Men's Involvement in Family Planning and Unmet Needs of Contraception among Women in Ido/Osi Local Government Area, Ekiti State, Nigeria

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ABSTRACT

Background: Unmet need of contraception is a serious issue in Nigeria that has caused unintended pregnancies and bad reproductive health results. The role of men in family planning has been very important and in patriarchal society such as Nigeria where men serve as the key influencers of reproductive choices. This research paper explored the level of participation of men in family planning and how it is connected to the unmet contraceptive needs among women at Ido/Osi Local Government Area (LGA) in Ekiti State, Nigeria.

Methods: Cross-section survey of 246 women of reproductive age (15-49 years) who had given birth within the past three years in Ido/Osi LGA was carried out. The respondents were selected through multistage sampling and data gathered through self-completed questionnaires. The associations between men involvement and unmet contraceptive needs were tested with chi-square and logistic regression models, and the fertility preferences and male involvement were summarized with descriptive statistics.

Findings: The research findings indicated that the prevalence of unmet need to contraception among women is high (59.8%). Although 46.3% of the respondents said their husbands participated in family planning, the actual use of male contraceptives was minimal with only 33.3% of the participating males using contraceptive methods, mainly condoms (73.7%t). A report on spousal communication on family planning showed that 58.1% of women had it, and it had a significant impact on contraceptive use and support. The statistical computation revealed that there was significant correlation between the participation of men in family planning and a low rate of unmet contraceptive need (2 = 31.583, p = 0.005). Logistic regression revealed that Husband involvement was the only significant independent variable (OR = 0.197, $p < 0.001$), and the odds of Respondents whose husbands were not involved were significantly low (OR = 0.20, $p < 0.001$), thus other socio-demographic factors may also contribute.

Conclusion: Despite the high demand of contraceptive use among women living in Ido/Osi LGA, men participation in family planning is not as optimum as it should be. Increased engagement of men by means of better communication, education and sociocultural interventions can help decrease unwanted pregnancies and improve reproductive health outcomes. Strategies to actively involve the men should be implemented by policymakers and reproductive health programs in order to ensure improved uptake of family planning.

Keywords: Men's involvement, family planning, unmet need, contraception, reproductive health, Nigeria, Ido/Osi LGA.

INTRODUCTION

Unmet need for contraception is an essential metric for monitoring reproductive health policy and performance. It serves as a starting point for figuring out how many women's needs for family planning are unmet. It is used to track the progress toward the achievement of Sustainable Development Goals (SDGs), especially, goal number three, good health and well-being and target seven, granting universal access to sexual and reproductive care, family planning and education[1]. Unmet family planning need is a worldwide health burden. Unmet needs relate to the number of sexually active females who want to avoid or postpone motherhood but are not using or do not have access to an effective means of contraception[2]. According to World Health Organization (WHO) data, about 21 million young women aged 15-19 years become pregnant in developing countries each year, with around 49% of these pregnancies being unplanned[3]. Contraception, when used correctly, reduces unplanned conceptions, high gestation, and hence the maternal mortality rate[4]. Every year, around 6.8 million undesired pregnancies occur in Nigeria[5]. To address this difficulty, a thorough understanding of the barriers to birth control is essential. According to[1], the unmet needs for family planning are between 20% and 58% in Nigeria.

To achieve goal three of the Sustainable Development Goals, men may need to be actively involves in reproductive health concerns, including family planning[6]. Family planning promotion and provision can make a substantial contribution to women's empowerment and the accomplishment of universal primary education in poor nations. Furthermore, family planning can lower maternal mortality by 32% and infant mortality by 10%[7]. However, contraceptive usage remains low in sub-Saharan Africa (SSA)[8]. Men's hostility to or non-involvement in family planning is a key contributor to poor contraceptive usage and high unmet needs in Africa[8].

The role of males in family planning is critical, particularly in Nigeria, where men are the main decision-makers in the vast majority of households[9]. Women, particularly in patriarchal settings, have little or no influence in things concerning reproduction or reproductive health. They must get their spouses' permission before seeking health care or utilizing contraceptives[10].

It is widely established that men's general knowledge and views on optimal family size, gender preference of children, ideal spacing between child deliveries, and contraceptive method use have a significant impact on women's preferences and beliefs[11]. According to[12], there has been significant research on contraceptive use among women, less has been done on men's involvement. Research and initiatives suggest that consistent use of family planning tools by male partners can help prevent unintended pregnancies and sexually transmitted infections (STIs). Age, kind of marriage, religious affiliation, and educational attainment all influence men's involvement in family planning decisions[13]. Men have a major effect on household decisions in Nigeria, especially about family planning[14]. Men are the heads of homes, the breadwinners, and mostly the older spouse[9]. Attempts to enhance the use of family planning in Nigeria may benefit from an understanding of the responsibilities played by males in the process. In Nigeria, women receive the majority of reproductive health care, even though men are also heavily involved in women's contraception use. At the 1994 International Conference on Population and Development, this was emphasized. The involvement of men in family planning programs might have serious repercussions. Women may decide not to use contraception despite being informed and motivated to do so because of their spouses' disapproval[16]. Consequently, in the southwest of Nigeria, in the Ido/Osi Local Government Area (LGA) of Ekiti State, this study examined the role that males play in family planning and the unmet need for contraception among women.

METHODS

The study was conducted in Ido-Osi is a Local Government Area situated in the state of Ekiti, Nigeria. The local government has many rural towns and villages. It shares boundaries with many local government areas, including Moba, Ijero, Ilejemeje and Oye. Ido/Osi Local Government Area had a total population of 239,600 inhabitants according to NPC estimation of 2024, one of the sixteen local government areas in Ekiti State, Nigeria. Specifically, Ido/Osi LGA has ten wards, with about fifteen towns. The Local Government Area is predominantly agricultural, with a significant number of individuals engaged in the cultivation of root crops

and cereals. There are a few cottage industries in the Local Government Area. They are devoted primarily to processing of agricultural produce. Other industrial undertakings are in the area of printing, bakeries, weaving, carpentry, e.t.c.

The study employed a cross-sectional survey quantitative research design. The quantitative research design was used in this study by collecting information from women in Ido/Osi Local Government Area, Ekiti State, Nigeria with the aids of questionnaires in order to get sufficient data to analysis the research questions. Given the magnitude of the population and the limited time available for the study, it becomes necessary to choose a few elements of the population to accurately represent the entire population. According to the National Reproductive Health Policy and Strategy (2024), 22.6% of the population projection represents the population of women within the reproductive age group amounting to 54.150 women.

The Fischer's formula below was used to calculate sample size of women of child bearing age (15years to 49years) living in Ido/Osi Local Government Area, Ekiti State who gave birth in the last one year to participate in the study.

$n=Z^2P(1-P)/I^2$

Where: n = Sample size [where population> 10,000]

Z= Normal deviation at the desired confidence interval. Z-value at 95% is 1.96

P= Contraceptive Prevalence Rate (Estimated prevalence rate of unmet need for family planning in Ekiti state is 17.8% NPS and NDHS 2024)

Q = (1-P)

D^2 = Degree of precision 0.05.

$N =Z^2P(1-P)/D^2$

$N = 1.96^2 . 0.178(0.822)/ 0.05^2$

N = 3.8416 X 0.19 (0.81)/ 0.0025

N = 224

Considering 10% inclusion due to likely non-response rate. The sample size of the study that was used is 246

A multistage sampling technique was used in selecting the respondents. First step involved all women of child bearing age who gave birth in the last three years prior to this study within Ido/Osi LGA where random selection of five wards from the ten wards in Ido/Osi LGA was done using balloting method. Second stage was the simple random selection of one settlements each from the wards selected. The third stage was the simple random selection of fifty houses per settlements for the first four wards and forty six houses for the fifth settlement. The fourth stage was the household listing and selection of one household from the houses selected. The fifth stage was the random selection of an eligible respondent based on the target population ie one person per household, one household per house, two hundred and forty six houses in the five settlements per ward while (246) houses per the LGA. Where no one is eligible in the house selected, we moved to the next house.

An elaborated, self-administered questionnaire was employed as the study's instrument. It was created to collect the necessary variables for the investigation as well as supporting data from the literature. In order to investigate the influence of socio-demographic factors (such as age, education, religion, and employment status) on unmet needs for family planning among women in Ido/Osi LGA, Ekiti State, Nigeria, the questionnaire's items were developed based on the variables deemed required.

Data was quantitatively evaluated. The Statistical Package for Social Sciences (SPSS version 25.0) was used to analyse the data using descriptive statistics, and the results were shown in a frequency and percentages table, and the relationship between men's involvement in family planning, and unmet needs for contraception was examined using the chi-square test for bivariate analysis and logistic regression models for multivariate.

The Ethical Committee on Health in Ido/Osi LGA was consulted before the study began to ensure ethical considerations were met. After approval, the researcher informed the participants of the study's voluntary nature and their right to withdraw at any time.

RESULT

Unmet Needs of Contraception among Women in Ido/Osi Local government Area, Ekiti State, Nigeria

The table below shows the level of awareness, knowledge and use of contraceptives methods among respondents. The results indicate that most of the respondents (91.5%, n = 225) had heard about contraceptives, with a mere 8.5% (n = 21) indicating that they had never heard about these contraceptives. This is a sign of a good degree of general knowledge of contraception among the women in the study area. With respect to information sources on contraception, almost half of the respondents (47.6% n=117) rated healthcare workers as their main source of information. This was accompanied by electronic media (18.7%, n = 46) and family and friends (17.5%, n = 44). Less information was received by fewer respondents via radio (11.0%), television (2.8%), and printed media/books (2.0%), which indicates the primary role of healthcare professionals in spreading the contraceptive information. When it came to being familiar with contraceptive methods, the male condom was the most widely familiar length of birth control (43.5%, n = 107). Awareness of alternative techniques was relatively low, injectables (12.2%), withdrawal technique (11.0%) and natural techniques (10.6%). Long-acting reversible contraceptives like implants (6.9%) and intrauterine contraceptive devices (IUCD) (2.0%) had a very low awareness, which indicated that some gaps in comprehensive contraceptive knowledge existed. Regarding contraceptive experience, a little over half of respondents (53.7% n= 132) said that they had once used a contraceptive technique, with 46.3% (n= 114) never used any form of contraception. Nonetheless, only few are currently using contraceptives with only 34.1% (n = 84) responding that they were currently using a contraceptive method and about 65.9% (n=162) who are not. Among the current or past users, contraceptive use purpose demonstrated that, 53.5% (n= 45) used contraception to restrict births, and 46.4% (n= 39) used contraception to space births, thus showing a slight tendency to control family size. Lastly, the outcome of the pregnancy intention assessment showed that 59.8% (n = 147) of the respondents indicated that their last pregnancy was unwanted, which means that they needed contraception, and 40.2% (n = 99) indicated that they needed contraception because their last pregnancy was wanted. This observation indicates that there is a high degree of unmet contraceptive demand among women in the research region.

Table 1.1: Unmet Needs of Contraception among Women

S/N	VARIABLE	RESPONSES	FREQ	%
1	Have you heard about contraceptive	Yes	225	91.5
		No	21	8.5
2	What was your source of information on contraceptive	Radio	27	11.0
		Printed media/books	5	2.0
		Television	7	2.8
		Electronic media	46	18.7

		Healthcare workers	117	47.6
		Family and friends	44	17.5
3	What contraceptive methods do you know	Withdrawal method	27	11.0
		Natural method	26	10.6
		Condom	107	43.5
		Injectable	30	12.2
		Pills	17	6.9
		Implants	17	6.9
		IUCD	5	2.0
		Copper	5	2.0
		Ring	2	.8
		Others (specify)	7	2.8
		None	3	1.2
4	Have you ever used contraceptives	Yes	132	53.7
		No	114	46.3
5	Are you currently using contraceptives	Yes	84	34.1
		No	162	65.9
6	Purpose of Contraceptive Usage move	Spacing	39	46.4
		Limiting	45	53.5
7	Wanted to Have Last Pregnancy	Yes (met need)	99	40.2
		No (unmet need)	147	59.8

Men's Involvement in Family Planning and Socio-demographic Characteristics of Women in Ido/Osi Local government Area, Ekiti State, Nigeria

The table reflects the correlation between socio-demographic variables among respondents and husband involvement. The Chi-square χ^2) statistics were employed to test significant associations at the 5% level. In terms of age, the involvement of husbands differed greatly among age groups (χ^2= 15.05, p = 0.010). Respondents 15-19 years old (100.0%): No involvement of husbands was reported. Participation with age was higher with 33.3% of husbands having participated in the age group of 20-24 years. The involvement was higher among the respondents who were aged between 25-29 years (49.1%), 30-34 years (50.0%), 35-39 years (55.8%), and 40-44 years (51.0%). This implies that age plays a major role in husband involvement. In terms of religion, 43.1% of the Christian participants said that husband involvement was present in comparison with 55.7% of the Muslims and 45.5% of other religions. Nevertheless, the differences were not found to be statistically significant (χ^2= 2.90, p = 0.234), which indicated that the role of religion in the involvement of husbands was not statistically significant. Regarding the level of education, the statistically significant

correlation among education and husband involvement was observed ($\chi^2 = 11.75$, p = 0.008). Individuals who had no formal education registered the highest husband involvement level (64.3%), then those with post-secondary education (58.1%). Less engagement was seen in respondents whose education was primary (33.3%), and secondary (40.4%). This observation implies that the level of education has a major influence on husband involvement. With regard to the residence, the involvement of husbands was more among urban dwellers (60.0) than among rural dwellers (43.8). It was not, however, statistically significant ($\chi^2 = 3.72$, p = 0.156) which means that residence did not play a significant part in husband involvement. Lastly, on the employment status, 47.3% of the working respondents indicated that the husband is involved compared to 43.6% of non-working respondents. There was no significant relationship between employment status and involvement of the husband (χ^2= 3.12, p = 0.538). Overall, it is possible to conclude that the elements of age and educational level were closely related to husband involvement, and the elements of religion, residence, and employment status have no statistically significant relationship.

Table 2.1: Men's Involvement in Family Planning and Socio-demographic Characteristics of Women

Variable	**Category**	**Husband Involved Yes n (%)**	**No n (%)**	**χ^2**	**p-value**
Age (years)	15–19	0 (0.0)	12 (100.0)	15.05	0.010*
	20–24	11 (33.3)	22 (66.7)		
	25–29	27 (49.1)	28 (50.9)		
	30–34	27 (50.0)	27 (50.0)		
	35–39	24 (55.8)	19 (44.2)		
	40–44	25 (51.0)	24 (49.0)		
Religion	Christianity	75 (43.1)	99 (56.9)	2.90	0.234
	Islam	34 (55.7)	27 (44.3)		
	Traditional/Other	5 (45.5)	6 (54.5)		
Education	No formal	9 (64.3)	5 (35.7)	11.75	0.008*
	Primary	19 (33.3)	38 (66.7)		
	Secondary	36 (40.4)	53 (59.6)		
	Post-secondary	50 (58.1)	36 (41.9)		
Residence	Urban	24 (60.0)	16 (40.0)	3.72	0.156
	Rural	89 (43.8)	114 (56.2)		
Employment status	Working	89 (47.3)	99 (52.7)	3.12	0.538
	Not working	24 (43.6)	31 (56.4)		

Men's Involvement in Family Planning, Socio-demographic Characteristics of Women by Unmet Needs of Contraception among Women

In the relationship between the husband involvement in family planning and use of contraceptives, a significant relationship was noted. Out of those respondents whose husbands actively participated, 59 (51.8%)

stated that they used contraceptives and 55 (48.2%) did not. Conversely, of the women who did not have husbands involved, the proportion of contraceptive use was 23 (17.7%) of 107 (82.3%) of those that did not. This disparity was statistically significant (χ^2= 31.58, p < 0.001) which shows that husband involvement has a positive effect on the use of contraceptives. In terms of religion, the use of contraception was greatest and most respondents who were Muslim maintained the use with 28 (45.9%) indicating contraception usage and the Traditional/Other and Christianity had 4 (36.4) and 50 (29.1) respectively. This was however not significant (χ^2= 5.76, p = 0.056) indicating that religion is not a strong factor in the use of contraceptive among this sample. Contraceptive use was slightly different in terms of level of education: 6 (42.9%) respondents who had no formal education used contraceptives, 20 (35.7%) had primary education, 26 (29.2%) had secondary education, and 30 (35.3%) had post-secondary education. These variations were not statistically significant (χ^2 = 1.53, p = 0.676) meaning that there was no strong tendency of contraceptive use based on educational level. Concerning residence, 11 (27.5%) of the urban population reported the use of contraceptives over 71 (35.3%) of the rural population. The correlation was found not to be significant (χ^2= 2.45, p = 0.293), which implies that the place of residence does not have a significant impact on the utilization of contraceptives. Lastly, in employment, contraceptive use was given by 65(35.0%) of the working respondents and 16 (29.1%) of the non-working respondents. This was not significant statistically (χ^2= 3.64, p = 0.457), meaning that the employment status did not significantly influence the use of contraceptives. Summary: Generally, the only factor that was significantly correlated with contraceptive use was the involvement of the husband, and the rest of the factors included in the study, such as religion, education, residence and employment status, were not statistically significant in predicting contraceptive use.

Table 3.1: Men's Involvement in Family Planning, Socio-demographic Characteristics of Women by Unmet Needs of Contraception among Women

Variable	Category	Yes n (%)	No n (%)	χ^2	p-value
Husband Involvement	Yes	59 (51.8)	55 (48.2)	31.58	<0.001*
	No	23 (17.7)	107 (82.3)		
Religion	Christianity	50 (29.1)	122 (70.9)	5.76	0.056
	Islam	28 (45.9)	33 (54.1)		
	Traditional/Other	4 (36.4)	7 (63.6)		
Level of Education	No formal	6 (42.9)	8 (57.1)	1.53	0.676
	Primary	20 (35.7)	36 (64.3)		
	Secondary	26 (29.2)	63 (70.8)		
	Post-secondary	30 (35.3)	55 (64.7)		
Residence	Urban	11 (27.5)	29 (72.5)	2.45	0.293
	Rural	71 (35.3)	130 (64.7)		
Employment Status	Working	65 (35.0)	121 (65.0)	3.64	0.457
	Not working	16 (29.1)	39 (70.9)		

Determinants of Unmet Needs of Contraception

The binary logistic regression model identified the impact of education, age, and Husband involvement on the probability of the outcome. Husband involvement was the only significant independent variable (OR = 0.197, $p < 0.001$), and the odds of Respondents whose husbands were not involved were significantly low (OR = 0.20, $p < 0.001$). It means that husband non-involvement decreased the possibility of the outcome by approximately 80% and the relationship is statistically significant, since the confidence range (0.10 0.37) is not close to 1. The level of education, such as primary (OR = 1.074, p = 0.915), secondary (OR = 0.686, p = 0.559), and post secondary education (OR = 0.678, p = 0.536) did not have a significant effect on the probability of the outcome. Likewise, the age groups between 20 -24 years and 40 - 44 years did not have a statistically significant correlation with the outcome, but the respondents in the age group of 20 to 24 years had higher odds (OR = 5.36) than those in the reference category. In general, the model was statistically significant (LR χ 2 (9) = 37.43, $p < 0.001$) and accounted for about 12% of the variation in the outcome (Pseudo R 2 = 0.1201), indicating a moderate fit.

Multivariable Associations between Men's Involvement in Family Planning/Socio-demographic Characteristics and Unmet Needs of Contraception

Variable	Category	Odds Ratio	Std. Err.	z	p-value	95% CI
Education	Primary	1.07	0.72	0.11	0.915	0.29 – 3.98
	Secondary	0.69	0.44	−0.58	0.559	0.19 – 2.43
	Post-secondary	0.68	0.43	−0.62	0.536	0.20 – 2.33
Husband involvement	No	0.20	0.06	−5.06	0.000	0.10 – 0.37
Age	20–24 yrs	5.36	5.99	1.50	0.133	0.60 – 47.89
	25–29 yrs	2.48	2.74	0.82	0.412	0.28 – 21.67
	30–34 yrs	2.47	2.74	0.82	0.413	0.28 – 21.68
	35–39 yrs	1.66	1.87	0.45	0.654	0.18 – 15.14
	40–44 yrs	1.72	1.93	0.48	0.628	0.19 – 15.48
Constant	_cons	0.59	0.74	−0.42	0.675	0.05 – 6.75

DISCUSSIONS

This study determined the unmet needs of contraception and involvement of men in family planning among women in Ido/Osi Local Government Area in Ekiti State, Nigeria. The results provide valuable information on awareness, the use of birth control methods, socio-demographic factors and the significance of husbands in fulfilling the contraceptive interests of women[16]. According to the research findings, the respondents had a high awareness of contraceptives (91.5%), which means that the information on the family planning is accessible in the study area. This level of awareness compares with the previous studies conducted in Nigeria that indicated that, most women have known at least one form of contraceptive[17]. Nevertheless, with this level of awareness, the current use of contraceptives remained relatively low (34.1%), and 59.8% of the respondents acknowledged that their most recent pregnancy was unwanted, which means that there is a high unmet need of contraception. Such a difference between awareness and use is an indication that awareness alone is not associated with effective use of contraceptives[18]. Possible cultural norms, misconceptions, and fear of side effects can be some barriers that would prevent actual utilization enhancing the risk of unintended pregnancies[19]. Medical personnel were found to be the best source of contraceptives information (47.6%), and

their importance in family planning education was highlighted. The identified finding underscores the need to enhance health facility-based counseling and outreach services. Nevertheless, the minimal contribution of the mass media and printed materials implies the absence of opportunities to provide inhabitants with sensitization on a larger community scale.

The perception of contraceptive methods was so biased towards short-term methods, especially male condoms, and little was known about long-acting reversible contraceptives (LARCs) including implants and IUCDs[20]. This constrained approach can limit knowledge options in women and mean that they can only make more effective and long-term choices, which is contributing to the unmet contraceptive needs. According to the study, the age and the level of education were found to play a significant role in determining the involvement of husbands in family planning. The participation of husbands was more supported by the age of the women implying that maturity, longer marriages and more communication in relationships might facilitate male involvement in the reproductive health decisions[21]. No involvement of husbands was reported by younger females especially between the age of 15 and 19 years and this could be an indication of power relationships, the early marriage relationship, or even lack of independence. The level of education was also significantly associated with husband involvement. Females who had post-secondary education reported more husband involvement than their counterparts who had either primary or secondary education. Education can increase communication proficiency, bargaining strength and mutual decision-making at homes, hence promoting male participation[22]. Interestingly, the great participation of women with no formal education can also be a sign of traditional male-dominated marriages where the man has more powers over reproductive decisions. Religion, residence and employment status did not show significant association with husband involvement and this implies that male participation in family planning in this context goes beyond religious affiliation, location and economic status of women.

One of the major results of this research was that there was a strong and statistically significant relationship between contraceptive use and husband involvement. Women who had husbands who participated in family planning also had a high probability of using contraceptives than women who did not have husbands who participated in family planning. This result is also consistent with the current literature that highlights the role of male partner support as a determinant of contraceptive uptake in patriarchal societies[23,24]. The absence of any major relationships between contraceptive use and religion, education, residence, and employment status also highlights the overwhelming role played by husband involvement as opposed to the other socio-demographic variables. This implies that despite the education or economic empowerment of women, lack of support by her spouse can be a constraint to contraceptive use and may be a source of unmet needs. The binary logistic regression analysis also supported the result that husband involvement was the only significant predictor of unmet contraceptive needs. The women who did not have their husbands involved had much less chance of having their contraceptive needs attended to meaning that they had a much greater chance of having unmet needs. This observation underscores the role of husbands as protective factors to unwanted pregnancies. The statistical significance of education and age, though significant socio-demographic characteristics, was not achieved in the multivariate model. It implies that their impact on unmet needs can be indirect or through husband involvement. The moderate explanatory power of the model suggests that although the involvement of husbands is a determinant, there are other unknown factors that could have led to unmet contraceptive needs: cultural beliefs, service quality, fear of side effects, and gender norms[25]. In general, the results show that a good knowledge of contraception is not the same thing as its use and that unmet contraceptive requirements are still common among women in the research community. The involvement of husbands is always a significant factor in bivariate and multivariate analysis, which underscores the need to have male-based family planning programs. Interventions to minimize unmet contraceptive needs should thus be directed at the engagement of men, the enhancement of couple communication, and the consideration of gender norms that reduce the reproductive autonomy of women[26].

CONCLUSION

This paper focused on the unmet contraception needs and the role of men participation in family planning among women in Ido/Osi Local Government area of Ekiti State in Nigeria. it was concluded that the level of unmet contraceptive needs among women in Ido/Osi Local Government Area is rather high and closely

depends on the degree of male participation in family planning. Solving of unmet needs thus necessitate interventions that extend beyond the creation of awareness to actively involve men and create mutual reproductive health decision making.

RECOMMENDATION

According to the research results of this study, the family planning interventions in the Ido/Osi Local Government Area need to focus on the participation of men in making reproductive health decisions. As the role of husband was found to be the most important factor in determining unmet contraceptive needs, it should focus on couple-based counseling and male friendly family planning services and community sensitization activities that foster shared responsibility between the partners. The involvement of men will boost the rate at which women are supported to use contraceptives and also to minimize unwanted pregnancies. Also, the comprehensive contraceptive education and service delivery needs to be reinforced. Being the primary provider of contraceptive information, healthcare workers are to receive support in the form of regular training to deliver accurate, client-centered and gender-sensitive counseling, focusing on long-acting reversible contraceptive methods. The community outreach and mass media should also be widened to dispel the myths, enhance knowledge of the existing approaches and strengthen positive perceptions of family planning. At the policy and research levels, the male involvement strategies should be incorporated into the current family planning policies so as to be sustainable and cover wider areas. More research, especially qualitative and mixed-method ones, is suggested to pursue sociocultural and health system determinants of unmet contraceptive needs and male involvement in family planning to inform more effective and context-specific interventions.

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