International Journal of Multicultural and Multireligious Understanding

http://ijmmu.com
editor@ijmmu.com
ISSN 2364-5369
Volume 5, Issue 1
February, 2018
Pages: 63-76

The Right to Family Planning Services in Sokoto, Nigeria

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http://dx.doi.org/10.18415/ijmmu.v5i1.157

Abstract

The study examines all options and stipulations to family planning services as recognized in national laws, international human rights documents and other United Nations consensus documents. The study adopts quantitative method of data collection and a cluster sampling procedure in selecting respondents. The total sample size for the study was four hundred and eight (408) and two types of questionnaires were administered to the three hundred and eighty-four (384) respondents who were clients of family planning services and twenty-four (24) respondents, who were government agents providing family planning services in the metropolis of Sokoto in north western Nigeria. Descriptive statistics was used for data analysis and Statistics Package for Social Science (SPSS) to compute the data into frequency and percentage. The study reveals that government has been able to play its obligatory role as rights bearer by its provision and protection of client's rights to family planning services and maternal health, but more effort is still required in capacity building of personnel. The study recommends that government should intensify its efforts on the dissemination of accurate and adequate information on family planning. Efforts on capacity building of providers should be accelerated; poverty eradication and increased literacy level should be a major focus.

Keywords: Ethics; Human rights; International law; Contraceptives; Women

Introduction

Reproductive health which family planning is a sub-theme has been a major concern to people and government around the world. More than half of the world's married couples are family planning users (Hatcher *et. al*. 2001, p. viii). The linkage between population, sustained economic growth and sustainable development has always been articulated by successive governments in Nigeria (Obono, 2002, p.248-249). Implicit to sustainable development, is the right of men and women to be informed and have access to safe, effective affordable and acceptable methods of family planning of their choices as adopted at the International Conference on Population and Development (ICPD) Cario,1994; World Population Conference (WPC) 1975; Convention of the Elimination of Discrimination Against Women (CEDAW) 1976-1986; International Covenant on Civil and Political Rights (ICCPR); International Covenant on Economic, Social, and Cultural Rights (ICESCR) 1976; African Charters on Human and People's Rights 1981; The 1992 and 2012 conferences on women reproductive rights and health in Brazil, and Brazil respectively. In effect, section 17(3) (C) of the Nigerian Constitution although under chapter II on

Directive Principles of State Policy states that: the state shall direct its policy towards ensuring that the health, safety and welfare of all persons in employment are safeguarded and not endangered or abused.

Other local enactments include the Anambra State Women's Reproductive Rights laws 2005 and Imo state Women's Reproductive Bill 2009 all geared towards protection and promotion of the reproductive health of women under chapter II on Directive Principle of State Policy. Similarly, Protocol to African Charter on Human and Peoples Rights on the rights of women in Africa has its provisions to include amongst others (i) state parties shall ensure the rights to health of women (ii) state parties shall ensure the rights of women to choose any method of contraception (PACHPR, 2005). Articles (Obono, 2002), (Napaporn et al., 1984) and (Population Council, 2012) (1) of the International Covenant on Economic, Social, and Cultural Rights (ICESCR) also points to this direction. In effect, (Obono, 2002) protects the rights of all persons to enjoy the highest attainable standard of physical and mental health. Specifically, Article 10 grants special protection to pregnant women thus, the provision requires governments to make reproductive health, Family planning and safe motherhood services and information accessible to women. In this regard, it is the duty and obligation of governments (right bearers) of nations that are signatory to the international documents and instruments to make the afore-mentioned conditions implicit to sustainable development a reality. However, laws of the state exist in order to regulate social interaction, to create rights and impose duties and obligations such that conflict would be restricted and channel of cooperation would be promoted (Abdulsalam and Usman, 2003, p.148). In the same vein, human rights law is based on the principle that the state (government) is the primary entity obligated to respect, protect and fulfill the rights of those in its territory (Donelly, 2002, p.34). Further, the state is to ensure that its constitution, law, policies, budgets and practices reflect these legal obligations and help to achieve, rather than undermining the enjoyments of the full spectrum of human rights (Donelly, 2002, p.34).

Material and Method

Study Area

Sokoto state is the seat of the Caliphate and was carved out from the former North Western state in 1979. Sokoto state is located in North-Western part of Nigeria with latitude 11^0 30^i to 13^0 54^iN and longitude 4^0 10^i to 6^0 40^iE. It shares boundaries with the Republic of Niger to the North, Kebbi State to the South and West and Zamfara State to the East. Sokoto state is made up of twenty three (23) local government areas, covering a total land mass of approximately 36,200.86 square kilometers. Sokoto metropolis which is the state capital comprises Sokoto North; Sokoto South; Wamako, Dangeshuni and Kware local government areas (NPC-Census Reports, 2007. Both the Sokoto North and South local government areas fall entirely within the metropolis and a larger part of Wamako local government area fall within the metropolis. A little land mass of Dangeshuni and Kware L.G.A also fall in the metropolis. The metropolis has within it, the Sultan Palace, the Military Barracks, the Usmanu Danfodiyo Teaching Hospital, the Usmanu Danfodiyo University, Government Primary, Secondary and tertiary Health Care Centers, as well as several Private Maternity Health Care Centres. The study area is populated by Hausa-Fulani and many other ethnic groups from within and outside Nigeria.

Population of the Study

The population of the study was married cohabiting or ever married women who were clients of family planning services agencies and principal officers of government agencies providing family planning services within the metropolis of Sokoto. The population of females in Sokoto North; Sokoto South; Wamako; Dangeshuni and Kware was 108,878, 94,479, 87,780, 95,734 and 67,306 respectively as of 2006 (NPC-Census Reports, 2007). World Development Report (2005) put it that in every female

population, 25% constitutes women of child bearing age between 15-49 years in Third World countries. Consequently, a total estimate of 114,000 was of child bearing age between 15-49 years in the metropolis of Sokoto, Nigeria.

Sampling Procedure

The research design was descriptive survey and a cluster/area sampling procedure was used in selecting respondents. The total sample size for the study was four hundred and eight and two types of questionnaires were administered to three hundred and eighty-four respondents who were clients of family planning services and twenty-four respondents who were government agents providing family planning services in Sokoto metropolis. To ensure a correct administration of questionnaires, female research assistants with post-secondary education were employed and trained after which the trainees were allowed to explain how each question on the questionnaires should be answered. The questionnaires were pilot tested. The questionnaires were given to colleagues for content and face validity, Pearson's Product Moment Correlation and Crombach's alpha test was used to established the reliability (stability and internal consistency) of the instruments (questionnaire A& B) and the reliability estimate of the two instruments was ascertained by the results of the computation with a strong positive correlational index; r = 0.83 and r =0.89 respectively.

The metropolis was divided into five clusters/area according to the number of LGAs and enumeration areas that constituted the metropolis .Enumeration areas were selected proportionately based on the total number of EAs in each of the LGAs in the following percent: 7 EAs (1%), 6 EAs (1%), 6 EAs (1%), 2 EAs (0.5%), 3 EAs (0.5%) for Sokoto North/Sabon Birni Area, Sokoto south/ Tudun Wada Area,Wamako/ Arikila Area, Dangeshuni/Kwanawa Area, and Kware/More Area respectively. The total households selected from the order afore-mentioned were 364, 354, 366, 162, and 144 respectively. The total number of respondents systematically and randomly selected were 90, 90, 90, 57 and 57 at an interval of 4, 3, 4, 2, 2 respectively thus making a total of 384 respondents for type A questionnaires (households questionnaires). The respondents for type B questionnaires were purposively selected. Two respondents each were selected by facility type in the following order PHC 9, Secondary Health Center 2 and Tertiary Health Center 1. Over all, a total of 24 respondents were sampled for type B questionnaires. The period of the study was from 2008-2013 using the Nigerian Demographic and Health Survey (NDHS) 2008 as base line.

Table 1 Distribution of respondents using sample size 384 by Cluster, Enumeration Area (EA) and household in Sokoto Metropolis

Cluster	Total no of (EAs)	Total no of households	Estimated households per (EA) by average	% total no of (EAs) selected	Total no. households by (EAs) selected	Interval Nth	Total no of respondents by (EAs) selected
Sokoto North Sabon Birni Area	735	38,216	52	7 (1%)	364	4	90 (25%)
Sokoto South Tudun Wada Area	581	34,031	59	6 (1%)	354	3	90 (25%)
Wamako Arikilla Area	602	36,491	61	6 (1%)	366	4	90 (25%)
Dange/shuni Kwanawa Area.	459	37,571	81	2 (0.5%)	162	2	57 (12.5%)
Kware More Area	581	28,137	48	3 (0.5%)	144	2	57 (12.5%)
Total	1390						384 (100%)

Total number of households, EAs was sourced from (N.P.C-Census Reports, 2007)

Table 2 Distribution of respondents (principal officers and sample size 24 purposively selected) of government agencies by facility type providing family planning services in Sokoto Metropolis

Facility type	Number of facility	Number of respondent
Primary Health Center	9	18
Secondary Health Center	2	4
Tertiary Health Center	1	2
Total	12	24

Total sample size for the study = 384+ 24= 408

Results Analysis and Discussion of Findings

Table 3 shows that 25.3% of the respondents fell within the age bracket 14yrs-18yrs, 47.4% fell within the age bracket 19yrs-30 yrs. While 27.3% were within the age bracket 31yrs-49 yrs. This implies that those who use modern family contraceptives in Sokoto metropolis are highest in number in the age bracket 19yrs-30 yrs, followed by 31yrs-49 yrs and 14yrs-18yrs respectively. Further, the Table shows that 10.7 % of the respondents were Tertiary level school certificate holders. While 17.2%, 26.3% of the respondents had Secondary and primary education. Similarly, 45.8% of the respondents had Koranic

education only. This implies that sizeable number of the respondents had no formal education, a condition that is rooted in ignorance which further inhibits the recognition and agitations for basic fundamental human rights. With regards to spouses' category of occupation, 9.6% of the respondents' spouses are of professional cadre such as lawyer, accountants, lecturers, doctors, commissioned military and para military officers, etc., 33.1% and 34.9% of the respondents' spouses were non manual skilled labourer such as teachers, non- commissioned military and para military officers, executive officers in government parastatals, secretaries etc., and manual skilled labourer such as Achaba riders, shop owners, traditional farmers, carpenter, mechanics, Goldsmith etc., respectively. 22.4% of the respondents' spouses were manual unskilled, such as casual labourers, Street cleaners, truck pushers etc. Regarding the religion of respondents, 82.6% of the respondents were of Islamic faith, while 17.4% was of Christian faith. This implies that Sokoto metropolis and Sokoto State in particular is a Muslim majority society.

Table3 Socio-economic and demographic characteristics of respondents

	Frequency	Percentage (%)
Age		
14yrs-18yrs	97	25.3
19yrs-30yrs	182	47.4
31yrs-49yrs	105	27.3
Total	384	100.0
Level of Education		
Tertiary	41	10.7
Secondary	66	17.2
Primary	101	26.3
Koranic education only	176	45.8
Total	384	100.0
Spouse category of occupation		
Professional	37	9.6
Non manual skilled	127	33.1
Manual skilled	134	34.9
Manual unskilled	86	22.4
Total	384	100.0
Religion		
Islam	317	82.6
Christianity	67	17.4
Traditional	-	-
Total	384	100.0

Source: Author's Field Survey

Table 4 shows that 30.5%, 57.6%, of the respondents sourced their information and contraceptive method from government hospital and family planning clinic respectively. While, 4.4%, 2.9%, and 4.6% sourced their information and method from private doctor, pharmacy and private hospitals respectively. This implies that, 88.1% of the respondents sourced their information and method from government agencies providing family planning services, while a total of 11.9% sourced their information and method from private doctor, pharmacy or private clinic. Besides, 80.5% and 11.7% of the respondents had the knowledge of their source from television/ radio and family members respectively. While, 4.2%, 2.3% and 1.3% got to know their source through mosque, church and friend respectively. This implies that the media is playing a significant role in the dissemination of information on family planning services.

Table 4 Respondents on source of family planning knowledge

	Frequency	Percentage (%)
Agency Type		
Government hospital	117	30.5
Government Family planning clinic	221	57.6
Mobile clinic	-	-
Private doctor	17	4.4
Pharmacy	11	2.9
Private hospital/clinic	18	4.6
Others	-	-
Total	384	100.0
Source of Knowledge of Agency		
Television	309	80.5
Family member	45	11.7
Mosque	16	4.2
Church	9	2.3
Friend	5	1.3
Others	-	-
Total	384	100.0.0

Source: Author's Field Survey

Table 5 and 5.1 show that, 82.6% of the respondents agree that the provider gave key information to specific needs and methods. 14.1% of the respondents had a contrary opinion, that is, no key information regarding their specific needs at the time of visit to provider. On accurate understanding of methods by clients, 88.1% agreed that they understood accurately their method. But, 11.9% had a contrary opinion. This implies that a great majority of the respondents accurately understood their method. With regards to practical display of method such as cervical cap, diaphragm, jelly/spermicides, Iud as preventive measures against cancer and other diseases, 92.2% of respondents agreed to the fact that, provider displayed to them how methods such as cervical cap, diaphragm, spermicide etc., prevent contraception, while 7.8% had a contrary opinion. Further, 76.0% of the respondents agreed that provider gave detailed information regarding side effects of their contraceptive method, 22.4% agreed but claimed that, the information was not too detailed, and 1.6% claimed that there was no discussion of such by the provider. Similarly, Table 5.1 shows that 94.0% of the respondents agreed that the provider assured them of their rights to discontinue methods that threatens their lives. While, 6.0% had a contrary opinion, that is, no assurance was given regarding their rights to discontinue methods that threaten their lives. Besides, 88.1% of the respondents agreed that there was knowledge on the possibility to choose another method under poor health status. While, 11.9% of the respondents had a contrary opinion, that such information was not available to them. On the respondents' knowledge regarding methods that can protect against HIV/AIDs, cancer and other diseases, 86.5 % of the respondents attested to the fact that provider educated them on how certain methods of contraceptive prevent HIV/AIDs, cancer and other diseases. But, 11.7% had a contrary opinion. Further, 98.2% of the respondents claimed that they were asked to return when problems are noticed, while 1.8% of the respondents claimed otherwise.

Table 5 Respondents on adequate knowledge of contraceptive method

	Frequency	Percentage (%)
Key information to specific needs		
Yes	317	82.6
No	54	14.1
Missing cases	13	3.3
Total	384	100.0
Accurate understanding of methods		
Yes	338	88.1
No	46	11.9
Total	384	100.0
Practical display of methods on conception prevention		
Yes	354	92.2
No	30	7.8
Total	384	100.0
Specific and detailed information on side effects of methods		
Yes and detailed	292	76.0
Yes but not detailed	86	22.4
No discussion of such	6	1.6
Total	384	100.0

Table 5.1 Respondents on specific information on life threatening conditions

	Frequency	Percentage (%)
Assurance to discontinue methods that threatens life		
Yes	361	94.0
No	23	6.0
Total	384	100.0
Knowledge to and possibility to choose another method under poor health status		
Yes	338	88.1
No	46	11.9
Total	384	100.0
Knowledge about methods that can prevent diseases		
Yes	332	86.5
No	45	11.7
Missing cases	7	1.8
Total	384	100.0
Instructions to return as soon as problems noticed		
Yes	377	98.2
No	7	1.8
Total	384	100.0

Source: Author's Field Survey

Table 6 shows that 93.2% of the respondents claimed they have never experienced un-intended pregnancy within first year of using method. While, 6.8% claimed they experienced un-intended pregnancy. This finding suggests that the various methods adopted by clients have been good enough to prevent conception. In the same vein, 5.5% of the respondents claimed that they made complaints to provider within the first year of using their adopted method. While, 94.5% claim they never made complaints within the first year of using their method. On anticipation of fear of pregnancy by clients, 11.7% of the respondents claimed that they entertained fear of pregnancy, while 88.3% claimed they never entertained any fear whatsoever within the first year of using their method. Besides, Table 6.1 shows that 26.8% and 47.9% of the respondents claimed that the cost of their contraceptives was very cheap and cheap respectively. 4.2%, and 21.1% of the respondents rated their contraceptive method as very costly and costly respectively. This suggests that, 74.7% of the respondents agreed that their contraceptive method were cheap and 25.3% agreed that their contraceptive methods were costly. By implication, contraceptive method is cheap and affordable to the clients.

Table 6 Respondents on access to safe and affordable contraceptive methods

	Frequency	Percentage (%)
Experienced un-intended pregnancy within first year of using method		
Yes	26	6.8
No	378	93.2
Total	384	100.0
Complained to provider within first year of using method		
Yes	21	5.5
No	363	94.5
Total	384	100.0
Anticipated fear of pregnancy within first year of using method		
Yes	45	11.7
No	339	88.3
Total	384	100.0

Table 6.1 Rating monetary costs of contraceptive method

Response	Frequency	Percentage (%)
Very Cheap	103	26.8
Cheap	184	47.9
Very Costly	16	4.2
Costly	81	21.1
Total	384	100.0

Source: Author's Field Survey

Table 7 shows that 88.3% of the respondents agreed that there were adequate consultation times with the provider to discuss their problems. 11.7% of the respondents had a contrary opinion. The implication of this finding is that clients were treated with a "human face" and readiness by the provider to understand clients' problems thus supporting the notion of 'accessibility to method' according to Napoporn *et al.* (1984). Besides, 39.3 % of the respondents claimed that they have participated actively in the discussion and selection of method. While, 60.7 % of the respondents claimed they have not actively participated in the discussion of method. This finding re-affirms the patriarchal beliefs regarding who takes decision between husband and wife in matters concerning women in Muslim majority societies. With regards to encouraging clients to ask questions by provider, 86.7% of the respondents attested that the provider encouraged them to ask questions, while 13.3 % had a contrary opinion. This finding suggests that providers are democratic when relating with their clients. In the same vein, 47.9% of the respondents claimed they have asked questions and received courteous and complete answers from the provider. While,2.9% of the respondents also asked questions but never received courteous answers. However, 49.2% of the respondents claimed they have never bordered to ask questions from the provider let alone received courteous and complete answers from the provider. This finding further supports the strong hold of patriarchy in decision making in matters relating to women in Muslim majority societies and in general, African societies. On acceptance of methods without preferences and values interjected and interfered with, 55.9% of the respondents agreed that they received their method without their preferences not interfered with. While 42.9% of the respondents claimed that they received their method, but their preference was interfered with. This finding suggests that, some clients still prefer the traditional method of birth control. In which case, the respondents still hold tenaciously to some socio-cultural beliefs regarding the adoption of modern contraceptive. Besides, Table 7.1 shows that 47.7% of the respondents claimed they have never switched from one method to another before. While, 52.3% of the respondents claimed that they have switched at one time or another. This finding suggests that clients that have switched might have done so perhaps on medical grounds, failure of method or lack of adequate knowledge of suitable methods. Besides, 85.8% of the respondents claimed that provider respected their decision to switch from one method to another, while 14.2% had a contrary opinion that is; their decision to switch from one method to another was not respected by provider. On refusal of suggestions and services of providers, 7.1% of the respondents claimed that they have refused the suggestions given to them by provider. While, 92.9% claimed they never refused provider's suggestions at any one time. This finding suggests that some clients still exercise their rights to reproductive choice perhaps out of sheer ignorance or on some reliable grounds best known to clients. 66.7% of the respondents maintained that the provider respected their decision to refuse provider's suggestions, while, 33.3% had a contrary opinion. This finding suggests that providers still respect clients' views. Further, 93.2% of the respondents agreed that they had experienced and enjoyed cordial treatment from their providers. While, 6.8 of the respondents claimed that they never had never experienced and enjoyed cordial treatment with their respondents. Given the 93.2 % of respondents that claimed that they have experienced and enjoyed cordial treatment from the provider, this finding suggests a client-centered approach to family planning services by the providers.

Table7 Respondents on government personnel imbued with counseling techniques and communication skills necessary for quality care and respect for client's rights

	Frequency	Percentage (%)
Adequate consultation time to discuss with provider		
Yes	339	88.3
No	45	11.7
Total	384	100.0
Actively participated in the discussion and selection of methods		
Yes	151	39.3
No	233	60.7
Total	384	100.0
Encouraged to ask questions by provider		
Yes	333	86.7
No	51	13.3
Total	384	100.0
Received courteous and complete answers from provider		
Yes	184	47.9
Yes with no courteous answer	11	2.9
Never attempted any question	189	49.2
Total	384	100.0
Acceptance of method without preferences interfered with		
Yes	215	55.9
No	165	42.9
Missing cases	4	1.2
Total	384	100.0
Table 7.1 Cognizance and respect for client's basic rights		
	Frequency	Percentage (%)
Switched from one method to another at any one time		
Yes	183	47.7
No	201	52.3
Total	384	100.0
Provider respected switch even if frequent	Frequency	Percentage (%)
Yes	157	40.9
No	26	6.8
Missing cases*	201	52.3
Total	384	100.0
Have refused provider's suggestions and services before		
Yes	27	7.1
No	357	92.9
Total	384	100.0
Refusal of suggestions and		

services respected by provider		
Yes	18	4.7
No	9	2.3
Missing cases*	357	93.0
Total	384	100.0
Experienced and enjoyed cordial treatment from provider		
Yes	358	93.2
No	26	6.8
Total	384	100.0

Source: Author's Field Survey
*respondents that skipped the question

Table 8 shows the mean value of each item from 1-13 are 4.9, 4.8, 4.4, 3.9, 5.0, 4.9, 4.9, 4.7, 4.1, 4.5, 4.9, 3.3, and 2.7 respectively. Table 8, further, shows that the average means of item 1-12 are above the average mean 3.0 while the mean for the last item (13) is below the average mean 3.0. The implication of this is that all of the respondents agreed on the questions for each item from item 1-12 and disagreed only on item 13 that clients do not readily accept contraceptive methods because of their cherished cultural values when average mean decisional rule is considered. However, considering frequency distribution, 4, 1,4,10 and 14 respondents disagreed on item 4, 8,9,12 and 13 respectively. Overall, this suggests that government efforts have been adequate enough to provide and protect client's basic rights to family planning.

Table 8 Respondents on government's adequate efforts to provide and protect client's basic rights

S/N		SA	A	UD	DA	SDA	N	X	DECISION
1	Government policy specifically mentions the right to free and informed choice to plan one's family	22	2	-	-	-	24 118	4.9	Agree
2	Government's policy specify make informed choice as a key goal	20	4	-	-	-	24 116	4.8	Agree
3	Government's policy on family planning is adequate enough to provide and protect the basic rights of clients	13	8	3	-	-	24 106	4.4	Agree
4	Government through its planning agencies have been able to eliminate all unnecessary barriers and arbitrary restrictions on who can be served	9	11	-	2	2	24 95	3.9	Agree
5	The programme procedure for ensuring informed choice for all women of social class is the same	24	-	-	-	-	24 120	5.0	Agree
6	Informed choice is adequately covered in agency's training	22	2	-	-	-	24 118	4.9	Agree
7	There are adequate and sufficient methods approved for	23	1	-	-	-	24 119	4.9	Agree

	distribution								
8	There is a wide range of contraceptive method available at your service point	20	3	-	-	1	24 113	4.7	Agree
9	Clients receive their methods without their preferences interfered with	15	5	-	1	3	24 100	4.1	Agree
10	You always satisfied with the services your agency render	16	4	4	-	-	24 108	4.5	Agree
11	Government trains its agencies' personnel in the area of technical and communication skills needed for service delivery	22	2	-	-	-	24 118	4.9	Agree
12	The training of agencies' personnel is on a regular basis	9	3	2	7	3	24 80	3.3	Agree
13	Clients readily accept contraceptive methods irrespective of their cherished cultural values	3	2	5	14	-	24 66	2.7	Disagree

Source: Author's Field Survey
SA= strongly Agree
S= Agree
UD= Undecided
D= Disagree
SD= Strongly Disagree
Decision Rule /Average Mean=5+4+3+2+1=15/5=3.0

Discussion of Findings

The study shows that clients accessed their contraceptive method from government agencies and the Media has strongly influenced their decision to inquire on family planning services. Population Council (2012) had noted in a previous study that strategic and effective communication campaign can increase knowledge of modern family planning method and use of contraceptive. Regarding adequate counseling on contraceptive and relating information to client's specific circumstances, a majority of clients confirmed that they enjoy this from their provider. Young et al., (1998) posited that when clients are made to understand the merits and de-merits of contraceptive method, better decisions would be made by clients and client's rights would not be undermined. Hezo and Diaz (1992); CCP (1991) also noted that, the right of clients to have detailed and accurate information to specific needs and make their decision about reproductive health, such as the rights to informed choice has been perceived as very fundamental to the success family planning programme. A large number of respondents confirmed access to safe and affordable contraceptive method. To this end, Prata et al., (2001); Prata (2006); Chen and Ravallion (2007) argued that the need to make family planning accessible is also compelling from the stand point of alleviating the burden of poverty. To them, giving the rising level of women living in poverty, consumers would not be able to afford the increasing cost of family planning services; as the poor are believed to be sensitive to price changes and the resultant effect would be a decline in contraceptive use. The study broadly reveals that clients are provided with quality care and are treated well with dignity and respect. According to Vera (1992), the client's view of "quality care" is being treated like human being. It is against this back drop that, Berstein (2012) argued that human rights approach to family planning programme would enable access to proper information, good and non-

discriminatory treatment and quality services; such that clients would not just be treated as a target of demographic programme. Similarly, Obono (1995) argued that the basic rights of clients to health, sexuality, social status and dignity can best be protected in a population policy. As such, policies must be sensitive to legislation, empowerment of the people (clients/rights holder) and accountability of the state (government/rights bearer) to family planning services have been the central theme of this study. A peaceful society is a society that is built on strong ethical foundation and respect for human rights and dignity. Ethical judgments about population programmes begin with a consideration of human rights in two ways (Manson, 2004). One, human rights apply to everyone regardless of age, gender, race, nationality, and ethnicity or other characteristics. Second, human rights are fundamental in that they take precedence over other rights and privileges (Manson, 2004).

Conclusion

The right to family planning services in the metropolis of Sokoto was the focus of the study. Results from the study proved that clients rights to family services were provided and protected; as government institutions such as the Media, the teaching hospitals and Primary Health care Centres (right bearer) have been able to play their obligatory roles to the satisfaction of clients (right holder) on family planning services. However, Women are still not empowered to make decisions for themselves without the consent of their husbands as husbands are to make final decisions that pertain to family matters which includes reproductory health after due consultation with their wives; as demanded by Islamic religion. And, for knowledge and more awareness of contraceptive method and family planning, government, through its Media institution should increase its efforts on campaign as well as literacy level of its population. Agency's personnel should be trained on regular basis to meet up with emerging challenges in reproductive health. The eradication of poverty should also be a focus.

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