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Power Dynamics and Family Planning Services Utilisation: Theoretical Perspectives on Gender Influence in Northern Nigeria

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Abstract **Review Article**

Maternal mortality in Nigeria remains among the highest globally, with northern regions experiencing particularly severe outcomes despite decades of global and national investments in reproductive health. Evidence shows that access to family planning (FP) could prevent a substantial proportion of maternal deaths; however, FP uptake in northern Nigeria remains persistently low. This paper examines theoretical perspectives on how gender structures contribute to the poor utilisation of FP services in northern Nigeria, drawing on feminist and masculinity theories and the broader framework of gender as a social determinant of health. While cultural, religious, economic and geographic factors influence contraceptive use, gendered power relations emerge as the most significant barrier. In many northern communities, patriarchal norms grant men control over reproductive decisions, household resources and women's mobility. Studies consistently show that male opposition, whether through explicit disapproval, financial restriction, or social sanctions, significantly reduces women's ability to access or use FP services. Even highly educated women often internalise gender norms that position men as primary decision-makers in matters of fertility and contraception. These dynamics demonstrate that gendered expectations, rather than knowledge or service availability, frequently determine FP use. Feminist theories highlight how gender inequality is structurally produced, while masculinity theories reveal how dominant forms of male identity reinforce hierarchical power relations and restrict women's reproductive autonomy. Connell's relational theory of gender further illustrates how hegemonic masculinity shapes institutional and interpersonal practices that marginalise women's agency in reproductive health. Together, these perspectives explain why FP interventions that overlook gender norms show limited impact. The paper concludes that addressing poor FP utilisation in northern Nigeria requires transformative, gender-responsive strategies that challenge harmful norms, promote equitable decision-making, and build accountability within health systems. Without confronting gendered power relations, efforts to reduce maternal mortality will continue to face substantial obstacles.

Keywords: Gender norms, Family Planning (FP), Maternal mortality, Northern Nigeria, Patriarchal norms, Reproductive autonomy.

INTRODUCTION

Despite advances in obstetric medicine and public health over the past century, maternal mortality continues to claim the lives of women of childbearing age worldwide [1, 2]. In 2023 alone, over 700 women died everyday across the globe from preventable causes related to pregnancy and childbirth [3]. Though pregnancy is recognized as neither a disease nor a disorder, complications related to pregnancy and childbirth resulted in the death of a woman every 2 minutes in 2023, with approximately 260,000 maternal deaths recorded worldwide, 92% of which occurred in low-resourced developing countries [3]. Although over the last three decades many countries have reduced their maternal mortality and contributed to the global decline in maternal deaths, maternal mortality rates have stagnated in sub-Saharan Africa where 70% of deaths occur [2,3].

Nigeria is the second largest contributor to maternal mortality worldwide, losing about 145 women of childbearing age daily [4]. Although the country has the largest economy in West Africa, its annual rate of decline in maternal mortality is slow (1.5%) and the maternal mortality ratio (MMR) remains high at 576 per 100,000 live births [4-7]. Regional differences within the country are substantial due to variations in education, socioeconomic status, culture, religion, access to health

care, and quality of services [8,9]. While the South-West records an MMR of 166 per 100,000 live births, the North-East reaches 1,549 per 100,000 [2].

A large proportion of these deaths are preventable because effective interventions exist (3). Around 74% of maternal deaths could be averted through access to services that help women delay motherhood, space births, avoid unintended pregnancies, and manage complications [10-13]. Access to modern contraceptives alone could prevent about 32% of maternal deaths [14,15]. Over four decades, global family planning (FP) initiatives have helped avert 4.1 million maternal deaths, driven by falling fertility from 6–7 to 2–3 children per woman across much of the developing world—except sub-Saharan Africa, where fertility remains around five children per woman [16,17].

Nigeria's family planning landscape

Despite a high global demand for FP services [18], Nigeria Demographic and Health Surveys (DHS) data from 2003 to 2018 has shown that the uptake of FP services among women of reproductive age remains low despite investments to generate demand and increase utilization at primary and secondary health care centers. Whilst government's effort resulted in increased availability and improved knowledge of modern contraceptives among both married men and women (94%), there have been less than expected gains in contraceptive uptake from 1990 to 2018 by women living in Nigeria (3.8% to 17%) and the North-West geopolitical zone in particular (0.7% to 6.2%). This low uptake of modern contraceptives has resulted in the high total fertility rate that characterizes northern Nigeria (6.6 in North-West and 6.1 in North-East) [19-23].

In contrast, modern contraceptive use rose significantly in the South-West (10.5% to 24.3%) and South-East (3.9% to 12.9%) over the same period [23,24]. Southern TFR ranges from 3.9 to 4.7 [23]. It is important to recognize that northern Nigeria is ethno-linguistically diverse and religiously differentiated from the south, with a predominant Hausa-Fulani and Kanuri Muslim population [23]. However, beyond culture and religion, a wide array of social factors, including education, poverty, gender norms, and women's autonomy, shape access to modern FP.

Social determinants of access to family planning services

Differences in health outcomes across populations often result from social conditions rather than biological predispositions [26,27]. These determinants, shaped by political, economic, social, and cultural environments, influence the distribution of resources, access to health care, and exposure to risks [27,28]. They encompass the social, economic, and physical conditions in which individuals live, grow, learn, work, and age [28]. Because society is structured along lines of gender, wealth, and power [29], women and girls frequently face inequities that negatively affect their health [30,31].

In FP, national data consistently show disparities in access and use linked to socioeconomic status, ethnicity, rural-urban residence, education, and geography [30]. Although government policies have aimed to increase access through free or low-cost FP services, disparities persist, especially between the north and south.

Studies from sub-Saharan Africa show that gender inequalities, religious beliefs, and cultural norms that favour high fertility often exert a stronger influence on contraceptive use than other factors such as cost or distance to facilities [32-34]. Resistance to contraception remains common and often stems from male opposition based on religious interpretations, cultural ideals promoting large families, or fears about side effects [35].

Gender norms determine who holds decision-making power, controls resources, and influences health-seeking behaviour. In most communities, men have greater authority in household decisions, including whether women can access health services [36]. These inequalities result in notable gender differences in health outcomes and access to care [33]. Yet there is still limited understanding of how gendered roles, expectations, and power relations specifically shape women's FP decision-making in northern Nigeria.

Understanding these gender dynamics is essential. Examining FP utilisation through a gender lens can reveal whether social expectations and unequal power prevent women from accessing something they may genuinely desire, contraception, to avoid pregnancies they do not want [37]. It also highlights how structural inequalities and cultural norms impede the effectiveness of FP interventions. Because gender shapes autonomy, mobility, negotiation power, and access to information, analysing FP use without considering gendered constraints risks overlooking the primary barriers facing many women in northern Nigeria. Ultimately, addressing maternal mortality and improving FP utilisation in northern Nigeria requires recognising how gender intersects with religion, culture, poverty, and education to influence reproductive choices. Without understanding these underlying dynamics, efforts to improve FP uptake and reduce fertility will continue to face significant challenges.

Gender as a social determinant of health

Gender is increasingly recognized as a major determinant of health because gender norms, roles, and expectations shape how men and women access services and how health systems respond to their needs [38]. In 2005, the World Health Organization's Commission on Social Determinants of Health (CSDH) identified gender as a key structural driver of unequal living conditions that produce health inequalities [39]. However, scholars

such as Bates, Hankivsky and Springer in 2009 [39] criticized the commission's conceptualisation of gender as too limited and inadequate for purpose. This paper therefore draws on theories of femininity and masculinity to deepen understanding of how gendered practices influence access to family planning (FP).

Whilst socially constructed models of masculinity can have deleterious health consequences for men, women generally tend to bear the major burden of negative health effects from gender-based social hierarchies, partly due to systematic discrimination in access to power and resources, and due to less visible biosocial processes, norms and expectations [38]. These gender relations of power are now understood to constitute the root causes of gender inequality and are among the most influential of the social determinants of health [40]. This is demonstrated by a growing body of evidence which shows that even in health, biology is not destiny, as sex and society, nature, nurture and environment interact in fascinating ways to determine who is well or ill, who is treated or not, who is exposed or vulnerable to ill-health and how, and whose health needs are acknowledged or dismissed [40].

Theoretical overview of gender

In this section, attention is focused on gender theories to examine how societies define masculine and feminine behaviour and how these definitions' structure relationships and institutions [41]. While sex refers to biological categories (male/female), gender refers to the socially produced, varied and complex arrangements between men and women, encompassing the organization of reproduction, the sexual divisions of labour and cultural definitions of masculinity and feminity [41-43]. Understanding gender theory is crucial for analysing how social drivers influence household and community decision-making, including reproductive health choices.

Feminist theories of gender

Feminist theory, a branch of conflict theory, examines gender inequalities and how they are reproduced through social structures [44]. Although feminist scholarship in medical sociology is relatively recent, it has challenged patriarchal assumptions embedded in both sociology and health care systems [45]. Several feminist traditions offer insight into how gender affects women's health and FP access.

Liberal feminism, the mainstream tradition rooted in 18th–19th century rights-based thought, focuses on women's oppression and argues for equality through political and legal reform [29,46]. Many liberal feminists promote androgyny as a means of enabling individuals to combine masculine and feminine traits. Some argue for "monoandrogyny," while others propose "polyandrogyny," where individuals vary across masculine–feminine combinations [29]. While this focus on individual rights supports diversity, critics argue that liberal feminism underestimates collective social forces and offers limited practical strategies for real-world change [47].

Radical feminism emphasizes patriarchal structures as the root of gender inequality [48]. It argues that patriarchy divides power, privilege, and rights along sex lines, silencing women's experiences and privileging men. Radical feminists critique the family as a key institution that reproduces male dominance, especially in settings where men's contributions are more valued and women's perspectives are marginalised. They argue for dismantling patriarchy and ensuring women's full reproductive and sexual freedom, including rejecting compulsory heterosexuality [46,48]. However, critics suggest that radical feminism can be overly narrow in its understanding of gender oppression and fails to offer workable strategies for social change [49].

Marxist feminism focuses on how capitalism and private property systems underpin the exploitation of women [29]. It highlights the gendered division of labour, unpaid domestic work, and the economic foundations of male privilege. Marxist feminists argue that gender oppression cannot be separated from class oppression, and therefore only the overthrow of capitalism can eliminate patriarchy [47]. However, critics note that women's oppression predates capitalism and persists even in communist or low-resource contexts, suggesting that economic change alone cannot eradicate patriarchy (Thompson, 2016).

Psychoanalytic feminists argue that the roots of women's oppression lie within deep psychological processes that shape female identity from early childhood (Tong, 2008; 29). Across various psychoanalytic traditions, they link unconscious mental development with the formation of femininity at both psychological and social levels. They argue that gender and sexuality only emerge once a child acquires language and enters symbolic social structures [29]. This approach highlights internalised gender norms but has been critiqued for lacking clear pathways to structural change.

Other feminist theories, including postmodern feminism, also contribute to understanding gender, although they are not elaborated here [46,50]. Across its three historical waves, feminism has influenced nearly all academic and social domains, challenging entrenched assumptions about human nature, gender roles, and the meaning of "maleness" and "femaleness" [46]. The cumulative effect of feminist theory is a more nuanced understanding of how gendered power relations operate in society, including in health systems and reproductive health decision-making.

Masculinity theories of gender

Much gender scholarship has focused primarily on women's subordination and the disadvantages they face within social structures [51]. However, scholars

note that inequality involves both disadvantage and privilege. Masculinities research therefore examines the social roles and meanings attached to men, the privileges men collectively hold, the costs of those privileges, and the reality that not all men have equal access to them [51]. Masculinity refers to the socially defined roles, behaviours and relations associated with men, which vary historically, culturally, psychologically and contextually [51-53].

Although masculinity now dominates cultural and academic discussions, it is a relatively recent conceptual development, gaining prominence only from the mid-twentieth century [54,55]. Early work labelled these ideas as *sex-role theory*, and Connell (1993) observed that serious historical research on masculinity was rare until the late twentieth century, gradually growing from the 1950s (Hacker, 1957) through the 1980s (Hesselbart, 1981) and 1990s (Messner, 1998) [56]. Masculinity studies attempt to show how gender is socially constructed and how men participate in reproducing gender and sexual inequality [51].

The earliest explanation of masculinity came from sociobiological theory, which interpreted masculine behaviour as an expression of biological maleness [57]. Hormones such as testosterone and genetic factors were seen as driving traits like territoriality, aggression, competitiveness, emotional restraint and sexual promiscuity [58]. While such explanations may help interpret some male behaviours, including men's control over women's decision-making and health access in northern Nigeria, they cannot fully explain the wide health inequalities between men and women [58]. Their essentialist nature also allows little room for social change [57].

Critiques of biological determinism led to the development of role theory, emphasising that behavioural differences arise from socially expected roles attached to gender statuses [57]. Individuals conform to these roles due to rewards, sanctions, and social pressures. Failure to meet societal expectations can produce strain, stress, and negative health consequences [58]. However, role theory was criticised for homogenising behaviour, reinforcing rigid sex differences, ignoring power relations, and failing to account for micro-level socialisation processes [57,59].

In response to these limitations, scholars such as Coleman (1990), Gutterman (1994), Peterson (1998) and Messner (1998) situated masculinity within a postmodern framework, questioning whether masculinity is a coherent or unified concept at all [57]. Clatterbaugh (1998) argued that men's identities are so diverse that the term "masculinity" lacks analytic usefulness [58]. Even if used in plural form ("masculinities"), it remains unclear how these categories are defined, what their components are, or how individuals are assigned to them.

More recent gender and health researchers have turned to Connell's relational theory, which provides a more comprehensive framework for understanding masculinity, gender and health [39]. This approach places emphasis on the patterned social relations between men and women, and among men themselves. Connell's theory conceptualises gender as multidimensional, shaped simultaneously by power relations, economic roles, emotional interactions and symbolic meanings. Gender thus operates at multiple levels: intrapersonal, interpersonal, institutional and societal.

Relational theory highlights everyday social practices such as housework, paid labour, sexuality and childcare as key sites where gender is enacted. These practices also illustrate that gender relations within societies (gender orders) and within institutions (gender regimes) evolve over time [39]. Based on this, Connell (1995) identified several relationally patterned masculinities in contemporary Western gender orders, including hegemonic, subordinated, marginalised and complicit masculinities [58].

Hegemonic masculinity represents the culturally exalted form of manhood that legitimises men's dominance over women and the hierarchy among men [60]. It is not the most common form of masculinity but is treated as normative and is the standard against which other masculinities are positioned [59,60]. It embodies the most honoured way of being a man and sets expectations that other men must navigate in relation to it [59]. Hegemonic masculinity is maintained not primarily through violence but through cultural ideals, institutional power and social persuasion. It supports and justifies men's superiority and the subordination of other gender identities [58,59,60].

Connell argues that even men who do not personally enact hegemonic masculinity still benefit from what she calls the patriarchal dividend; the collective advantages men receive through women's subordination and through the marginalization of certain groups of men [58]. While hegemony does not always involve direct violence, it can be reinforced by coercion or force when needed to maintain men's dominance.

Overall, masculinity theories, from biological determinism to role theory, postmodern critiques and Connell's relational model, demonstrate that masculinities are socially produced, relational, hierarchical and influential in shaping health behaviours, decision-making and access to services. These theories offer critical insight for understanding how men's roles and privileges may influence women's reproductive autonomy and family planning utilisation, particularly in patriarchal contexts such as northern Nigeria.

Gender and family planning

In patriarchal societies such as northern Nigeria, men typically exercise greater authority over women, who often require their permission to access health services, even in emergencies [61]. Although global evidence shows that gender equality promotes contraceptive uptake, African studies examining how gender norms intersect with FP decisions remain limited [61-63]. Some scholars argue that gender inequalities are natural extensions of biological differences and therefore resistant to change, but Sen and Ostlin in 2010 [40] challenge this, asserting that such inequalities are socially produced and amenable to intervention. This was indeed demonstrated in a six-year longitudinal study on FP in Nigeria from 2010 to 2016 by Okigbo *et al.* in 2018 [61]. The study evaluated the association between gender-equitable attitudes and modern contraceptive use by utilizing four exposure variables, namely: wife beating, house-hold decision making, couples' FP decisions and FP self-efficacy, which may differentially affect modern contraceptive use. They were able to demonstrate an increase in the proportion of women reporting higher levels of gender-equitable attitudes towards couples' FP decisions from 40% to 58%, with an increase in FP use from 21% to 32%.

In a study by Rabiu *et al.* in 2016 [64] with grand multiparous women in northern Nigeria, a high-risk group that has an increased risk of complications and poor maternal and perinatal outcomes [65], only 42% were using any FP method due largely to objection by their husbands, despite more than 95% being aware of modern contraceptives. Similarly, some studies in north-central Nigeria, where more than 90% of the participants were either multiparous or grand multiparous, revealed nearly 50% of women were unable to utilize contraceptives due to male partner's hinderance either through complaints to spouse's family, denial of money for feeding or refusal to pay for transport to the clinic [66,67]. Only 7.2% reported covert use of contraceptives. In other communities in the north, women remove contraceptive pills from the sachet and put them in unmarked envelops due to fear of husbands' fury if they discover they use contraceptives [68]. In these parts of the country where cultural division of labour limits women's economic potential and constrains them to unpaid domestic work, it results in widening of economic inequalities and power imbalance in favour of male gender, which contributes to adverse health outcomes among women.

However, even among well-educated women working in or utilizing the services of tertiary health centers in north-east Nigeria, more than two-thirds of them were of the opinion that men do and should influence the contraceptive acceptance and choice by their spouses and objected to the use of any contraceptive without their consent [69]. Despite their high educational status, they objected to the independent right of women to contraceptive acceptance, choice and practice, which suggests that gender and culture may have more influence than education in matters of procreation. As observed by Sen and Ostlin in 2010 [40], gender relations of power constitute the root causes of gender inequalities and are among the most influential of the social determinants of health.

However, women in south-west and south-east Nigeria enjoy a slightly higher degree of gender equity as they are more likely to be involved in joint decision with their partners or be the main decision-makers regarding contraception and family size [70,71]. Despite this, studies in these geopolitical zones revealed that disapproval by husbands, the desire to have more children and the perception that FP promotes infidelity by women were among the main reasons for non-use of FP methods [72-74].

Interestingly, a totally different picture emerged in the study by Ijadunola *et al.* in 2010 [75] and Ezeanolue *et al*. in 2015 [76] in southern Nigeria which showed that men who had partners that expressed a desire to use contraception were more likely to be aware of modern contraceptives and support their spouses' use. Thus, it appears good spousal communication about FP could significantly improve men's approval of contraception by women. Although this indicates an imbalance of power and control over contraceptive use decision making, it nevertheless underscores the fact that taking adequate steps to minimize gender bias in programme design and implementation by using systematic approaches that build awareness and transform values among service beneficiaries can improve utilization of services [40].

CONCLUSION

Although global surveys since the 1970s have shown a clear desire for fertility control [77], FP uptake in Nigeria remains low, with little progress despite expansion of services [78]. This review demonstrates that imbalanced gender relations strongly shape contraceptive decisions. Women are frequently denied service access through direct male opposition or choose not to use FP due to gendered expectations, fear of conflict, or cultural norms. Contrary to our understanding that educational status and capabilities of women influence their behaviour, we have seen that even highly educated women may internalize these norms, indicating that education alone does not overcome gendered power structures. The persistence of these dynamics in northern Nigeria underscores the need for deeper understanding of how gender relations exert modicum of control and shape women's perceptions of reproductive rights and their ability to exercise them. As public health professionals and family physicians, we recognize that minimizing gender bias in FP programmes requires approaches that transform provider and community values, strengthen accountability, and expand equitable access to services [40]. Addressing gendered power relations is therefore essential for

improving maternal health and increasing FP utilisation in northern Nigeria.

REFERENCES

1. Zureick-Brown S, Newby H, Chou D, Mizoguchi N, Say L, Suzuki E, Wilmoth J. Understanding global trends in maternal mortality. Int Perspect Sex Reprod Health. 2013;39(1). doi:10.1363/3903213.
2. Meh C, Thind A, Ryan B, Terry A. Levels and determinants of maternal mortality in northern and southern Nigeria. BMC Pregnancy Childbirth. 2019; 19:417. doi:10.1186/s12884-019-2471-8.
3. World Health Organization. Maternal mortality [Internet]. 2025 [cited 2025 May 12]. Available from: https://www.who.int/news-room/fact-sheets/detail/maternal-mortality
4. UNICEF. Nigeria: Maternal and child health [Internet]. 2017 [cited 2024 Oct 29]. Available from: https://www.unicef.org/nigeria/children_1926.html
5. Durojaye E. Substantive equality and maternal mortality in Nigeria. J Legal Pluralism Unoff Law. 2013;44(65):103–132.
6. National Population Commission, ICF International. Nigeria Demographic and Health Survey 2013. Abuja: NPC; 2014.
7. World Health Organization. Maternal mortality in 1990–2015. Geneva: WHO; 2015.
8. Siegrist J, Marmot M. Social inequalities in health: new evidence and policy implications. Oxford: Oxford University Press; 2006.
9. UNICEF. Maternal health: current status and progress [Internet]. 2017 [cited 2024 Oct 29]. Available from: http://data.unicef.org/topic/maternal-health/maternal-mortality/
10. Department for International Development. Choices for women: planned pregnancies, safe births and healthy newborns [Internet]. 2010 [cited 2024 Oct 27]. Available from: http://www.dfid.gov.uk/documents/prd/rmnh-framework-for-results.pdf
11. UNFPA. Reducing maternal mortality: the contribution of the right to the highest attainable standard of health. New York: UNFPA; 2012.
12. Chola L, McGee S, Tugendhaft A, Buchmann E, Hofman K. Scaling up family planning to reduce maternal and child mortality: costs and benefits of modern contraceptive use in South Africa [Internet]. 2015 [cited 2024 Oct 16]. Available from: http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0130077
13. Ganatra B, Faundes A. Role of birth spacing, family planning services, safe abortion services and post-abortion care in reducing maternal mortality. Best Pract Res Clin Obstet Gynaecol. 2016;36:145–155.
14. Population Reference Bureau. Family planning saves lives [Internet]. 2009 [cited 2024 Dec 2]. Available from: https://www.prb.org/fpsl/
15. Osotimehin B. Family planning saves lives, yet investments falter. Lancet. 2012;380(9837):82.
16. Global Health eLearning Centre. Maternal survival – programming issues: deaths averted with family planning [Internet]. 2008 [cited 2024 Jun 28]. Available from: http://www.globalhealthlearning.org/page.cfm?course=53&topic=3&page=2
17. Rossi P. Strategic choices in polygamous households: theory and evidence from Senegal [Internet]. 2016 [cited 2024 May 17]. Available from: https://economics.stanford.edu/sites/g/files/sbiybj9386/f/pauline_rossi_2016_restud.pdf
18. Mwaikambo L, Speizer IS, Schurmann A, Morgan G, Fikree IS. What works in family planning interventions: a systematic review. Stud Fam Plann. 2011;42(2):67–82.
19. Izugbara C, Ibisomi L, Ezeh AC, Mandara M. Gendered interests and poor spousal contraceptive communication in Islamic northern Nigeria. J Fam Plann Reprod Health Care. 2010;36(4):219–224.
20. Kana MA, Tagurum YO, Hassan ZI, et al. Prevalence and determinants of contraceptive use in rural Northeastern Nigeria. Ann Niger Med. 2016; 10:3–10.
21. World Health Organization. Family planning/contraception [Internet]. 2016 [cited 2024 Feb 2]. Available from: http://www.who.int/mediacentre/factsheets/fs351/en/
22. Adanikin AI, McGrath N, Padmadas SS. Impact of men's perception on family planning demand and uptake in Nigeria. Sex Reprod Healthc. 2017; 14:55–63.
23. National Population Commission, ICF International. Nigeria Demographic and Health Survey 2013. Abuja: NPC; 2019.
24. Federal Office of Statistics. Nigeria Demographic and Health Survey 1992. Lagos: FOS; 1992.
25. Gwarzo TH. Islamic Religious Leaders and Family Planning in Northern Nigeria. J Muslim Minor Aff. 2011;31(1):143–151.
26. World Health Organization. A conceptual framework for action on the social determinants of health [Internet]. 2010 [cited 2024 Dec 19]. Available from: https://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf
27. Rubin L. Social determinants of health. In: Rubin L, Merrick J, Grydanus DE, Patel DR, editors. Social determinants of health in health care for people with intellectual and developmental disabilities. Switzerland: Springer; 2016.
28. World Health Organization. Social determinants of health [Internet]. 2020 [cited 2024 Dec 2]. Available from: https://www.who.int/health-topics/social-determinants-of-health
29. Monro S. Gender politics: citizenship, activism and sexual diversity. London: Ann Arbor; 2005.

30. World Health Organization. Social determinants of sexual and reproductive health. Geneva: WHO; 2010.
31. World Health Organization. Women and gender equity [Internet]. 2019 [cited 2024 Dec 26]. Available from: https://www.who.int/social_determinants/themes/womenandgender/en/
32. Unumeri G, Ishaku S, Ahonsi B, Oginni A. Contraceptive use and its socio-economic determinants among women in north-east and north-west Nigeria. Afr Pop Stud. 2015;29(2):1851–1867.
33. Ezeah P, Achonwa C. Gender inequality in reproductive health services and sustainable development in Nigeria. Int J Sociol Anthropol. 2015;7(2):46–53.
34. Measure Evaluation. Contraceptive prevalence rate (CPR) [Internet]. 2017 [cited 2024 Aug 23]. Available from: https://www.measureevaluation.org/prh/rh_indicators/family-planning/fp/cpr
35. Cleland JG, Ndugwa RP, Zulu EM. Family planning in sub-Saharan Africa: progress or stagnation? Bull World Health Organ. 2011;89:137–143. doi:10.2471/BLT.10.077925.
36. Sahay KH. Couples' agreement on gender norms and modern contraceptive use in urban Nigeria. Sci Eng. 2018;78(11-B)(E).
37. Creanga AA, Gillespie D, Karklins S, Tsui AO. Low use of contraception among poor women in Africa. Bull World Health Organ. 2011;89:258–266.
38. World Health Organization. Gender as a social determinant of health: gender analysis of the health sector in Cambodia [Internet]. 2011 [cited 2024 Dec 19]. Available from: https://www.who.int/sdhconference/resources/draft_background_paper15_cambodia.pdf
39. Connell R. Gender, health and theory: local and world perspectives. Soc Sci Med. 2012;74:1675–1683.
40. Sen G, Ostlin P. Gender equity in health. New York: Routledge; 2010.
41. Jule A. Gender theory. In: Michalos AC, editor. Encyclopedia of Quality of Life and Well-Being Research. Dordrecht: Springer; 2014.
42. Holmes M. What is gender? Sociological approaches. London: Sage; 2007.
43. Bradley H. Gender. 2nd ed. Cambridge: Polity Press; 2013.
44. Parpart JL, Connelly MP, Barriteau VE. Theoretical perspectives on gender and development. Ottawa: IDRC; 2000.
45. Annandale E, Clark J. What is gender? Sociol Health Illn. 1996;18(1):17–44.
46. Tong R. Feminist theory. Int Encycl Soc Behav Sci. 2001;5484–5491.
47. Gerson G. Liberal feminism: individuality and oppositions in Wollstonecraft and Mill. Polit Stud. 2002;50:794–810.
48. Lewis JJ. What is radical feminism? [Internet]. 2019 [cited 2024 Dec 29]. Available from: https://www.thoughtco.com/what-is-radical-feminism-3528997
49. West E. The pitfalls of radical feminism [Internet]. 2017 [cited 2024 Dec 30]. Available from: https://jacobinmag.com/2017/07/radical-feminism-second-wave-class
50. Elbert TL. The "difference" of postmodern feminism. Coll Engl. 1991;53(8):886–904.
51. Kimmel M, Bridges T. Masculinity [Internet]. 2014 [cited 2024 Feb 19]. Available from: https://www.oxfordbibliographies.com/view/document/obo-9780199756384/obo-9780199756384-0033.xml
52. Kimmel M. Masculinities and feminities [Internet]. 2001 [cited 2024 Feb 20]. Available from: https://www.sciencedirect.com/topics/medicine-and-dentistry/masculinity
53. Mac an Ghaill M, Haywood C. Understanding boys: masculinity and suicide. Soc Sci Med. 2012;74(4):482–489.
54. Connell RW. Masculinities. 2nd ed. Cambridge: Polity Press; 1995.
55. Whitehead SM. Men and masculinities. Oxford: Blackwell Publishing; 2002.
56. Tosh J. The history of masculinity. In: Arnold J, Brady S, editors. What is Masculinity? London: Palgrave Macmillan; 2011.
57. Robertson S. Theories of masculinities and men's health-seeking practices [Internet]. 2008 [cited 2020 Feb 18]. Available from: http://man-ni.org/resources/stevespeech.pdf
58. Robertson S. Understanding men and health. Berkshire: Open University Press; 2007.
59. Connell RW, Messerschmidt JW. Hegemonic masculinity. Gender Soc. 2005;19:829–859.
60. Anderson E. Inclusive masculinity in a fraternal setting. Men Masculinities. 2008;10(5):604–620.
61. Okigbo CC, Speizer IS, Domino ME, Curtis SL, Halpern CT, Fotso JC. Gender norms and contraceptive use in urban Nigeria. BMC Womens Health. 2018;18:178.
62. Bogale B, Wondafrash M, Tilahun T, Girma E. Decision making power and contraceptive use in Ethiopia. BMC Public Health. 2011;11:342.
63. Nanda G, Schuler SR, Lenzi R. Gender attitudes and contraceptive use in Tanzania. J Biosoc Sci. 2013;45(3):331–344.
64. Rabiu A, Abubakar IS, Garba I, Haruna IU. Contraceptive choices in grand multiparous women in Kano. Ann Afr Med. 2016;15(2):58–62.
65. Mgaya AH, Massawe SN, Kidanto HL, Mgaya HN. Grand multiparity in pregnancy. BMC Pregnancy Childbirth. 2013;13:241.
66. Fakeye O, Babaniyi O. Reasons for non-use of family planning methods. Trop Doct. 1989;19:114–117.

67. Balogun O, Adeniran A, Fawole A, et al. Effect of male partner support on contraception. Ethiop J Health Sci. 2016;26(5):439–448.
68. Ujuju C, Anyanti J, Adebayo SB, Muhammad F, Oluigbo O, Gofwan A. Religion, culture and male involvement in contraception. Int Nurs Rev. 2011;58:484–490.
69. Bukar M, Audu BM, Usman HA, et al. Gender attitude and contraceptive acceptance. J Obstet Gynaecol. 2013;33(2):180–183.
70. Orji EO, Ojofeitimi EO, Olanrewaju BA. The role of men in family planning. Eur J Contracept Reprod Health Care. 2007;12(1):70–75.
71. Aransiola JO, Akinyemi AI, Fatusi AO. Male partners and family planning dynamics. BMC Public Health. 2014;14:869.
72. Okwor EU, Olaseha IO. Men's perception of spousal contraceptive use. Int Q Community Health Educ. 2010;30(3):223–238.
73. Durowade KA, Omokanye LO, Elegbede OE, et al. Barriers to contraceptive uptake. Ethiop J Health Sci. 2017;27(1):121.
74. Chigbu CO, Onyebuchi AK, Onwudiwe EN, Iwuji SE. Denial of women's rights to contraception. Int J Gynecol Obstet. 2013;121:154–156.
75. Ijadunola MY, Abiona TC, Ijadunola KT, et al. Male involvement in family planning. Afr J Reprod Health. 2010;14(4):45–52.
76. Ezeanolue EE, Iwelunmor J, Asaolu I, et al. Male partner awareness and contraceptive support. BMC Public Health. 2015;15:879.
77. Schenker JG, Rabenou V. Family planning: cultural and religious perspectives. Hum Reprod. 1993;8(6):969–976.
78. Blackstone SR. Determinants of contraceptive use among Nigerian couples. Contracept Reprod Med. 2017;2:9.