religious injunction; it is the hardship that people face that gives rise in this decision in spacing children.” The religious leader continued to say that children also suffer because parents are not able to provide for them adequately (K2R2_RL)

Unacceptable circumstances for child spacing practice

In general, respondents felt that young married women should not purposefully practice child spacing if a woman has not had her first child, or if the young woman naturally spaces for two to five years. For example, one of the young married women said, “A woman who naturally gives a three year interval between each child should not use FP or any other child spacing methods.” (K2R1_YMW)

D. Communication and Decision-Making on Family Planning and Child Spacing Practices

What encourages young married people to communicate about FP and child spacing?

According to young married men and women, the following encourages them to discuss and learn about FP and child spacing:

- mass media, especially the radio
- peers
- health talks at the clinic
- health care providers

Mass media – the radio: The majority of young married men and women living in both urban and rural Kano and Zamfara said they were first exposed to FP and child spacing through the radio. Many respondents felt the radio was a key source of information reaching a wide range of people, including those not connected to a health clinic or a community organization. For example, a female community member said, “People should be enlightened through the radio about this issue because some people do not go to the hospital, but most women listen to the radio. So if this enlightenment is broadcasted through radio houses, it will reach people easily. Radio houses are the best places that this enlightenment should be aired because if it is through an organization, it may be that you are not a member of any organization. And if it is through friends, you may not have time to discuss this issue with your friends. Therefore, [the] radio is the best medium of reaching young married men and women with FP.” (K4U1_FC) Respondents felt the radio was especially important to reaching people who live in remote communities without a health facility. A male community leader from rural Kan said, “Young couples access information about FP and child spacing only through [the] radio because there are not hospitals.” (K1R2_MCL)

In urban Kano, young married men identified B.B.C World Service, Voice of America, and Radio Kano as radio programs airing discussions on FP. (K3U2_YMM) Respondents said they learned about the dangers of “kwanika” on the mother and child’s health. Some respondents also learned about different FP methods and where they could be accessed. (K3U2_YMM, K3U2_MC, and K4U1_FC)

Many of the young married men and women felt FP messages from the radio were credible information and trustworthy. However, several young married men from rural Kano felt the radio dramas on FP to be unbelievable. A young married man said, “Of course we hear about this issue in the radio but mostly we don’t consider them. Sometimes dramas [are] aired in the radio in order to enlighten people on this issue, but if you listen to the drama wisely, you will not even believe what is said because they are not putting it in the proper manner.” (K2R1_YMM)

Also, some young married women and female community members felt the radio was a drawback in communicating FP messages because it did not facilitate interaction through personal dialogue, questions and answers. For example, a female community member said, “There is no place to learn about child spacing here except on the radio. Even then you can only listen, you cannot ask questions. You will just have to give up even if you want to because there is no one to guide you.” (K2R2_FC) Similarly, another female community member recommended personal dialogue in raising awareness on FP so that people will have a chance to ask questions. “The best way of communicating to young married men and women on FP is through dialogue because a person may have some questions to ask. But if it is through the radio, you cannot be able to ask any questions.” (K4U1_FC)

Peers: Peers are another major source of information and support for young married people to learn about and practice child spacing in Kano and Zamfara. According to a male community member in Zamfara, “Many young married men and women learn about FP through gatherings of friends.” (Z5R2_MC) Several young married men and women from urban Kano explained that they felt free to discuss FP with their friends because it was a “modern issue” that could only be understood by those living in the same generation. A young married man explained, “Issues like FP and child spacing would only be discussed openly with my friend and not my parents because they are too old to understand modern issues.” (K4U1_YMM) With similar sentiments, a young married woman said, “They [young married women] don’t wait. They sometimes ask their friends. [It] is not like before, they do not feel shy to ask; they do what is right. The world has changed.” (K3U2_YMW)

Many young married men said they would consult and seek advice first among male friends on the issue of FP before discussing about it with their wives. In rural Kano, some of the young married men gave examples of friends advising them to practice periodic abstinence and withdrawal as child spacing methods. (K1R2_YMM) Similarly, young married women said they would ask other women about child spacing practices when they observed that woman’s children are healthy. For example, a young married woman said, “Married woman learn about child spacing and FP through their friends. For example, sometimes a woman will see that her friend’s children are very healthy and also there is spacing between them. So she will prefer to learn from her friend about how she plans her family.” (K2R1_YMW)

In addition to being a source of information, peers are considered to be an important source of support in practicing FP and child spacing. Young married men support their peers by convincing a friend’s wife to practice FP. (K4U1_YMM) Young married women support their peers by accompanying a friend to access a FP method at the health clinic. (K2R1_YMW)

Health talks: Health talks at the clinic are another major source of information for young married women in the Kano and Zamfara study sites where they are FP services. Many young married women said they learned about FP during antenatal care visits, or when they have brought their babies in for a check-up at the clinic. Accordingly, some young married men said they learned about FP and child spacing practices through their wives who attended health talks at the clinic.

Many of the health care providers interviewed in Kano and Zamfara felt health talks were an effective, low-key way of raising awareness on FP in the context of maternal and child health. (K2R1_MHP; Z6U1_MHP; K2R1_FHP; K1R1_FHP). A female health care provider in Kano explained that in her experience, many women first learn about FP through the antenatal care visit health talks and then approach her later on to start a FP method. She said, “What we do is keep informing them [young married women] when they come for antenatal care. Before starting [a method], we tell them about the necessary diet and health care and FP. We don’t just tell them to come and start it [FP method]. We show them that it is not compulsory. Anybody that is interested knows who they give birth [to] and how many children they have, knows the interval between her children or lack of it. Later on, they call me aside and explain to me and I start them on it.” (K1R1_FHP)

Health care providers: In Kano, many young married couples directly seek advice on the issue of FP and child spacing from health care providers. “The couple usually source [look for] a solution by themselves by approaching a medical doctor for assistance on modern methods of FP.” (K1R1_MC) Several community members noted how this behavior is unlike traditional practices whereby young married people first consulted parents and elders. For example, a female community member from urban Kano said, “Things have changed now from before. In the past, young women came to our houses and told us about their situation and we gave them so many things to take. But now people are more aware.

They [couples] go to the hospital and get information and then they tell us what they were told to do.” (K3U2_FC)

Several young married people explained that it was in their best interest to consult a health care provider on FP issues because

- one must be proactive to deal with the situation of “kwanika”
- only a doctor is in the position to offer advice on modern FP methods
- confidentiality is maintained

Young married men and women felt one should be proactive in dealing with the situation of “kwanika” instead of not seeking help. A young married woman from urban Kano said, “It is not good for people to suffer in life. It is compulsory that people should look for help elsewhere and God said that we should look for help and God will assist us. It is necessary that married people should seek assistance about planning at the hospitals... In this case, if you are tired of giving birth, or need spacing, the only solution is to go to the hospital and get help, but don’t just stay at home.” (K3U2_YMW) Many respondents felt that only a doctor could give them sound advice on modern FP methods. A male community member from rural Kano said, “The doctor is in a position to advise them [young married people] regarding this ‘kwanika’ that has happened. The doctor would explain the different methods of FP, such as injection, pills, also to reduce the problem of ‘kwanika’. Only a doctor could advice on these methods of FP.” (K3U2_MC) Finally, a few young married men and women said they would consult a health care provider because the providers would maintain confidentiality on such a private matter as FP. A young married woman said, “In my own view, FP is a private matter so you shouldn’t discuss the matter with anybody, only with your husband and doctors.” (K4U1_YMW)

What discourages young married people from communicating about FP and child spacing?

Parents: In general, young married men and women expressed mixed feelings on whether they could talk about FP and child spacing with their parents and/or elders. The data suggest differences by State in whether young married men and women could communicate to their parents and elders on FP. Young married men and women from Zamfara were more likely than young married people from Kano to consult their parents and elders on FP matters. Young married people who communicated to their parents on FP and spacing believed their parents offered useful advice and life experiences on issues such as FP and spacing. For example, a young married man in rural Kano said he would consult his father on FP because “what an elder person will do is better than what a younger person does.” (K2R1_YMM)

However, the data suggest that many young married men and women, particularly those from Kano, felt that matters of FP were too “private” to be discussed with parents and elders. Many young married men and women believed FP matters could only be discussed between the husband and wife. Some respondents explained, saying that they felt too “shy” to talk about such private issues with their parents. “In Hausa culture, we are very shy and cannot talk to our parents about matrimonial issues. Intimate marital issues should only be restricted to man and wife, except when there is [a] health problem, then you should see a doctor.” (K3U1_YMM) Other respondents said parents could interfere and upset a couple’s relationship with each other. A young married woman said, “If they [parents] come in to give you such advice [on FP], [then] they can destroy the relationship between you and your husband.” (K4U1_YMW)

Further, many young married men and women felt that matters of FP were too “modern” to be discussed with parents and elders. These respondents explained that their parents came from a different generation that has not been exposed to modern FP, and they felt their parents could neither understand nor support them on FP. A young married man from urban Kano said, “It is myself alone, not my parents, because they are in their own world and it is a different world. They have very little impact with regards to my

family size and affairs.” (K3U1_YMM) Similarly, a young married woman said, “Just as she said, you can talk freely about fertility norms but child spacing and FP you cannot go to your elderly parents and talk about them. The fact is those things were not practiced during their time. They will continue saying it is modern mentality. People like your friend---you can talk to her---but not your parents.” (K4U1_YMW) Finally, a young married woman said, “Our parents are people we cannot consult on such issue because they are mostly elderly people and do not believe in such things. We are the people that take courage to do such things... that are why we don’t confront them with such issues because they will not support us.” (K4U1_YMW)

How do young married couples communicate to each other about FP and/or child spacing practice?

The following section discusses young married couples’ communication on FP and child spacing:

- who initiates communication on FP and/or child spacing?
- expectation of partner’s reaction to FP use
- “appealing” to one’s husband
- indirect communication through a mediator

Who initiates communication on FP and/or child spacing? The data show that both young married men and women initiate communication on FP and/or child spacing. However, young married women are more likely than young married men to initiate communication on FP and child spacing. Usually, a wife suggests FP use to her husband when she experiences health problems related to pregnancy, labor, or “kwanika” (frequent births). For example, a young married woman described how she would propose the idea of FP use to her husband: “If a woman keeps on delivering one child after another without any spacing, she can seek the advice and permission from her husband. She can tell him that she is tired and would like to rest.” (K4U2_YMW)

A young married man may also initiate communication on FP use if he observes that his wife is suffering. For example, a young married man said, “If a person observes that his wife is really suffering when she is pregnant or at child birth, [then] this gives him an encouragement to allow her to use FP or other child spacing methods.” (K2R1_YMM)

Expectation of partner’s reaction to FP use: Both young married men and women seemed anxious about their partner’s reaction to the suggestion of FP use. Respondents feared that their partners would feel rejected or unloved if they proposed FP use. For example, a young married man explained why a young married woman may not be willing to speak to her husband directly on FP: “She may think that he [the husband] probably thinks that she does not want to sleep with him or that she does not love him.” (K4U1_YMM) Fear of a husband’s reaction to FP use may hinder young married women’s from communicating her needs to him. “Sometimes a woman may not be able to tell her husband [her need for child spacing] when she believes he will not agree.” (K1R2_YMW)

“Appealing” to one’s husband: The majority of young married women and female community members said they communicate to their husbands in an “appealing” manner. This can be explained largely by the anxiety of the wives over anticipated responses to the suggestion of FP, or perhaps in terms of cultural expectation that women are shy. A young married woman will try to gauge her husband’s mood before broaching the issue of FP and child spacing. “When you are just spending time with him talking about everything, you just feel his mood and tell him.” (K1R2_YMW) Next, a young married woman speaks to her husband in a “kind” and “obedient” manner so to persuade him to practice FP and/or child spacing. (K2R1_YMW) Finally, a young married woman tries to get her husband to relate to her plight. “She should appeal to him in such a way that he will approve of it and will not worry about it. When she does that, he can relate to her and allow her to rest.” (K1R1_YMW)

Female respondents felt it was important to communicate to their husbands in such a way that the husband feels in control and in authority of the situation. For example, a TBA explained, “A woman should rest between deliveries if she has complications while pregnant.... However, she must consult her husband. Sometimes if he realizes how she suffers, [then] he will bring up the idea. (Smiling) She is a woman (laughter). She knows what to do to convince her husband. It is between a husband and wife.” (K1R1_TBA)

Indirect communication through a mediator: Young married men and women also communicate with each other indirectly through a mediator who is usually a family member, such as parents or older siblings. In Zamfara, several young married men said they ask their mothers to first talk with their wives so to prepare her for their discussion on FP use. (Z6U1_YMM) In Kano, young married couples relied on a family member to indirectly communicate with each other when the issue of FP and/or child spacing could not be resolved between the couple. “If the issue [of child spacing] cannot be settled among us [the couple], then we can involve other family members.” (K4U2_YMM) Similarly, another young married man explained, “Most routes followed are through the elders as they may have connection his parents, or through her parents to resolve the problem.” (K4U1_YMM) Besides parents, many young married women said they talk to their sisters in order to communicate indirectly with her husband. For example, a young married woman from urban Kano said, “In my own opinion, if I had anything to say I would prefer to talk to my elder sister because if there is any problem or if any arise, she may likely tell my husband.” (K3U1_YMW)

Who are the decision-makers in a young married couple’s decision to practice FP and/or child spacing practice?

In general, the husband has the most influence on a young married couple’s decision to practices FP and/or child spacing. There are some instances when young married men and women make a joint decision on FP and/or child spacing practice. Finally, there are a few young married men who feel their wives have the most influence on FP practice through secret use. Below, we discuss three scenarios:

- the husband is the main decision-maker
- the husband and wife make a joint decision
- the wife has the most influence through secret practice of FP

Husband is the main decision-maker on FP: The majority of young married men and women in Kano and Zamfara felt that the husband had the most influence on a couple’s decision to practice FP. Respondents explained that the husband had the most influence because he was the head of the household. Many of the young married women felt they could not do anything without their husband’s consent. A young married woman explained that her husband had the “last words.” “To tell you the truth just as she has said, you talk to your husband. If he gives you his support, then you can go. But if he does not agree, then nobody can give you the go-ahead. He has the last words.” (K3U1_YMW) Notably, young married women were required to produce evidence of their husband’s permission even in accessing FP services at the hospital. “I think even FP cannot be done without the consent of our husbands. They have to agree. Even if you go to the hospital, you have to show the hospital evidence or a letter of permission from your husband. Sometimes they ask you to come along with him [husband].” (K3U1_YMW)

Husband and wife makes joint decision on FP: Although the majority of young married men believed they were the ultimate decision-maker, several young married men from both urban and rural Kano felt it was important to make a joint decision with their wives on FP practice. A major reason why some young married men felt a husband should not take the decision alone is because it is the wife who is most affected by the need for FP. A young married man from rural Kano said, “This is my wife’s problem because she is the one [that is] affected. She is the one that suffers. The husband will even go out and

leave her with the problems of pregnancy and caring of children so she is the one that I will discuss the matter with.” (K2R2_YMM) Similarly, a young married man from urban Kano said, “It is the man who is the head of the family but that does not mean that he should take the decision alone. They [the husband and wife] should sit together and discuss the issue as a couple. They should discuss the benefits and the potential harm [of using FP]. If God [is] willing, [then] the wife is wise enough to understand easily and there would be no problem.” (K3U1_YMM)

Another reason why some young married men believed it was necessary for a couple to make a joint decision on FP was so to avoid any misunderstanding between the husband and wife. “However, there has to be mutual agreement between the two couple to take the decision. I have seen a woman who delivers after every nine months and the couple wanted to space for even a year interval. But it becomes difficult because after consulting friends who tell you not to have constant intercourse with your wife, your wife will see it as if you don’t love her. Hence, you must involve her in the decision.” (K1R1_YMM)

Wife has the most influence on FP through secret practice: Finally, some young married men believed the wife has the most influence on FP because she could practice it secretly without the knowledge of her husband. For example, a young married man said, “The woman has more influence because if she confronts her husband and he refuses it, she may be practicing it [FP] secretly. Likewise, if the husband is the one that brings the idea and the wife refuses, the man cannot force her to take the pills even if he buys the pills for her.” (K3U1_YMM)

E. Knowledge and Attitudes toward FP Practices

Here we describe the natural, traditional, and modern FP methods identified by young married men and women and community members in Kano and Zamfara. Then we discuss young married men’s and women’s attitudes towards FP methods, including perceived efficacy, perceived ease of use, perceived accessibility, and perceived cultural and religious acceptability. The methods identified by respondents:

- Natural FP/child spacing methods
 - breastfeeding
 - post-partum abstinence (goyon ciki)
 - periodic abstinence
 - withdrawal (azi)
- Traditional FP/child spacing methods
 - talisman and amulets (guru, karhu, laya)
 - rubutu
 - traditional medicine (local herbs and seeds)
 - lime, salt paste method
 - other traditional beliefs (lock-and-key method, broom)
- Modern FP/child spacing methods
 - oral contraceptive pill
 - injectables
 - male condoms

Natural Family Planning/Child Spacing Methods

Breastfeeding: The most commonly practiced child spacing method in Kano and Zamfara is the temporary infertility associated with breastfeeding. Young married women said they breastfeed for approximately one to two years before weaning the child. According to young married men and women, breastfeeding was culturally and religiously most acceptable because it was a “natural” method

specifically approved by Islam. Many of the religious leaders and scholars also agreed, citing the Quran which tells women to breastfeed their children for two full years. (K2R1_RL; K4U1_RS). **Authors' note:** Respondents lacked information on how to get the most contraceptive protection from breastfeeding and were unaware that breastfeeding is an effective method only if a woman is amenorrheic and is fully (or nearly fully breastfeeding) and that effectiveness diminishes over time. To obtain the maximum effectiveness, the Lactational Amenorrhea Method guidelines recommend starting another method 6 months after child birth.

Post-partum abstinence (goyon ciki): Another traditional approach (post-partum abstinence) is sending a breastfeeding woman back to her maternal home. A few young married men from rural Kano also mentioned “goyon ciki,” a traditional Fulani practice whereby a breastfeeding woman and her infant are sent to stay at her maternal home for one to two years. The purpose of goyon ciki is to separate the husband and wife and prevent them from having sexual intercourse during the breastfeeding period. (K1R2_YMM) A male community leader described his experience with goyon ciki: “Being a Fulani person, I practiced this during my first marriage. My wife went home and came back. When she came back she stayed for [a] good one year during the time which the child became very healthy before we had any sexual interaction.” (K2R2_MCL) The male community leader continued to say that this method would not be very practical for “modern couples” as they did not have the patience to control one’s sexual desire. “There is the issue of patience. However, our modern couples cannot practice this, hence, [there is] the issue of one having a large family.” (K2R2_MCL)

Periodic abstinence: Several young married men in Kano identified periodic abstinence as a spacing method that they had tried with their wives. Young married men described periodic abstinence as not having sex with one’s wife for several days after she has completed menstruation. These respondents varied as to the number of days of abstinence needed to avoid conception, ranging from four days to fifteen days of abstinence. According to these young married men, periodic abstinence was a very effective method if practiced correctly. However, many respondents felt it was a very difficult method to practice because it required a man to control his sexual desire. For example, a young married man explained, “This [the effectiveness of periodic abstinence] depends on how the husband can control his sexual desire. Since the womb is opened immediately after menstruation, and if the husband cannot be patient and wait after some days before he has sex with his wife, maybe because she is his only wife, then anything can happen surely.” (K2R1_YMM) **Authors' note:** Knowledge of the fertile period was often inaccurate.

Withdrawal: Withdrawal (azi), “the act of withdrawing the penis from the vagina during sexual intercourse before ejaculation,” was identified by several male community members and religious leaders as a child spacing method. (K1R1_MC) Curiously, neither young married men nor young married women mentioned withdrawal as a FP and/or child spacing method. According to the male community members and religious leaders, withdrawal is a method that is both culturally and religiously acceptable. A male community member explained that withdrawal was culturally acceptable because it was “not a white man’s idea” and “it has been practiced long before.” (K1R1_MC) Many of the religious leaders said withdrawal was permitted in Islam. However, a traditional barber felt that this method was unfair to the woman because “she requires sexual satisfaction and you deny her through withdrawal or abstinence.” (K3U1_Barber)

Traditional Family Planning/Child Spacing Methods

Many young married men and women said they did not know any traditional FP methods. However, when probed, respondents identified traditional methods ranging from use of talismans and amulets, to drinking traditional medicines called rubutu, and ingesting local herbs and seeds. Furthermore, female

community members from Kano identified several superstitious practices such as the lock-and-key method, broom method, and use of lime or salt paste.

Use of talismans and amulets: The most frequently mentioned traditional FP methods were “guru,” “karhu” (Zamfara), and “laya.” In general, these are charms or small objects worn to protect a breastfeeding woman from “kwanika” (frequent births).

A “guru” is a charm with a string that can be tied around a woman’s waist, or kept under her pillow, to prevent her from getting pregnant while she is still breastfeeding. According to some women, many are made of rabbit excrement wrapped in a piece of cloth; others said a guru is a strip of animal skin. “Karhu” is a method identified by respondents in Zamfara only. It is described as an amulet made of “adhua” (herbs) or a string of beads tied around a woman’s waist. Unlike “guru” or “karhu,” a “laya” is an amulet that can be worn around a woman’s leg, head, neck; plaited into her hair; or stitched to the wrapper carrying the baby. Many people believed that as long as a breastfeeding woman wears the guru, karhu, or laya, she will not become pregnant until she has weaned her child. However, if the guru, karhu, or laya breaks, is untied, or gets lost, then it is a sign that it is time for the woman to become pregnant.

Rubutu: Several young married men and women identified “rubutu” as an Islamic drink sometimes used for limiting births. Rubutu is made by washing off a board on which selected verses of the Quran have been written. “In Islam we do birth control by going to the Islamic scholar and he will write some incantations and wash it with water, and once the woman is given that, it will help in controlling the family.” (K2R2_MC) According to community members, “rubutu” is a relatively effective method because “all things are actualized by the grace of God so mostly it works.” (K2R2_MC)

Traditional medicines: Young married men and women also mentioned various traditional medicines used to prevent pregnancy such as “tuna,” “hanu,” “chab,” “gandana” and “tsume”. These medicines were made of local herbs and seeds. Unlike “rubutu” which must be prepared by an Islamic scholar, these herbal medicines were prepared by community members, including traditional barbers, TBAs, and other elders. (K1R1_Barber, Z5R2_MC)

Lime and salt paste: According to a female health care provider in rural Kano, a woman in the community might insert half a lime or a salt paste into her vagina for several days prior to sexual intercourse. It is believed that the lime and salt can prevent a woman from becoming pregnant. (K1R1_FHP)

Other traditional beliefs: Community members from rural Kano identified several other traditional methods, including the broom method and the lock-and-key method. According to local belief, a woman is susceptible to pregnancy if a broom that was placed underneath her bed falls onto the ground. Similarly, a woman can become pregnant if a key falls out of the padlock. (K1R1_FC)

Modern Family Planning/Child Spacing Methods

Oral contraceptive pills were the most frequently identified modern FP method by young married men and women, followed by injectables and male condoms. Community members, TBAs, and health care providers mentioned other modern methods such as implants, intrauterine devices and female sterilization.

Oral contraceptive pills: The majority of young married men and women had heard of oral contraceptive pills. The pill was commonly referred to as the “modern tablet”. The majority of young married people thought the pill was an effective FP method with very few side effects. Some women listed weight gain and irregular menses as side effects of the pills. Mostly, young married men and

women were concerned about the long-term impact of pills use on the body, whether it would harm the body or cause permanent infertility. Some of the community members compared the pills to the “guru” or “laya,” saying that they felt safer with a method that is tied externally on the body instead of being ingested. For example, a male community said, “People fear that [if] modern methods are taken, it prevents a woman from ever becoming pregnant... The traditional method is used externally while the modern one is taking orally. Swallowing the modern one seems to threaten childbearing permanently, whereas the traditional method applies only when it is tied on the body. People run away from modern methods because they think it would damage the womb permanently.” (K1R1_MC)

Injectables: The injectable was the second most frequently identified modern FP method. Similar to the pills, many young married men and women thought it was effective. Several young married women associated the injectable with side effects such as weight loss, excessive bleeding, and feeling of nausea. But they said these side effects would not deter them from using the method. These respondents said they preferred the injectable to the pill because they did not need to remember to take the pills daily. (K2R1_YMW)

Several young married men also said they preferred the injectable to the pills because they did not want to be seen in the community with contraceptives. The injectable was advantageous because it could be used once a month instead of on a daily basis. “Because it is given once a month unlike the tablets that is taken on a daily basis, young men do not want to be seen with these pills in the society.” (K3U1_YMM) These respondents explained that being seen with contraceptives might affect their prospects of marrying more wives.

Despite the overall acceptance of injectables by young married people, several people from the older generation expressed mistrust of injectables. Several TBAs and a religious leader from rural Kano associated the injectable with childhood immunization, which they believed caused infertility. (K1R1_TBA, K1R2_RL, K2R2_MCL) For example, a TBA said, “They [women] refused to accept injections and immunizations because they believed it stops delivery. And it is believed that even our children may not be able to bear children - that is why women rejected that.” (K1R1_TBA)

Male condoms: Several young married men and male community members also identified male condoms as a modern FP method. These respondents thought the male condom was an effective FP method. Some respondents from Zamfara felt that the male condom was beneficial because it could prevent both pregnancy and sexual transmitted infections. (Z6U2_MC) However, the overall sentiment expressed by young married men was negative. Many of the respondents said they would not use male condoms because they “did not feel a need for it” and they “felt healthy” – perhaps because male condoms were associated with STIs. (K2R2_YMM) Further, a religious leader in urban Kano felt male condoms should not be promoted as a FP method because it may encourage men to have commercial sex. The religious leader said, “My concern has to do with wealthy individuals who use FP methods of any kind, like the condom, and in the process [they] patronize prostitutes.” (K4U2_RL)

Comparison of Family Planning/Child Spacing Methods: Natural, Traditional, and Modern

The following compares and summarizes respondents’ attitudes towards natural, traditional, and modern FP methods:

- perceived efficacy
- perceived ease of use
- perceived accessibility
- perceived cultural and religious acceptability

Perceived efficacy: Respondents believed that natural and traditional FP methods were not consistently effective – that they worked for some people and not for others. In general, respondents attributed the inconsistent effectiveness of methods to the will of God. For example, a young married woman said of breastfeeding: “Sometimes breastfeeding serves as a birth control, but sometimes if God wishes, you conceive.” (K3U2_YMW) Similarly, a male community member said of the seeds to prevent “kwanika”: “There are seeds that they take. If you take one, your wife will not conceive for a year. I was once given those seeds to take. I took seven of them but that very moment, my wife conceived. So I just stopped taking them. You see, getting pregnant was God’s will.” (Z5R2_MC)

The majority of young married men and women felt modern methods were the most effective of the different kinds of FP methods. In Kano, several young married women said they started using a modern method because the traditional methods did not work for them. “But now in these days, if these Malams [religious leaders] give you these methods, it will not necessarily work. That is the reason why it is best to go to the hospital and use the modern methods.” (K1R1_YMW) Similarly, a female community member explained, “The traditional method is not as effective as the modern one because in some cases, like the “guru” method, a woman can conceive even if the “guru” didn’t break – this happens most often. If you ask most women, they will tell you that they have practiced the “guru” method but it failed. So because of its failure, they will decide to move on to the modern method.” (K2R1_FC)

Perceived safety: Although many respondents recognized the advantage of an effective FP method, several young married men and women felt that modern method were was too “accurate” and “potent”. Some young married women felt a modern method was so accurate that one could not change her mind and get pregnant when one is using it. “The disadvantage of it is it has to be accurate. It has specifications. If it is for two years, then after two years you will get pregnant, [and] if it is three years, then it has to be three years.” (K1R2_YMW) Also, some young married men and women feared that a modern method was so powerful, it could damage the womb. (Z5R1_MHP, K2R2_YMM, K2R1_YMW) For this reason, some respondents preferred a traditional method which was not seen to be very powerful but was not perceived to cause harm. “Traditional FP has no problems compared with the modern methods. For example, “guru” is just tied around the waist. It won’t cause bleeding or anything else.” (K4U1_FC)

Perceived ease of use: Young married men and women had mixed perspectives on perceived ease of use of different methods. Some young married women felt that traditional FP methods were very easy to use because one could stop using them at anytime. (K2R1_YMW) However, many young married men and women felt they did not know how to use the traditional methods effectively because there were no directions or dosage. “Traditional way has no control. It has no order anybody can guide you. You just take it anyhow.” (K3U2_YMW)

Many young married women preferred modern methods because they could be guided by a health care provider on the most suitable method and on how to use it. A young married woman from urban Kano said, “When you go to the hospital, they advise you on what to do, either injection or the tablet, they will give [you] to use it. When you go with the intention, they lecture and explain more for you... The modern one is better because you will be guided on what to do and not to do even before the problem could arise.” (K3U2_YMW) Similarly, a female community member said, “The benefit of the modern FP method is that a woman undergoes [a] blood test to find out the most suitable method for her before she is given the one to use.” (K4U1_FC)

Perceived accessibility: The issue of access was especially salient among respondents who lived in rural areas--compared to those who lived in urban areas in Kano and Zamfara. In general, young married men and women felt that traditional methods were cheaper in cost and more conveniently accessed than modern methods. Respondents pointed to direct and indirect costs as the main deterrent to their use of

modern FP. For example, a young married man said, “You see, the modern FP devices are expensive and the traditional ones are easier to get.” (K2R2_YMM) “As for the advantages [to traditional methods], to them they spend very little money for the medicine and even maybe they collect the medicine from a neighbor or a person in their house. Therefore, she does not have to spend much money. And if he [one who provides the traditional medicine] is a neighbor or lives in the house, she will find it easier to visit him... convenience in their opinion, or in my opinion, is what is considered advantageous, and not its effectiveness.” (K2R1_RL)

In another instance, a male community member described transportation fees as an important indirect cost to accessing modern FP methods. He said, “There are ‘guru’ which are tied around the waist and talisman which are specially prepared – these are used by the women. We are very proud of them because the hospital is too far. Honestly, it is difficult to provide food for the very family, much less talk of transporting women to the hospital and back. Employment opportunities here are very limited. You see, if you undertake to be going to the hospital, which is very far away, you [are] putting a big burden on yourself... It is not compulsory to use the traditional medicine. One can also use the modern medicine if one has the means. If there is a hospital close by, one will not be compelled to [be] looking for traditional medicine. It is because there is not access for modern medicine that we rely on the traditional ones.” (K1R2_MC)

Perceived cultural and religious acceptability: According to young married men and women, breastfeeding is the most culturally and religiously acceptable FP method because it has been practiced for many generations in the past. Similarly, respondents did not identify cultural or religious objections to the use of traditional FP methods. Many of the respondents simply said these methods depended on the “grace of God”. For example, a religious leader said of the “guru,” “None of them can work except [when] Allah permits. I know various methods like the ones you mentioned works, but only if Allah permits.” (K1R1_RL) Similarly regarding local herbs and seeds used to prevent conception, another religious leader said, “All these methods will not work by God’s will. If God is going to make some creations, all these medicines will not work.” (K2R1_RL2)

Young married men and women expressed mixed feelings on the cultural and religious acceptability of modern FP methods. Many respondents expressed a willingness to practice modern FP because they felt it was a part of living in the modern times and they believed the modern methods were effective. For example, a young married man said, “Now since God has brought us to modern times, we use the modern method and leave the traditional method. That is because the modern method works very well.” (K2R1_YMM) Even a traditional barber said, “Now the hospital method of FP is better than the cultural method people used in the past. But now people have embraced going to the hospital because these are the modern times that God has brought us into.” (K1R2_Barber)

However, several young married men felt that modern FP use was not culturally accepted in the larger community and pointed to the stigma of using FP, saying that it would negatively affect their chances of marrying another wife. For example, one of the young married men explained, “If it is known that you are giving your wife a FP device, in future, you will have difficulties before you can be able to get a woman to marry. But if it becomes well accepted, then there won’t be fear in using it.” (K2R1_YMM)

Some of the young married men were also uncertain of the religious acceptability of FP use. They wanted guidance from religious leaders on Islam’s stance on FP use. For example, a young married man said, “Since religion makes people not to practice FP, I feel that a concrete Islamic reason has to be given to people telling them that Islam does not prevent FP.” (K3U1_YMM) Similarly, a young married man said, “We have both Islamic and modern scholars. So what I want personally is I want to be helped to have fewer children. I want Islamic advice on this.” (K3U2_YMM2) A few young married men said

they preferred natural child spacing (i.e. through breastfeeding) because it promoted maternal and child health “without crossing the boundaries of religion.” (K3U1_YMM2)

F. Provider Attitudes toward Family Planning Service Delivery

In addition to exploring the perspectives toward FP of young married men and women and community members, we also examined provider attitudes towards delivery of FP services. This section highlights three provider attitudes:

- belief that FP is beneficial to maternal and child health
- ambivalence toward providing FP services
- unwillingness to provide services to women seeking FP by themselves

Belief that FP is beneficial to maternal and child health: Many health care providers mentioned the benefit of FP methods for child spacing, a practice that benefits both mother and child health. According to providers, child spacing benefits women’s health by allowing her time to regain strength and health from the pregnancy and labor. Also, child spacing enables the parents to take better care of their children, such as mother’s health to breastfeed, time to pay attention to a young child, and adequate resources for a child’s education, health care, and shelter. For example, a male health care provider from Zamfara said, “FP is very important to both the mother and child. The mother will have enough time to regain her strength and health, and as well as the blood she lost, and finally can be able to take a very good care of the child... The child will be healthy unlike the one whose mother has him on [her] back while she [is] still pregnant.” (Z6U1_MHP3)

Ambivalence toward providing FP services: Although the majority of health care providers knew of the benefits of FP and child spacing, several health care providers also expressed personal ambivalence in providing FP services. They mentioned religious, moral, and health-related beliefs on why they would not recommend a young woman to use FP methods. A male health care provider from urban Zamfara felt that FP was not justified in Islam if the partner’s intention was to avoid economic hardship. He said, “One should not really think of planning or spacing children. Islamically, God (SAW) stated ‘do not kill your children in fear of poverty. It is He who provides.’” (Z6U1_MHP)

Some providers felt that contraceptive use facilitates immorality of young women by allowing them to live promiscuously. “It [a FP method] allows teenagers to commit adultery.” (Z6U1_MHP) Similarly, a female health care provider explained, “They [young women] will not tell you they are not married. They will pretend to be married and get contraceptives so that they can have affairs, especially [in] this town. That is why they usually go [to the FP clinics] with their husbands or elders.” (K1R1_FHP) Finally, one of the health care providers felt that both traditional and modern FP could cause permanent infertility if they were used incorrectly. (Z6U1_MHP)

Unwillingness to provide services to women seeking FP by themselves: Several female health care providers said they were hesitant to provide services to women who seek FP alone. These providers said they would not provide services until they were sure these women had their husbands’ permission to use FP because they did not want to “cause trouble” in the community. For example, a matron in urban Kano said, “Nobody has ever challenged me [on providing FP in the community] because I don’t attend to women alone. I ask them to come with their husband or I ask her to bring a note from her husband, or if she has been to the hospital, I ask her to bring her card because that is what will guide me, or my evidence.” (K4U1_FHP) Similarly, another female health care provider in rural Kano said, “There are some women that even come without their husband’s knowledge in order to do FP. But we advise them to get permission from their husbands to avoid causing trouble.” (K2R1_FHP)

G. Community and Stakeholder Recommendations for Increasing FP and Child Spacing Use by Young Married People

Young married men, young married women, community members, and key stakeholders such as health care providers and religious leaders were asked to recommend ways of increasing FP uptake among young married people. Their recommendations were to:

- raise awareness of the benefits of child spacing among young married people
- address common misperceptions surrounding FP
- involve religious leaders, community leaders, and elders to increase social acceptability of child spacing and FP
- improve access to FP services

Raising awareness of the benefits of child spacing

According to the majority of young married men and women, community members and health care providers interviewed, the way forward to increasing FP uptake is to increase young married people's awareness of the benefits of child spacing. These respondents believed that more young married people would be willing to try FP if they knew of its benefits for maternal and child health. Respondents identified many different ways of raising awareness on the benefits of child spacing, including:

- use of mass media (radio, television, theater, pamphlets)
- educational health talks and couple counseling at the clinic
- community outreach
- raising the issue of poor moral training in large families and health challenges faced by women bearing many children---during Friday prayers
- encouraging children (males and females) to stay in school longer, rather than rushing into marriage and childbirth
- greater government support

Mass media: The majority of young married men and women felt the radio was the most effective way to reach young people with child spacing and FP messages. Many respondents said their first exposure to FP was through a radio program. They believed the radio was able to reach a wide audience, including those who lived in remote rural areas, as well as people not connected to women's groups or NGOs. In addition to the radio, some young married men living in urban Kano said the television and theater were effective ways of reaching young men with child spacing messages. Some of the health care providers felt that pamphlets were effective ways of passing on information about child spacing to couples who were literate.

Health talks and couple counseling: Many health care providers in Kano and Zamfara felt that health talks at the clinic were particularly effective ways of reaching young married women. These health talks are typically delivered during regular antenatal care visits or well-child check ups. (K2R1_MHP; Z6U1_MHP; K2R1_FHP; K1R1_FHP) Health care providers said health talks highlight the benefits of child spacing and the danger of "kwanika" to women in the context of maternal and child health. If a woman felt a need to start FP, then she would approach the health care provider for more information. For example, a female health care provider in Kano said, "What we do is we keep informing them when they come for antenatal care - before starting - we tell them about the necessary diet and health care and FP. We don't just tell them to come and start it. We show them that it is not compulsory. Anybody who is interested knows when they give birth and how many children they have, knows the interval between her children or lack of it. Because we can't tell a person that she gives [birth too] frequently. But we just inform them about it. Later on they call me aside and explain to me and I start them on it." (K1R1_FHP) Several providers mentioned that couple counseling at the clinic could be helpful. However, providers might need training in this.

Community outreach: Some respondents suggested several means of community outreach to increase young people’s awareness on the benefits of child spacing and FP. These included gathering community members at schools and Friday prayers to hold “enlightenment campaigns” (K2R1_YMM; K3U1_YMM); working with youth groups and NGOs on peer education (K2R1_MHP); and holding small group discussions – similar to the Participatory Learning and Action groups – for youths to talk and learn about child spacing (K2R1_YMM).

Many respondents felt that community outreach should involve traditional leaders, religious leaders, and elders in order to lend legitimacy and acceptability to the awareness campaign. (K2R1_FHP; K2R2_YMM) For example, a religious leader from rural Kano said, “I also think the traditional and religious institutions should be involved. When anything of importance comes through these institutions, it will be accepted.” (K1R2_RL) Similarly, a male health care provider from urban Zamfara said, “Use [of] religion influences us. The religious leaders should preach and tell all their people to embrace the program of FP, and our traditional leader should also embrace the program. By so doing, a number of people will start to practice FP.” (Z6U1_MHP3)

Raising the issue of poor moral training in large families and health challenges faced by women bearing many children during Friday prayers: Given the concern of Islam for moral training of children and the health of women and children, several respondents suggested that Friday prayers might be an appropriate venue for messages on the potential contribution of child spacing to moral education of children and the health of women and children.

Encouraging males and females to stay in school longer, rather than rushing into marriage and childbirth: The abbreviated education and the low median age of marriage for young women, age 14 according to the NDHS, have a clear impact on the status of women, their lack of decision-making power, their high fertility, and low use of FP. Several respondents mentioned the importance of both boys and girls staying in school longer.

Greater government support: Many respondents felt that campaigns required the support of the government such as the Ministry of Health. For example, a religious leader from rural Kano said, “I think it is only the government that can boldly say the benefits of FP and child spacing... Nobody can tell the community about this and they will agree other than the government. We can talk in our Islamiya schools about FP but we need the support of the Government for us to do it properly.” (K1R2_RL) Similarly, a traditional barber from rural Zamfara said, “The government should support them. The traditional barbers are not recognized... we are important to the society but the government does not recognize us.” (Z5R1_Barber).

Addressing common misperceptions surrounding family planning

Many young married men, community members, and health care providers felt it was important to address misconceptions surrounding FP in order to increase FP use among young people. These respondents said FP messages should be framed in such a way to help people understand the purpose of child spacing and its benefits for maternal and child health. Major misconceptions include:

- FP methods causes permanently infertility
- FP use is against Islam

FP causes permanent infertility: According to the majority of respondents, the main misconception hindering young people’s use of FP is the fear that modern methods will cause harm to the womb and permanent infertility. For example, a female health care provider said, “Mostly some people are resistant to it [FP] because they don’t know about it and they think that if you say FP it means if you are giving birth, you take medication and stop giving birth permanently. Lack of knowledge causes some of these

problems. But if one is knowledgeable, you'll find that it is very rare for him to have difficulties in life.” (K1R1_FHP) To address this misconception, respondents suggested emphasizing the use of FP methods for child spacing. A religious leader in rural Kano said, “It all boils down to [the] lack of information because it is not that FP is for you to stop having children completely. All that is needed is for the woman to be as healthy as the man.” (K1R2_RL)

Family planning is against Islam: Another common misconception among community members and religious leaders is that the practice of FP is against Islam. To address this misconception, several community members and health care providers suggested enlightening the religious leaders on the purposes of FP and child spacing and working with religious leaders to educate the community about FP. “Another way is to enlighten Islamic teachers to further educate people that it is not against Islamic teachings or injunctions to practice FP.” (K1R1_MC)

Improving access to family planning services

Some study sites had no FP services at all. In these sites, the priority is to establish services through hospitals, clinics, outreach workers, commercial establishments, or other means. But even in sites with FP services, community members and health care providers identified a need to improve access to FP services by:

- ensuring availability of commodities and services
- strengthening provider’s ability to counsel individuals and couples on FP use
- making commodities affordable

Ensuring availability of commodities and services: Both community members and health care providers identified a need for health care facilities to regularly provide services and FP commodities. This concern was particularly salient in rural communities. In rural Kano, a male community member said, “The main approach to convincing young couples to do child spacing is to strengthen the hospital, especially hospitals that we can go to directly for the medicine.” (K1R2_MC) Another male community member from the same area said, “The major strategy is to strengthen our hospitals with medical supplies. A hospital has been built here with no medical personnel, no drugs---a year ago.” (K1R2_MC) A similar problem is also found in rural Zamfara. Male health care providers from rural Zamfara said the health facilities were inadequate to provide FP services because of “absence of commodities.” (Z5R1_MHP) Another male health care provider from another rural area in Zamfara said, “In addition, we have clinics offering FP in our various health facilities but we need to do something about the problem of drugs not being there. We are lacking drugs and other necessities.” (Z5R2_MHP2)

Strengthening provider’s ability to counsel individuals and couples on FP use: Health care providers in Kano and Zamfara identified a need to strengthen provider’s ability to deliver FP services. For example, one provider felt that health care workers needed to be trained on the importance of FP so not to miss opportunities in counseling couples on FP use. He said, “So many times we try to educate our health professionals encouraging them to establish a FP unit in their clinic. We tell them even if there is no drug available, let them just guide and counsel the couples. And if they have condoms, then they should give them out. So far we have been disappointed because they will let couples go without counseling them.” (Z5R1_MHP2). Several health care providers also felt a need to undergo training in couples counseling of FP use. “In some cases, the husband may agree on FP methods while the wife refuses, and in other cases, the wife will suggest it but the husband may refuse. There is [a] need to make each party understand about the importance of FP method.” (Z5R2_MHP2)

Making commodities affordable: Finally, many community members and health care providers felt that FP methods should be available free-of-charge in order for more people to afford it. In particular,

community members from rural areas pointed to the costs incurred in traveling to the health facility, and how this deterred them from accessing modern FP methods (Z6U1_MHP2, K3U1_FHP, K2R1_YMM)

IV. DISCUSSION AND RECOMMENDATIONS

Discussion

This study found that poor family planning uptake in Kano and Zamfara was related to both low demand for, and poor accessibility of, modern contraceptives. Low demand for contraceptives may be explained by the profound pronatalist values expressed in Hausa culture and Islamic faith, and also by inadequate knowledge and misperceptions surrounding modern contraceptives. Even when there is a demand for contraceptives, many young married people find it costly and inconvenient to access them.

The low status of women is also a factor. The data revealed that young married women may desire to practice child spacing and FP, but are unable to communicate their needs, or obtain FP services without the permission and support of their husbands

However, this study also found factors that may lead to increase use of FP. Many young married men and women felt that it was acceptable to practice FP with the intention of child spacing. The data revealed glimmers of attitudinal change among young married men and women, particularly in urban areas of Kano and Zamfara. Although some argued that children were an economic benefit, increasingly, people were aware of the costs of children.

A generation gap is emerging. Respondents reported generational differences from their parents and elders and raised serious concerns over the practical aspects of raising a large family. In response to changing conditions, some young married people said they have started using FP in order to make their lives more manageable, even if they are not sure that the community or elders favor this.

What are the barriers and facilitators to FP among young married men and women in North West Nigeria?

Barriers

This study found that the key barriers to FP uptake by young married men and women, aged 15-30, in Kano and Zamfara were: a strong sense of pro-natalism; perceived disapproval of FP practice by influential people, such as spouses, parents and elders, community members, and religious leaders; lack of decision-making power by young married women; inadequate knowledge and misperceptions surrounding contraceptives; and difficulty in accessing modern methods.

We will discuss the following in turn:

- pro-natalism
- high infant and child mortality
- perceived disapproval of FP practices
- lack of decision-making power by young married women
- inadequate knowledge and misperceptions of contraceptives
- difficulty in accessing modern contraceptives

Pro-natalism: The majority of young married men and women expressed a strong sense of pro-natalism--an attitude that promotes childbearing. Young married people attached many positive values to family life, marriage, and procreation, which were deeply rooted in socio-cultural practices and religious beliefs. Respondents associated a large family with many children to economic and social gains. They pointed to

children as economic assets, such as insurance in old age and practical help at home or on the farm. These findings are consistent with the respondents' environment where there is an absence of social welfare and security programs (Isiugo-Abanihe, 1994) and in predominantly agricultural communities where families continue to rely on family labor (Duze and Mohammed, 2006). Socially and culturally, many young married men felt they would gain respect and recognition in the community by having a large family. This can be explained in part by the patrilineal practice of Hausa society whereby men are considered the custodians of their lineage; children are important because they continue the family name and can enhance a man's status and the prestige of his lineage (Duze and Mohammed, 2006; Isiugo-Abanihe, 1994). Finally, many young married people felt religiously compelled to have many children. They cited the Prophet Mohammed (SAW) who told Muslim believers to have as many children as possible in order to make the Prophet proud of them on the Day of Judgment.

High infant and child mortality: Both young men and young women, especially those living in rural areas, worry about whether their children will survive to adulthood. Since infant and child deaths still remain very common events, this concern is well founded. Thus, it is important not only to have family planning services available but also maternal and child health services.

Perceived disapproval of FP practices: These young married people lived within a highly pro-natal context and many perceived the influential people in their lives, such as spouses, parents and elders, community members (including Islamiya teachers, TBAs, traditional barbers, and religious leaders) to disapprove of FP practice. Overwhelmingly, respondents believed that, under Islam, children were given by God, and FP practice was unacceptable because it was akin to challenging God's will in their lives. In addition, some young married men, male community members, and religious leaders were mistrustful of FP, believing it to be a subversive Western policy to limit Muslim and/or African population. A male community member explained that this sentiment gained popularity over many years ago when it was first introduced by religious scholars who were opposed to FP and warned people against modern contraceptives use.

At the same time, approval of methods for child spacing were widely approved. The distinction between spacing children and limiting family size was very important to both the young people and the adult stakeholders. People were *comfortable* with child spacing and methods to achieve this but *uncomfortable* with the concept of family limitation which was thought to go against Islam.

This pervasive sense of disapproval of family planning for limiting family size has hindered young married men and women communicating about spacing needs and seeking FP services. Compounded by gender inequality and male dominance within the household, many young married women said they could not even talk to their husbands about child spacing or FP, anticipating a negative reaction. Also, some young married men were not willing to practice FP with their wives because of the stigma surrounding FP use. These young married men were concerned that they would not be able to marry another wife if the community discovered that their wives used contraceptive methods.

Lack of decision-making power by young married women: Another key barrier to FP uptake is the lack of power for sexual negotiation, reproductive decision-making and contraceptive use by young married women. Many young married women were apprehensive about their husband's reactions to suggestions about child spacing and FP. They feared that their husband would feel rejected and interpret these suggestions to mean refusal to comply with sexual demands, causing serious strife in their marital relationship. Consequently, many young married women said they would first gauge their husband's mood before initiating discussion on child spacing and FP. Then, they would speak to him in a submissive and obedient manner. In some instances, young married women would rely on a mediator, such as a parent or other relative to convince their husband to be sensitive to her reproductive health needs.

In general, young married women believed their husbands were the main decision-makers on contraceptive use. It was their duty to obey their husbands, and they could not use contraceptives without the permission and support of their husbands. The latter finding is also supported by similar sentiments expressed by health care professionals interviewed, who said female clients must provide evidence of their husbands' permission before they are provided with FP services. All in all, these findings are consistent with other studies, which emphasized the significance of Nigerian men in fertility and contraceptive decision-making (Duze and Mohammed, 2006; Isiugo-Abanihe, 1994; Lawoyin et al., 2002; Oyediran et al., 2002).

Inadequate knowledge and misperceptions of contraceptives: Inadequate knowledge and misperceptions of contraceptives are also substantial factors hindering young married men and women's uptake of FP. This study found a relatively high level of *superficial* awareness of contraceptive methods. At least two-thirds of respondents knew of at least one modern contraceptive method. Most respondents from Kano and Zamfara identified the oral contraceptive pills and the injectables. However, very few young married women reported modern FP practice. This finding is consistent with data from the 2003 Nigeria Demographic Health Survey where the majority of women, aged 15-49, knew of at least one contraceptive method (73% in Kano and 79% in Zamfara) but few had ever used a modern contraceptive method (16% in Kano and 6% in Zamfara). Also, this finding is consistent with many previous studies in Nigeria where knowledge alone was insufficient to promote FP use (Duze and Mohammed, 2006; Lawoyin et al., 2002; Oyediran et al., 2002)

FP uptake may be hindered by inadequate knowledge of modern contraceptive methods. Many young married men and women interviewed had only a vague idea about pills and injectables, saying they have "heard of" or "seen" these methods. The majority said they obtained information on FP through the radio and their friends. It is likely that these sources of information do not provide enough information (on how to use method, side effects, etc.), or accurate information (to dispel misperceptions on safety) for young married men and women to make an informed choice for contraceptive methods. Some young married women and female community members complained that they could not ask follow-up questions on FP messages heard through the radio. These findings are substantiated by another study which examined the quality of reproductive knowledge among Nigerian adolescents, and found that contraceptive information obtained at home or from friends was least likely to be correct (Nichols et al., 1986).

FP uptake may also be hindered by young married men and women's misperceptions of modern contraceptives. A major fear expressed by many young married people was that modern methods would damage the womb and cause permanent infertility. For this reason, some of the respondents preferred using traditional FP methods, which are not ingested like the pills, nor seen to be as potent. Some young married women and female community members had another misperception – associating the injectable with childhood immunization, which were believed to cause infertility.

Difficulty in accessing modern contraceptives: Respondents, especially those living in rural areas of Kano and Zamfara, pointed to cost and inconvenience as deterrents to accessing modern contraceptives. Some young married men felt it was not worthwhile to travel far away to the hospital, pay additional fees for transportation, and be unsure that the facility would have commodities or qualified staff available. Alternatively, these young married men preferred their wives to use traditional FP methods because they were cheaper and more easily accessible, even if less effective. Interviews with health care professionals from Kano and Zamfara also pointed to problems of irregular supplies and stock outs of commodities, supporting the concerns of young married people and community members about the availability of commodities.

Facilitators

Despite these barriers, this study also found facilitating factors to FP uptake:

- High acceptance of child spacing
- Concern about consequences of women getting pregnant while breastfeeding
- Awareness of traditional and modern methods and thought the modern ones were effective
- Changing norms and attitudes among young married people

High acceptance of child spacing: Although the majority of young married people were resistant to or ambivalent about FP practice, most respondents found child spacing to be permitted by Islam and culturally acceptable. Most respondents believed child spacing promoted maternal and child health by allowing the mother time to rest and the child to grow strong before another one comes along.

Concern about consequences of women getting pregnant while breastfeeding: Respondents discussed spacing in the context of “kwanika,” a condition of “frequent births” when a woman becomes pregnant while she is still breastfeeding her infant. Both young married men and women expressed pity and concern for a woman with “kwanika” – not only will she not be able to manage herself, but the child will also not be taken care of. Most young married women said they practiced child spacing through breastfeeding, but some young married men and women also felt it was acceptable to use modern contraceptives with the intention of child spacing.

Awareness of traditional and modern methods and thought the modern ones were effective: Most respondents were aware of both traditional and modern methods (mainly pills and injectables) and believed that modern methods were more effective although less accessible and possibly too effective (causing permanent infertility). Attitudes toward health care providers were also positive.

Changing norms and attitudes among young married people: Young married people’s fertility norms and attitudes towards FP were strongly influenced by a pro-natal culture and Islamic beliefs. These norms have negatively affected young married people willingness to practice FP. However, this study also found that many young married people, especially those from urban areas, were individually receptive to FP. These respondents’ openness to accept FP may be attributed to changing norms and attitudes as they adapt to urbanization, changing livelihoods, difficult economic circumstances, and other influences of modernization.

Some young married people reported a generation gap between themselves and their parents and other elders. One young married man said he lived in a “different generation” and a “different world” from his parents (K3U1_YMM). Many respondents felt that they faced a “modern problem” in regards to FP and felt their parents could not understand or support them on FP practice. As a result, these young married men and women did not feel comfortable talking about FP matters with their parents and elders.

This “modern problem” may be explained, in part, by changing circumstances faced by young married people as they adapt and live in urban centers with very different livelihoods and economic opportunities than when their parents lived in rural areas. Many young married men had concerns over the practical aspects of raising a large family and pointed to current economic hardships such as a lack of income, underemployment, and rising cost of living (especially the cost of education) as deterrents to having a large family. For these reasons, some young married men said they have started practicing FP with their wives. This finding is consistent with another finding from this study: young married men from urban areas preferred a smaller family sizes compared to young married men from rural areas.

Some young married women were willing to accept modern contraceptives because they believed them to be more effective and reliable than natural and/or traditional methods. Unlike the traditional methods which many young married men and women felt they were not sure of, respondents felt that a modern

method would be easy to use because it had a specific dosage, directions for use, and the health care provider could help troubleshoot for problems. Some young married women also accepted modern contraceptives because it was part of living in modern times. One young married woman said, “Now since God has brought us to modern times, we use the modern method and leave the traditional method. That is because the modern method works very well.” (K2R1_YMM)

Recommendations

Based on this study’s findings and successful FP experiences from other Muslim countries,⁶ the following recommendations are made for improving FP programs in North West Nigeria: (1) target behavior change using a multi-sectoral approach with the goal of changing fertility and FP practice norms at the community, family and individual levels; (2) introduce natural methods such as the Lactational Amenorrhea Method and the Standard Days Method as child spacing strategies that are likely to be culturally and religiously well-suited for adoption in North West Nigeria; and (3) expand and improve service delivery. A theme running throughout all the recommendations is to emphasize child spacing.

(1) Behavior Change

1. Conduct an inventory and analysis of influential religious and traditional leaders and establish a partnership for policy dialogue on FP and reproductive health in the region.
2. Educate local, state, and national legislators about FP and child spacing and seek to enlist them as advocates.
3. Establish programs targeting religious leaders as champions of FP and child spacing. Make sure religious leaders have accurate information on FP. Messages should emphasize the impact of child spacing on maternal and child health, and the congruence of FP programs with Islamic principles and values. Specifically,
 - a. Involve Muslim organizations and health care providers in reaching out to Muslim religious leaders. It is important to reach Muslim religious leaders because they may be suspicious that foreign or Christian organizations seek to erode Islamic beliefs and values of the Muslim community.⁷
 - b. Establish exchange programs for recognized Islamic teachers and scholars in other countries with successful FP programs to come to Nigeria and mentor Northern religious leaders.
 - c. Adapt FHI’s “Family Life Education: Teaching Adults to Communicate with Youth from a Muslim Perspective” (MFLE) to educate religious leaders on the benefits and Muslim perspective of reproductive health and child spacing and to enable them to talk to youth. The MFLE manual contains a 6-day long workshop on how to talk with youth about reproductive health, including FP and HIV. It has been designed for Muslim communities and could be further adapted to Nigeria and Northern Nigeria in particular.

⁶ Wolf M and Abubaka A, 2006 “Literature Review: Islam and FP, with a Special Emphasis on Northern Nigeria.” Family Health International. (Part I of this Final Report)

⁷ Mussad H (2007) “HTSP Video Conference Presentation: Reaching the Councils of Imams and Preachers (CIPK) in Kenya.” <http://www.jhuccp.org/training/WebConference/ChangingNorms07/KenyaHTSPpresentation.doc> (last accessed December 12, 2007)

4. Engage opinion leaders (e.g., religious leaders) and community gatekeepers (e.g., community leaders) in the planning and implementation of FP programs, avoiding pre-packaged programs. Obtaining their support from the earliest stages of a program is critical to FP program acceptance and ownership.
 - a. Enlist religious leaders as advocates and seek and publicize religious rulings in favor of FP.⁸ Specifically, build a strong Championship Program with locally influential religious and/or traditional leaders. These champions can act as “Agents of Change”. In the past, most programs working with religious leaders in the North have not partnered with those people who can effect change within their community.
 - b. Refer to and publicize examples of prominent Islamic scholars’ and leaders’ participation in FP activities in other countries and adopt practices that have been successful there.
 - c. Hold stakeholder meetings with local religious leaders to disseminate and generate dialogue on child spacing. Use published materials such as the “Reproductive Health Issues in Nigeria: the Islamic Perspectives” which includes statements from high profile religious leaders and scholars from Nigeria.⁹

5. Produce, adapt, and disseminate Behavior Change Communication (BCC) materials in local languages, making them culturally and religiously sensitive. BCC materials should go beyond basic FP awareness messages to provide substantive and accurate information on the different types of methods available, how they are used, possible side effects, and where they can be obtained.
 - a. Re-frame FP messages to present the perspective of health benefits to the mother and child, emphasizing child spacing instead of family limitation or population control.
 - b. Use culturally salient messages to promote child spacing and FP such as prevention of “*kwanika*,” the child spacing benefits to maternal and child health, and how child spacing can contribute to the moral education of children.
 - c. Address common misconceptions surrounding FP such as concerns that modern methods lead to permanent infertility, the association of injectables with childhood immunization, and the local concern that breast milk is contaminated when a woman is pregnant.
 - d. Frame separate messages for women and men. While child health is the first priority for both men and women, emphasizing maternal health and child care may be more salient for women while household expenses and moral education may be more salient for men.
 - e. Promote Health Timing and Spacing of Pregnancy (HTSP), an intervention using the child spacing concept and messages. It has been found to be an effective entry point in sensitive settings. HTSP focuses on improving the health outcomes of both mother and child. It has been well-received by religious leaders, service providers, and public health

⁸ Religious leaders in Iran sought and obtained a *fatwa* to address concerns on contraception overall, and religious leaders in Tunisia issued edicts supporting contraception, incorporation of health and development themes into sermons and other activities.

⁹ “Reproductive Health Issues in Nigeria: the Islamic Perspectives” (2004) Pathfinder International. http://www.pathfind.org/site/DocServer/Appendix_II_RH_in_Nigeria_Islamic_Perspective_Final_Co.pdf?docID=6382 (last accessed December 12, 2007)

officials in Muslim countries as a friendly and innovative way to discuss FP. The child spacing messages have been delivered by a diversity of stakeholders, ranging from religious leaders and professional health care providers to lay community health workers.

6. Develop and implement a media strategy for social mobilization and behavioral change communication. A strong radio-based program is particularly recommended to reach a wide audience.

(2) Child Spacing Strategies

7. Maximize high acceptance of breastfeeding and desire for a natural method that is not associated with permanent infertility by promoting the Lactational Amenorrhea Method (LAM). LAM is highly effective for up to 6 months after childbirth as long as menses have not returned and woman is fully or nearly fully breastfeeding. Women need accurate information on the use of breastfeeding as a child spacing strategy.
8. Promote the Standard Days Method – a fertility awareness-based method, using CycleBeads, which is a natural method and not associated with permanent infertility. This method requires a couple to commit to abstaining or using another method on fertile days and would need to be introduced to *couples*. This method may be challenging to implement in North West Nigeria where women have very little sexual negotiating power. However, it has been demonstrated to work in Niger when the method was promoted by Imams.

(3) Service Planning and Delivery

In areas without FP services:

9. Access to FP services in rural and remote areas continues to be a problem. Establish FP services where they are currently non-existent. Develop programs similar to the ELICO (Eligible Couples and Individuals) project where community mapping is done and couples eligible for FP are identified and counseling and services are provided at their homes.
10. Provide door-to-door FP services to women in *pardah* and to rural, remote communities with limited access to FP commodities. Promote community-based delivery (CBD) of FP services.¹⁰
 - a. Consider adapting the Navrongo Community-based Health Planning and Services (CHPS) initiative in Ghana for North West Nigeria. CHPS focused on generating FP services demand by engaging the community and supplying FP services through the deployment of community-based nurses.
 - b. Build on the experience of Pathfinder International which has developed strong community-based programs and has demonstrated success in increasing FP use.
 - c. Expand MCH services, especially in rural areas, to increase survival of mothers, infants, and children.

¹⁰ Experiences from Bangladesh, Ghana, Indonesia, and Pakistan have employed community-based health workers or nurses to raise awareness and deliver FP services in hard-to-reach areas.

In areas with FP services:

11. Promote and deliver FP services within a reproduction health framework, integrating FP services into valued existing RH programs such as PHC and MCH
12. Link reproductive health programs to universal basic education strategies.
13. Create and/or support effective systems for distribution and re-supply of FP commodities. The revolving fund system should be examined to understand problems surrounding stock-out of commodities.
14. Provide a full range of methods so couples have the broadest possible choices.
15. Create sustainable mechanisms for training health care providers in technical aspects of FP services, including training on quality of care, client-centered services, counseling (especially *couple-based counseling*), and dispensing of FP services.
16. Develop training programs that will build the capacity of a variety of health care providers, including private medical practitioners, trained TBAs, and community health workers to counsel and deliver FP services.
 - a. Utilize new opportunities to increase FP access such as the new National Youth Service Corps (NYSC) program that will engage midwives at the PHCs level to provide quality FP services.
17. Build the capacity of health care workers to be confident in passing information and counseling clients on natural methods of FP (LAM and Standard Days Method).
18. Develop (update) and disseminate operational guidelines and standards of practice to reduce provider biases in method distribution and other barriers to women wanting FP services.
19. Expand MCH services, especially in rural areas, to increase survival of mothers, infants, and children.

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