

**DETERMINANTS OF CONTRACEPTIVE USE AMONG NIGERIAN COUPLES.**

**BY  
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**A RESEARCH WORK SUBMITTED TO THE DEPARTMENT OF DEMOGRAPHY  
AND SOCIAL STATISTICS, FACULTY OF SOCIAL SCIENCE, FEDERAL  
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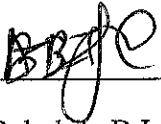
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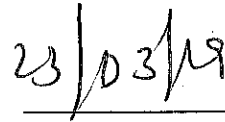
## CERTIFICATION

This is to certify that this research work, Determinants of contraceptive use among Nigerian couples was carried out by Faleke feyikemi oreoluwa, an undergraduate student of the department of Demography and Social Statistics, Faculty of Social Science, Federal University of Oye-Ekiti with Matric No DSS/14/1819.

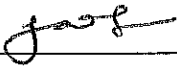


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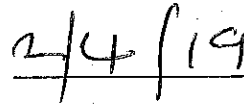


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## **DEDICATION**

I dedicate this project work to GOD almighty the author and the finisher of my faith, and I also dedicate this work to my family.

## ACKNOWLEDGEMENT

I am grateful to Almighty God for the success, guidance and protection he accorded me throughout this trying moments of higher academic endeavor. I have to thank my research supervisor Mr Babalola Blessing. Without his assistance and dedicated involvement in every step throughout the process, this project would have never been accomplished. I would like to thank you very much for your support and understanding over these past four years. I would also like to show gratitude to the other lecturers that took out time to train me academically for these past four years, which includes Dr L.F.C Ntoimo (head of department of demography and social statistics), professor Ogunjuyigbe who was formerly my project supervisor, Dr shittu, Dr E.K Odushina, Mr soji, Dr Adeyemi, their teaching style and enthusiasm for the topic made a strong impression on me and I have always carried positive memories of their classes with me. I must also thank two of my colleagues who graduated from the department too ( Kayode Agbelusi) for giving me the retreat to have this thesis finished on time and (oyeleke sulaimon) who guided me through my statistical analysis. Getting through my dissertation required more than academic support, and I have many people to thank for it, I cannot begin to express my gratitude and appreciation for their friendship. ( moyinoluwa ogunkorode), ( Aladetimi gbemisola), have been unwavering in their personal support during the time I spent at the university. Most importantly, none of this could have happened without my Family. My mother ( Morounmubo Faleke) and my father (Engr. Gbenga Faleke) who offered their encouragements through phone calls and prayers, to my siblings (titilope jolayemi), ( tobiloba Faleke), (praise Faleke), (seyi Faleke), I am forever grateful to them, this dissertation stands as a testament to your unconditional love and encouragement.

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## ABSTRACT

Nigeria remains a focus for increasing contraceptive use, as it is one of the most populous countries in Sub-Saharan Africa. Determinants of contraceptive use can be defined as the causal factors of contraceptive use or variables/elements that determines the nature of contraceptive use. This study examined the determinants of contraceptive use among Nigerian couples. The respondents for this study are couples of ages 15-49 who are in union or married residig in Nigeria at the time of the survey, using the 2013 Nigeria Demographic and Health Survey, we estimated the likelihood of contraceptive use based on concordance with male partner desire for family size, male and female fertility preferences, female decision making power, and male partner attitudes toward contraceptive use. male partner perception that decisions regarding health should be jointly or primarily by women was positively associated with use. Women were less likely to use contraceptives among couples in which male partners had greater earning power. Finally, men who viewed contraceptives as an enabler for promiscuity had female partners less likely to use contraceptives. These findings highlight the importance of male partners in women contraceptive decision making.

## CHAPTER ONE

### 1.1 BACKGROUND TO THE STUDY

In the last quarter of a century, the world has witnessed an increase in contraceptive use and revolution from traditional to modern method of contraceptives Donaldson and Tsui (1990). Modern contraceptives Offers men and women the ability to plan their family and attain optimal birth as intended, International organization for migration (2011). The current prevalence rate for contraceptive use in Nigeria is approximately 11%-13%. This rate is very low. The majority of contraceptive users in Nigeria rely on modern methods (10% of currently married women), 5% use traditional methods, 3% use injectable, and 2% use condom or pills as a method of contraception. Across the globe, fertility rate has fallen drastically due to the widespread and increasing use of modern methods of contraception. However, in some developing countries the uptake of contraceptives remains low due to cultural, economic and political barriers or differences, today sub-Saharan Africa is the region with the lowest levels of contraceptive use and the highest levels of fertility rates. The national contraceptive prevalence rate (CPR) for modern methods in Nigeria is 11%-29% if women reported in the Demographic and Health Survey (NDHS) that they want to have another child soon and 32% would prefer to have their next child in 2 or more years. There was no national response to high fertility trends until 1989, when the Nigerian government released its national population policy, calling for the reduction of the birth rate through voluntary fertility regulation methods compatible with national economic goals. Yet contraceptive decision making among couples remains a deeply personal and sensitive issue that often involves religious or philosophical convictions.



Contraceptive uptake has led to an increasing awareness among researchers, clinicians and program planners that the topic of contraception must be approached in a sensitive, emphatic and non-judgmental manner. There is a considerable variation in contraceptive uptake from country to country and region to region, One third of the developing countries have a skewed method mix, in which a single method accounts for more than half of all contraceptive use in many cases, this is an indication that knowledge or access to a broad range of contraceptive methods is limited. In places where a wider variety of methods has become available, contraceptive uptake has often been observed to rise. Nigeria is still characterized by high fertility rates and low use of modern contraceptives despite numerous reproductive and health programs which aims to increase level of use in these countries. Reproductive health program and services are commonly targeted at women's reproductive health and offered their services exclusively to women, especially conduct with couples planning, prevention of unwanted pregnancies, and maternal care during the pregnancy period, risky abortions and the improvement of safe motherhood. But the role of men in reproductive health and family planning has always been ignored by family planning programs and most contraceptive methods are designed for women only (Gayatri Devi, 2009). Reproductive health of couples, largely depend on the attitudes of men (husbands), towards contraceptive usage and their knowledge on reproductive health. Moreover, there is a traditional trend whereby men are known for taking decisions in their conjugal life in fertility related issues, especially on contraceptive usage or family planning, though they sometimes support their wives on contraception (Mojur et al, 2008). Nigeria's population is equivalent to 2.55% of the total world population making it the eight populous nations in the world, and its policy makers are becoming increasingly concerned about its demographic profile and population dynamics.

Nigeria is among the rapid growing countries and the most populated in the African continent which means it is a reference point of the population crises in Africa United Nations 2010.

Improved reproductive health care which includes the use of contraceptive method among couples to prevent unwanted birth also attributed to this decline especially in the developing world (Bongaats, 1997 UNFPA, 2011). However, despite the observed decline, most country in sub-Saharan Africa and some part of Asia still have very high fertility rates. Furthermore, contraceptive prevalence rate (cpr) is low with corresponding high unmet need and unintended pregnancies among women of reproductive ages in these regions (UNFPA, 2011). In modern societies, effective contraception is now widely available enabling couples to decide how many children they wish to have and when they will like to have them. Among couples it is well known that males exert considerable influence on female's reproductive decision (castle etal, 1999). The trend of contraceptive in developing countries has been increasing and various international organizations have reported that an important factor related to fertility. Authors found that increased change in contraceptive use in partly influenced by fertility intention among couples. The concept of contraceptive usage among Nigerian couples is partly influenced or determined by the fertility intention among couples. Reports from researchers indicate that parity influences a woman, chances of using modern family method. Many factors contribute to unwanted pregnancy in Nigeria, and a very important factor is the low level of contraceptive use. In addition, a desire to limit family size to enable the family provide a better education for the children, the increased participation of women in the labor force, and urbanization are other factors leading to the desire of Nigerian couples to have a predetermined number of children. The uses of modern

contraceptive method translate into prevention of unwanted pregnancy and subsequent abortions. If contraceptive use in the population increases among Nigerian couples who are sexually active. Research in Nigeria indicates that more than 60% of women with unplanned pregnancy are not using any form of contraception.

The literature review of contraception use in Nigeria identifies reasons for low levels of contraceptive use, the factors responsible for this low utilization recommends intervention programs, and policies to increase contraceptive utilization. Men and women needs information about contraceptive methods for women as well as about those for men. Well informed men can use a method themselves or support their partners in using a method. Contraceptive use helps couples and individuals realize their basic rights to decide freely and responsibly, if, when and how many children to have. The growing use of contraceptive methods has resulted in not only improvement in health related outcomes such as reduced maternal mortality and infant mortality (Ahmed and others, 2012; Bhutta and others, 2014; Rutsein and winter 2015), but also improvements in schooling and economic outcomes, especially for girls and women (canning and Scultz, 2012; Schultz and Joshi 2013). There is considerable variation of contraceptive usage from country to country and region to region. One-third of developing countries have a skewed method mix, in which a single method accounts for more than half of all contraceptive use. In many cases, this is an indication that the knowledge or access to a broad range of contraceptive methods is limited. Furthermore, there was some evidence of concern about a potential link between contraceptive use and infertility among couples. The national contraceptive prevalence rate (CPR) for modern methods in Nigeria is 11%. 29% of women reported in the Nigeria demographic and health survey (NDHS) that they want

to have another child soon and 32% would prefer to have their next child in two or more years.

There was no national response to high fertility trends until 1989, when the Nigerian government released its national population policy, calling for the reduction of the birth rate through voluntary fertility regulation methods compatible with national economic and social goals. Yet contraceptive decision making remains a deeply personal and sensitive issue that often involves religious or philosophical convictions. A long history of insensitivity and failed attempt by outsiders to encourage contraceptive uptake as led to an increasing awareness among researchers, clinicians and program planners that the topic of contraception must be approached in a sensitive, pathetic and non-judgmental manner. The national contraceptive prevalence rate which is the percentage of women who were practicing or whose sexual partners were practicing any form of contraception in Nigeria was reported at 14.6% in 2008(NPC, 2009). Such statistics showed that Nigeria is still one of the countries with the lowest contraceptives prevalence rate although; efforts by the government and NGOS to improve awareness on the use of modern contraceptive methods especially among males have yielded some progress.

The Planned Parenthood federation of Nigeria (PPFN) carried out awareness programs to motivate couples on the benefit and use of contraceptives. These programs comprise reaching out to traditional and religious leaders, family planning orientation for couples. Government workers like teachers, social and agric workers were among those targeted, as were new reporters. Statistics have shown that knowledge of modern family planning have shown that knowledge of modern family planning is has high as 70% in Nigeria, but this those not translate into uptake (Adebayo et al, 2012). Overall in Nigeria, less than 10% of women of reproductive

age use any modern contraceptive method (FMOH, 2009; NPC & ICF MACRO, 2009). Over a period of time, the very little improvement in contraceptive use rose from 3% in 1990 to 10% in 2008 (NPC & ICF MACRO, 2009). Also, between 1990 and 2008, contraceptive prevalence for all methods includes from 6% to about 15%. However, use of modern contraceptives methods increased from 4% to 10% within the same period (FOS, 1992; NPC, 200; FMOH, 2004, 2006; NPC & Macro 2009). It is imperative to analyze the determinants of modern contraceptive uptake in Nigeria as this would enable effective designing of intervention that can lead to increased usage of modern contraceptives in an attempt to taste for the determinant, several factors have being observed to be predictors of contraceptive usage including fertility intention or preference.

For many years empirical and theoretical literature was dominated by the schooling of the individual as the determinant of contraceptive behavior, implicitly assuming that a woman's behavior is unrelated to her social context. This seems an implausible supposition. We all live in a social reality and we are influenced by and learn from our realities and the people we share them with. If there is a causal relationship between a women's propensity to adopt modern contraceptives behavior and the level of contextual education where she resides, these externalities of education must be included in a cost-benefit analysis of investment in education (Kravdal, 2002).

The three preconditions of fertility decline appears to have been met; couples now have knowledge of contraception; methods are becoming increasingly available and, the downturn in the economy with its associated increase in child bearing cost has facilitated the rationalization of smaller family sizes. For purposes of comparability, modern methods of contraception are defined to include female and male sterilization, oral hormonal pills, the intra-uterine device (IUD), male and female condoms,

injectable, the implant (including Norplant), vaginal barrier methods and emergency contraception. Traditional or natural methods of contraception include rhythm (periodic abstinence), withdrawal and lactation amenorrhea method (LAM). Some surveys also include reports of prolonged abstinence; breastfeeding, douching or folk methods, and these methods are included in the traditional methods category.

Unmet need for family planning (or “unmet need” for short) is defined as the percentage of married or in-union women of reproductive age who want to stop or postpone childbearing but who report that they are not using any method of contraception to prevent pregnancy. Unmet need is an indicator that has a history of more than four decades in the international population field and broadens the policy and program focus from contraceptive use alone to enabling all individuals to realize their fertility preferences (Bradley & Casterline, 2014; Casterline & Sinding, 2000; Cleland, Harbison and Shah, 2014). Estimates and projections are also presented for an indicator of the gap between demand for contraceptives and contraceptive use: the percentage of demand for family planning satisfied with modern methods is computed as contraceptive prevalence (modern methods) divided by total demand for family planning (the sum of contraceptive prevalence (any method) and unmet need for family planning).

A focus on married or in-union women misses the contraceptive practices and needs of sexually-active women who are not married or in a marriage-like union. Surveys, particularly in Asia and Northern Africa, do not always include unmarried women when inquiring about the need for contraception or contraceptive practice. The present report is restricted to women who are married or in-union in order to be able to examine comparable information for as many countries as possible. Other ongoing

work in the Population Division aims to produce estimates and projections for all women of reproductive age, and not only married or in-union women.

## 1.2 STATEMENT OF RESEARCH PROBLEM

Contraceptive lies at the heart of proper family planning, but its use can be shaped by several factors. This includes cultural factors norms and values as well as the desires and decisions of couples. Myths and misconceptions also play a major role, including beliefs that people who use contraceptives end up with health problems or permanent infertility, or, at one detriment, that contraceptives reduce sexual urge, and at the other that they increase promiscuity among women.

Other contributing factors include low access to health care facilities and the patriarchal nature of societies. Nigeria has made no progress in improving the use of contraceptives for the past 10 years, Contraceptive use in the country is incredibly low. Studies have been conducted on the use of contraceptives (both traditional and modern methods) in many part of the world. However, this study is not only focusing on the use of contraceptives among Nigerian couples but on the causal factors of couples contraceptiveuse and the way it changes or vary over time. One of the general problems of this study is the unmet need for family planning,another problem is the choice of contraceptive use among couples and furthermore husband/wife disapproval on contraceptive use.

## SPECIFIC PROBLEMS

- ✓ Social pressure is a problem on the issue of contraceptive use, because women have an increased probability of having another child when there is pressure from parents, relatives and friends.
- ✓ Politics is another specific problem on the issue of contraceptive use because in Nigeria, politics are male dominated and this leads to the scenario where men are decision makers in issues like immunization, antenatal clinics and family planning programs. Men end up deciding whether these services are available, accessible and acceptable in certain areas.
- ✓ Level of education is also a problem on the issue of contraceptive use because if a woman is uneducated then she cannot enjoy her reproductive rights. Women with higher education are able to comprehend information about contraceptive methods, they are therefore more aware of their human rights including their reproductive rights.

## RESEARCH QUESTIONS

1. What are the levels of contraceptive use among couples in Nigeria?
2. How does the background characteristic of couples influence their choice of contraceptive usage?

## 1.4 RESEARCH OBJECTIVES

The general objective of this study is to examine the contraceptives uptake among couples and the determinantss of contraceptive among couples in Nigeria.



#### **1.41 SPECIFIC OBJECTIVES**

\* To examine the level of contraceptive use among couples in Nigeria.

\*To examine how the background characteristics of couples influence their choice of contraceptive usage.

#### **1.42 SIGNIFICANCE OF THE STUDY**

The result of this study may be useful to couples of reproductive ages in Nigeria, modern family planning service providers, health educators, counselors, policy makers, medical doctors and researchers among others. This study will contribute useful information in planning future family strategies in Nigeria and other interventions program. The findings of this study will be useful to maternal health care providers, the ministry of health and other health institutions to clearly understand the determinants of contraceptive use among couples. Furthermore, the findings may be helpful in designing appropriate programs and policies that will encourage utilization of family planning services. There are different modern methods of contraceptive use and accessing their services varies significantly which has resulted in the differences in child and maternal mortality. This study should provide more informative insights to policy makers about potential public health strategies that can increase the uptake of appropriate contraceptive use among couples in Nigeria.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.0 INTRODUCTION**

This chapter presents a detailed review of the literature as it relates to couples contraception use, its presentation follow a logical sequence by reviewing how scholars have interrogated the concept of use and implication of such conceptualization on government policies towards the provision of contraceptives. Owing to the fact that the study is concerned with the socio-cultural context of contraceptive, an extensive review of literature on important factors that have been identified by scholars is next presented.

#### **2.1 THE CONCEPT OF CONTRACEPTIVE.**

Contraceptives are methods or an act that helps prevent conception as a result of sexual intercourse. There are several methods of contraceptives all over the world but they are majorly categorized into two, namely: traditional/ folkloric method and modern method. Contraceptives are used by the majority of married or in-union women in almost all regions of the world. In 2015, 64 per cent of married or in-union women of reproductive age worldwide were using some form of contraception. However, contraceptive use was much lower in the least developed countries (40 per cent) and was particularly low in Africa (33 per cent). Among the other major geographic areas, contraceptive use was much higher, ranging from 59 per cent in Oceania to 75 per cent in Northern America. Within these major areas there are large differences by region and across countries. At least one in ten married or in-union women in most regions of the world have an unmet need for family planning.

Worldwide in 2015, 12 per cent of married or in-union women are estimated to have had an unmet need for family planning; that is, they wanted to stop or delay childbearing but were not using any method of contraception. The level was much higher, 22 per cent, in the least developed countries. Many of the latter countries are in sub-Saharan Africa, which is also the region where unmet need was highest (24 per cent), double the world average in 2015.

Modern contraceptive methods constitute most contraceptive use. Globally in 2015, 57 per cent of married or in-union women of reproductive age used a modern method of family planning, constituting 90 per cent of contraceptive users. When users of traditional methods are counted as having an unmet need for family planning, 18 per cent of married or in-union women worldwide are estimated to have had an unmet

Substantial gaps still persist in the use of modern methods among couples who want to prevent pregnancy. Large gaps remain in the proportion of total demand for family planning satisfied with modern methods in countries where overall contraceptive use is low or where many couples rely on traditional methods of contraception. In 2015, less than half of total demand for family planning was being met with modern methods in 54 countries (34 of which are in Africa). In an additional 76 countries, less than 75 per cent of total demand was met by use of modern methods.

Growth in contraceptive prevalence until 2030 is expected mainly in the regions of sub-Saharan Africa and Oceania. Between 2015 and 2030, the time period of the 2030 Agenda for Sustainable Development, contraceptive use is projected to grow particularly in regions where less than half of married or in-union women of reproductive age currently use contraception. Contraceptive prevalence is projected to

increase from 17 to 27 per cent in Western Africa, from 23 to 34 per cent in Middle Africa, from 40 to 55 per cent in Eastern Africa, and from 39 to 45 per cent in Melanesia, Micronesia and Polynesia. Yet unmet need for family planning is still projected to remain high in 2030, above 20 per cent in all these regions, except in Eastern Africa, where it is projected to decrease from 24 per cent to 18 per cent between 2015 and 2030.

Nearly 800 million married or in-union women are projected to be using contraception in 2030, and growth in the number of contraceptive users will be uneven across regions. The global number of married or in-union women using contraception is projected to rise by 20 million, from 758 million in 2015 to 778 million in 2030. Growth in the number of contraceptive users is projected to be high for all regions of Africa and in Southern Asia. Globally, the number of women with an unmet need for family planning is projected to change little, from 142 million in 2015 to 143 million in 2030, due to growth in the number of married or in-union women of reproductive age in sub-Saharan Africa and growth in the demand for family planning. Method-specific contraceptive prevalence varies widely across the world. Female sterilization and the IUD are the two most common methods used by married or in-union women worldwide: in 2015, 19 per cent of married or in-union women relied on female sterilization and 14 per cent used the IUD. Short-term methods are less common: 9 per cent of women used the pill in 2015, 8 per cent relied on male condoms and 5 per cent used injectable. Only 6 per cent of married or in-union women worldwide used rhythm or withdrawal. There are large regional differences in the use of some types of contraception. Overall, short-term and reversible methods, such as the pill, injectable and male condom, are more common than other methods in Africa and Europe whereas long-acting or permanent methods,

such as sterilization, implants and the IUD, are more common in Asia and Northern America.

In at least one out of every four countries or areas with data, a single method accounts for at least half of all contraceptive use among married or in-union women. In the 45 countries or areas where a single method constituted 50 percent or more of all use in 2015, the dominant methods included the pill (15 countries), injectable (10 countries), IUD (7 countries), and, in fewer countries, female sterilization, male condom, withdrawal or other traditional methods. Countries where contraceptive practice is heavily concentrated on one or two methods can be found in all regions and at all levels of overall contraceptive prevalence.

High levels of contraceptive prevalence reflect different mixtures of methods, but long-acting or permanent methods play a prominent role. More than one in three married or in-union women globally use long-acting or permanent methods: namely, female and male sterilization, IUDs and implants. These methods accounted for 56 per cent of contraceptive prevalence in 2015. In countries that had relatively high levels of contraceptive prevalence in 2015—60 per cent or higher and representing different geographic regions—married or in-union women relied on long-acting or permanent methods: in 34 of the 70 countries the prevalence was 25 per cent or higher. As contraceptive prevalence becomes more common, the share of all use by long-acting or permanent methods tends to increase. Contraceptive use helps couples and individuals realize their basic right to decide freely and responsibly if, when and how many children to have. The growing use of contraceptive methods has resulted in not only improvements in health-related outcomes such as reduced maternal mortality and infant mortality. (Ahmed & others 2012; Bhutta& others, 2014; Rutstein& winter,

2015), but also improvements in schooling and economic outcomes, especially for girls and women (Canning & Schultz 2012; Schultz & Joshi, 2013).

The landmark Program of Action of the International Conference on Population and Development (ICPD) in 1994 recommended that all countries seek to provide universal access to a full range of safe and reliable family-planning methods by the year 2015, United Nations. (1994, pp 7.16). Specific benchmarks for meeting the demand for family planning were specified in the review and appraisal of the Program of Action five years later, United Nations. (1999, pp 58). In 2010, the General Assembly, noting that gaps still existed in the implementation of different areas of the ICPD Program of Action, decided to extend the Program and the key actions for its further implementation beyond 2014, in order to fully meet the Program's goals and objectives. Millennium Development Goal 5 to improve maternal health brought renewed attention to efforts to reduce maternal deaths and ensure universal access to reproductive health, though progress by 2015 fell short of the targets set. (United Nations, 2015a). More recent global partnerships that include efforts to expand contraceptive information, counseling and services include Family Planning 2020, which focuses on 69 of the world's poorest countries, and Every Woman Every Child, which has a broader strategy of accelerating improvements in the health of all women, children and adolescents by 2030.

The United Nations General Assembly reaffirmed these commitments when it adopted the 2030 Agenda for Sustainable Development. (United Nations, 2015b). The new development agenda includes two targets relevant for family planning under broader goals on health and on gender equality and the empowerment of women and girls. Both targets aim to ensure by 2030 "...universal access to sexual and reproductive health-care services, including for family planning, information and

education, and the integration of reproductive health into national strategies and programs” (target 3.7) and “universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Program of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences” (target 5.6). The global community has committed to actions over the next 15 years to make access to sexual and reproductive health, including family planning, and the realization of reproductive rights a reality for all people. This report presents new evidence on contraceptive use trends, including the types of methods used, and the unmet need for family planning at the global, regional and country levels. This evidence on where the world stands now with respect to the extent to which couples are exercising their basic right to plan their families and, given past rates of change, where the world is headed by 2030 serves as a summary of progress made thus far and a signal of where further investments are needed. Contraceptives are used by the majority of married or in-union women in almost all regions of the world. In 2015, 64 per cent of married or in-union women of reproductive age worldwide were using some form of contraception (figure 3, dark bars). However, contraceptive use was much lower in the least developed countries<sup>1</sup> (40 per cent) and was particularly low in Africa (33 per cent). Among the other major geographic areas, contraceptive use was much higher in 2015, ranging from 59 per cent in Oceania to 75 per cent in Northern America.

Within these major areas there are large differences by region. Prevalence in 2015 was several times as high in Northern Africa and Southern Africa (53 per cent and 64 per cent, respectively) as in Middle Africa (23 per cent) and Western Africa (17 per cent). Contraceptive use has been increasing recently in Eastern Africa and now stands at 40 per cent. At the other extreme, Eastern Asia had the highest

prevalence (82 per cent) of all the world regions in 2015, due to the very high level of contraceptive use in China (84 per cent). In the other regions of Asia, the average prevalence was in a range between 57 per cent and 64 per cent. Regional contrasts are smaller in Latin America and the Caribbean, although the level of contraceptive use was lower in the Caribbean (62 per cent) than it was in Central America (71 per cent) and South America (75 per cent). Within Europe, prevalence in 2015 was lowest in Southern Europe (65 per cent) and highest in Northern Europe (77 per cent). In Oceania, the level of contraceptive use in Australia and New Zealand was typical of levels in regions of Europe, whereas the level was much lower, 39 per cent, in Melanesia, Micronesia and Polynesia.

At least one in ten married or in-union women in most regions of the world have an unmet need for family planning. Worldwide in 2015, 12 per cent of married or in union women are estimated to have had an unmet need for family planning; that is, they wanted to stop or delay childbearing but were not using any method of contraception (figure 3, light bars). The level was much higher, 22 per cent, in the least developed countries. Many of the latter countries are in sub-Saharan Africa, which is also the region where unmet need was highest (24 per cent), double the world average in 2015. In general, unmet need is high where contraceptive prevalence is low. Unmet need in 2015 was highest (above 20 per cent) in the regions of Eastern Africa, Middle Africa, Western Africa, and Melanesia, Micronesia and Polynesia. Unmet need was lowest (below 10 per cent) in Eastern Asia, Northern Europe, Western Europe and Northern America. Given that survey data on unmet need for family planning are limited, especially for countries in Europe and Eastern Asia, the median estimates presented for 2015 have relatively wide 80 per cent uncertainty intervals. The use and unmet need for family planning levels



vary widely across countries. Within Africa, countries or areas with contraceptive prevalence of 50 per cent or more are mainly islands (Cabo Verde, Mauritius&Réunion), or located in the north of the continent along the Mediterranean coast (Algeria, Egypt, Morocco and Tunisia) and in Southern Africa (Botswana, Lesotho, Namibia, South Africa and Swaziland) (figure 4). Five countries in Eastern Africa (Kenya, Malawi, Rwanda, Zambia and Zimbabwe) also had contraceptive prevalence levels of 50 per cent or more in 2015. In contrast, 17 countries of Africa had contraceptive prevalence levels below 20 per cent. This group includes the populous country of Nigeria, where contraceptive use was at less than half the level in Ethiopia (16 per cent and 36 per cent, respectively). Less than 10 per cent of married or in-union women of reproductive age were using contraception in Chad, Guinea and South Sudan in 2015. There are different types of contraceptives which can be broadly categorized as modern (effective) and non-modern (ineffective) methods. Modern methods of contraception include. Sterilization for male and female, pills, Intra-Uterine Devices (IUDs), male and female. Condoms. Others are injectable, implants (including Norplant), and vaginal barrier methods .Non-modern techniques of contraception include periodic abstinence, withdrawal method, lactation amenorrhea method (LAM) and folkloric methods. All of these contraceptives. Methods are used mainly as preventive measures of except male and female condoms. Condoms have a two way function of pregnancy and sexually transmitted infections. Prevention (WHO, 2009).

## 2.2 CONTRACEPTIVE USE

The use of contraceptive is inevitable for those who are in their reproductive ages whose intention is to postpone a birth or who do not want any more children, and those who are not ready for a birth at all. However, those who are faced with a contraceptive need may choose from a variety of contraceptive method and may as well decide not to use a method (Rind fuss et al, 1989). Proximate determinants of fertility includes contraceptive use and these determinants of fertility are behavioral variables through which socio-economic and other biological variables work to influence fertility rate in a population (Bongaarts,1978). In countries in which fertility reduction is prominent, evidences have shown that various fertility reducing variables are thought to be responsible for this population decline (Cohen, 1998). And among these fertility reducing variables, modern contraceptive use is the main factor affecting inter country variation when these countries are compared (Kirk &Pillet, 1998).

Family planning acceptance in Africa region has for long been low and the low contraceptive prevalence can be said to have influenced the resulting high fertility rates inSub Saharan Africa compared to other parts of the globe. World Bank in 2009, reports that the average number of births for woman in Sub-Saharan Africa was (5.1). This statistics shows that average number of births per woman in Africa is more than doubled as much in South Asia with (2.8) or Latin America and the Caribbean with (2.2). The prevalence (22%) for Caribbean, is almost half that of South Asia with (53%) and less than one- third of what is observed in East Asia with 77% (World Bank Report, 2009);Due to these patterns, Africa's population is growing at a fast rate (2.3%) compared toother regions in the developing world, which includes both some part of Asia and Latin America (1.1% each) (UN DESA, 2008). Low contraceptive

prevalence in Sub-Saharan Africa has been attributed to high cultural and religious influence which promotes resistance to family planning practice (Caldwell & Caldwell, 1987). Although contraceptive usage increased in some African countries, the increase that is observed is very modest. The Contraceptive Prevalence Rate (CPR) which is the proportion of women of reproductive ages who uses modern contraceptive methods differs across Sub-Saharan African countries (UNDP, 2009). It ranges from the lowest 1.2% in Somalia to the highest 60.3% in South Africa. Southern African countries like South Africa and Zimbabwe have the highest uptake of modern contraceptive, followed by countries from East Africa with Kenya at 31.5% leading the sub-region. Western and Central African countries reported very low rates of family planning uptake. Low contraceptive prevalence rates in the world can be observed in this sub-region with Chad with at 1.7%, Niger 5%, Nigeria 9.1% and Central African Republic with 8.6% (UNDP, 2009). It is imperative to study factors that predict modern contraceptive use in one of these countries with low contraceptive prevalence; in this case -Nigeria. Emphasis will be laid on whether the fertility intention of males especially influences their use of modern contraceptives.

## **2.3 CHALLENGES THAT EXIST BEFORE CONTRACEPTIVES CAN BE INITIATED**

### **2.3.1 Gender**

Gender refers to the economic, social and cultural attributes and opportunities associated with being female or male. It encompasses a set of qualities and behaviors expected by society from females and males. In most societies being a woman or a man means not only having different biological characteristics but also facing different expectations about appearance, qualities, behavior and work appropriate to being male or female.

Nelson (199,p.752) sees clinics as being stigmatized, they belong to women, not to men who are mostly seen at clinics after sport injuries. Men should be targeted and taught about contraceptives where they are seen the most. Teaching men about contraceptives could save the women arguments when condoms are to be used. Men could help with remembering information when emergency contraceptives are to be used. Erasmus and Bekker (1996, p.38) stated that in nurturing their egos, and in combating their wives' potential unfaithfulness, African men prefer to have their wives "permanently pregnant". If no children can be procreated in a marriage, it is a woman's fault, leaving the women feeling unhappy, guilty and depressed. In fear that contraceptives could lead to infertility, some women might fail to use contraceptives, because in many African cultures a man is never regarded as being infertile (Ehlers, 1999, p.50), unless he is impotent. Mfono (1998, p.180) highlighted that the teenage boys in her study in the Gauteng Province (RSA), did not use any form of protection against pregnancy. They assumed that the girls would use protection, as they regarded it as being the girls' responsibilities to be protected. Traditionally a man are regarded as providers and head of their families, even after all the socio- economic changes, whereby women were forced to seek jobs and to become providers too, they are still not provided equal rights (Pretorius, 199, p. 419). In many traditional societies African women hold inferior positions compared to those of men. Women are taught to be subservient to their husbands, men in general and specifically to their husbands' family members, especially their mothers-in-law (Troskie&Raliphada-Mulaudzi, 1999, p.43). Counseling women about the use of contraceptives might be worthless because women might not have any decision-making powers when it comes to procreation and sexuality issues. In African cultures this decision can lie with the husband, mother in law or the extended family

(Ehlers, 1999, p.82). Matladi (1998, p.26) further highlighted this issue by stipulating that preoccupation with educating women ignores the social significance of men and their role within the family, workplace, community and government. Men should be viewed as partners and potential clients with their own sexual and reproductive needs, as they hold a dominant role in decision-making, regarding fertility and sexual relations and many other issues that shape gender relations and directly affect women. If men were included in contraceptive education efforts this could improve communication within relationships and foster respect and shared responsibilities pertaining to the reproductive health processes. Because of gender issues women might sometimes be unable to initiate the use of contraceptives to prevent unwanted pregnancies, which is what Orem George (2002, p.127) calls the self-care construct.

Gender makes men to be regarded as never infertile, married women (but not married men) commit adultery, women can work and be providers for their families but they are still regarded as being subordinate to men. Reproductive decisions lie with men or with the woman's in laws. If contraceptives are allowed, it is the woman's (not the man's) responsibility to be protected against pregnancy. Socio-economic status Ehlers (1999, p.54) highlighted the effect socio-economic status has on the use of contraceptives. She stated that the low socio-economic status of African women puts them in a situation where they are dependent on their husbands for financial support. They, therefore, cannot independently decide on the number of children required in their families, the use of contraceptives, the husbands' use of condoms, nor about the husbands' polygamous marriages and/or extramarital affairs. Women's low socio-economic status puts them in a submissive role, where they lack self-confidence, assertiveness and self-value. Husbands might have to grant their wives permission to use contraceptives. The higher the woman's socio-economic

status, the more assertive she becomes, and the more she can enjoy her reproductive rights. Women who are not earning an income, or who earn smaller incomes falling below the breadline, will always depend on their husbands for support, therefore forfeiting the right to decide about the reproductive issues generally, and the use of contraceptives specifically (Troskie&Raliphada-Mulaudzi 1999, p.46). If a woman has a low socio economic status then she cannot belong to the self-care construct in terms of Orem's theory (George, 2002, pp.127-129). This means she cannot initiate contraceptive use on her own, but she requires someone to engage in a relationship with her, and support her to be able to take the decision. Extrapolating this theoretical assumption, it could be argued that unless significant other persons in the woman's life (such as her husband, partner or mother-in-law) support her decision to use contraceptives, she might not be able to sustain its use.

### 2.3.2 RELIGION

Ehlers (1999, p.54) indicated that religion could sometimes hamper the effective use of contraceptives. Islamic women tend to let men decide on the number of children required. (Such women are unlikely to use contraceptives.) The Roman Catholic Church is opposed to many birth control methods, favoring the rhythm method which is unreliable. This could be problematic in the African situation, characterized by low socio-economic status of women, men's dominant culture and the fact that most of these men are migrant laborers. Bankole et al (1998, p.127) stated that because religious values oppose contraceptives, women tend to use methods with high failure rates such as the rhythm method. On the contrary, Makhetha (1996, p.29) in his study of factors associated with contraceptive use by adolescents, mentioned that high religiosity made adolescents less likely to engage in premarital sexual relations. Murray et al (1998, p.140) stated that the teenagers who attended religious services

regularly delayed the timing of the first sexual encounters. According to Orem's self-care deficit construct (George 2002, p.129), the nurse must decide who needs health care when the nurse engages in a relationship with individuals, society and communities to help them meet their health care needs, including women's needs to use contraceptives to avoid unplanned pregnancies.

### **2.3.3 LEVEL OF EDUCATION**

Over the years researchers have tried to find factors that are related to the non-use of contraceptives. Never having been to school remains a strong predictor of non-contraceptive use. In the interviews of 883 women in Mexico, 49,0% of the illiterate women were found to have never used contraceptives, compared to 31,0% who did have either primary or secondary education who were using contraceptives. Unless a woman has achieved a grade 9 level of education, it is unlikely to have had any impact on her fertility behavior. In a study in the Transkei (SA), 67,0% of educated women were using contraceptives compared to 16,0% of the uneducated women. Several other studies demonstrated that the lower the level of education the woman has, the less likely she is to use contraceptives. The incidence of unwanted pregnancies is high amongst the less educated women (Fikree, Khan, Kadir, Sajan & Rahbav, 2001, p.135; UN, 1993, p.59). According to Troskie and Raliphada-Mulaudzi (1999, 41). If a woman is uneducated then she cannot enjoy her reproductive rights. Women with higher education are able to comprehend information about contraceptive methods, they are therefore more aware of their human rights including their reproductive rights. Ehlers (1999, p.48) stated that if a woman is uneducated she is unlikely to find a worthwhile job, so her hope for survival is to find a husband who will support her. She then performs her household duties, whilst the man decides on the size of the family and whether she can use

contraceptives or not. Education helps women to access and use the clinics properly. With regard to Orem's General Theory of Nursing (George, 2002, pp.127-130) educated women can initiate the use of contraceptives, constituting the self-care construct, but uneducated women's inability to access contraceptives belongs to the self-care deficit construct. The approach in helping both these groups of women differs. Women who are educated can be helped through the supportive – educative system, whilst illiterate women could require wholly compensatory actions from contraceptive providers.

#### **2.5.6 Culture, norms and values**

Culture is defined as a complex whole, which includes knowledge, beliefs, art, morals, law, customs and habits, acquired by man as a member of the society. Culture represents the way of perceiving, behaving, and evaluating one's world, it is a blueprint that is used for determining one's values, beliefs and practices (Andrews & Boyle, 1995, p.8). Norms are said to be the roles by which human behavior is governed, they provide direction for living according to values (Andrews & Boyle, 1995, p.10).

Values are personal perceptions of what is good or useful; they differentiate what is desirable from what is undesirable. Values are the universal features of culture (Andrews & Boyle, 1995, p.10). Humans do not exist without culture, nor without values.

Contraceptive providers are expected to know the effect cultural differences could have on the use, preferences, attitudes and beliefs concerning contraceptives. They are expected to know the cultural beliefs of the people they serve, as well as their own cultural beliefs that might influence preferences for a particular method or



prescription. It is also important to know the level of affiliation of an individual to his cultural beliefs, which might influence childbearing behaviors and thus also contraceptive usage/non-usage. In many African cultures prospective husbands pay "lobola" (bridal prize) in the form of money, or a particular number of cattle to the bride's family. Men, because they have paid lobola, could regard their wives as possessions that they have bought. Women end up not being able to decide on the number of children desired nor about use of contraceptives. In some circumstances the men can claim back his lobola if a wife fails to bear children.

They are expected to keep up with marital infidelity, emanating from the culture of polygamous marriage. Black South African men believe they have insatiable sexual needs. If a woman cannot bear children in a marriage her husband can easily engage in extramarital affairs and bear children outside marriage, and/or marry additional wives. Erasmus and Bekker (1996, p.43) stated that South African black women are expected to use their reproductive ability in order to be accepted by their in-laws and other members of the community. If contraceptives are perceived as rendering women infertile, this poses a serious challenge to effective contraceptive usage. Females are not regarded as real women until they are mothers. A child symbolizes a man's wealth and his future insurance. Manliness is mainly judged by the number of children fathered by the man. In polygamous marriages, the wife with most children is likely to be the husband's favorite wife. Women in this kind of a marriage are not likely to use contraceptives, if they are competing to be the husband's favorite wife with the largest number of children. Sometimes women are required to prove their fertility even before the payment of lobola, because children in many African cultures are very important, they give value, meaning, dignity and status to the couple. These cultural beliefs could imply that culture poses a barrier to the use of

contraceptives even before a woman can initiate the use of contraceptives. Such women cannot, according to Orem's General Theory of Nursing (George, 2002,pp.127-129), belong to the self-care construct, which means they cannot independently initiate the use of contraceptives. If indeed contraceptives are being used, they require what Orem calls the wholly compensatory nursing system.

### 2.5.7 Politics

In Africa politics are male dominated. This leads to a scenario where men are decision-makers in issues like immunization, ante natal clinics and family planning programs. Men end up deciding whether these services are available, accessible and acceptable in certain areas. This situation severely affects rural women who are not organized enough nor adequately educated to exert pressure on their governments nor on their male dominated social structures. In the RSA during the apartheid era, when the Nationalist government was the ruling party, family planning was introduced racially. That government feared that the black populations were growing so large that they could undermine the white supremacy. The Apartheid government promoted the use of contraceptives among black and colored women. All these efforts were aimed at reducing the growth of the black population, hence family planning became associated with the racist policies of the Apartheid government (Guttmacher, Kapadia, Naude & De Pinho, 1998,p.191).klugman (1990,p.270) further highlighted the history of politics and contraceptives in the RSA. She stated that the previous government viewed the growth of the black population as a "Swartgevaar" (Black danger).

When contraceptives were introduced for black women, black South African men frowned upon the idea. These men perceived the situation as being a threat to both their control over women and their right to have the number of children they wanted. Professionals like Sister Bernard Ncube who was the president of the federation of Transvaal Women defined contraceptives as "a safe way to murder a nation". There were reports that women were given injectable contraceptives without their consent or sterilized post caesarian section without their knowledge. One trade union exposed a procedure in a factory where women were asked to sign a contract granting the employer the right to dismiss them if they fell pregnant within one year of being employed (Klugman, 1990, p.266.). Family planning providers were trained within the framework of an over populated paradigm. The contraceptive provider was primarily not concerned with personal needs expressed by individual women, rather they were motivated to lower population growth rates. The physical, psychological and emotional aspects of the well-being of women were not necessarily considered in these drives to reduce the impact of the perceived future over-population of the RSA. These factors created challenges for contraceptive providers. It is possible that black South Africans still perceive contraception to be a means of lowering their population growth rates. In the male dominant African culture children symbolize a man's wealth for future insurance (Erasmus & Bekker, 1996, p.38). If these men believed that contraceptives aimed at lowering the black population's numbers, then politics could serve as a barrier even before contraceptive use could be initiated by many women in the RSA.

All available types of contraception have both strengths and weaknesses, and no is medically suitable, appropriate and acceptable for all couples in all circumstances. Most obviously, male and female sterilization are permanent methods that cannot be

used for delaying or spacing births. Women who want to delay a birth, but only for a few months or a year, may prefer a short-term method, one that they can start and stop on their own, over an IUD or implant, which usually requires a clinic visit to obtain the device and to have it removed. Individuals also vary in their experience of, and tolerance for, side effects of highly effective modern methods as well as in their willingness to tolerate the inconveniences, and the higher risk of an unintended pregnancy, that are posed by other methods. The drawbacks of the available temporary methods are reflected in the substantial rates at which women (and men) who try them later give them up. One study of 25 countries estimated that about 40 per cent of those who started to use the pill, injectable, rhythm or withdrawal discontinued the method within the first 12 months of use, and method-related reasons were the main cause for discontinuation.

Even though the mix of particular methods often changes slowly at the aggregate level, this appearance of stability is the net result of a good deal of flux as individuals take up and abandon different methods as they try to achieve their desired number and timing of births. Women and men who are dissatisfied with the first method they use are likely to want to try a different method. However, their range of choices depends on the local availability and accessibility of different methods. Method-specific contraceptive prevalence varies widely across the world. Two long-term methods, female sterilization and the IUD, are the most common methods used by married or in-union women worldwide (figure 13 and annex table III): in 2015, 19 per cent of married or in-union women relied on female sterilization and 14 per cent used the IUD. Short-term methods are less common: 9 per cent of women used the pill, 8 per cent relied on male condoms and 5 per cent used injectables. Only 6 per cent of married or in-union women worldwide used rhythm or withdrawal in

2015. There are large regional differences in the use of some types of contraception. Overall, short-term and reversible methods, such as the pill, injectable and male condom, are more common than other methods in Africa and Europe whereas long-acting or permanent methods, such as sterilization, implants and the IUD, are more common in Asia and Northern America.

Female sterilization is an important part of the method mix in the Americas, Oceania and some parts of Asia, but it is uncommon in Africa as well as in Central Asia, South-Eastern Asia and Western Asia (annex table III). With the exception of a small group of countries, male sterilization is much less common than female sterilization. The pill accounts for at least 10 per cent of contraceptive practice in over 70 per cent of the countries with sufficient data to enable estimates. No other method is so widely employed in so many countries. In 2015, the pill was used by 20 per cent or more of married or in-union women in 31 countries. Injectables are common in Eastern Africa, Southern Africa, and South-Eastern Asia and in the developing sub-regions within Oceania. This method is also widely employed in some of the poorest countries in Latin America and the Caribbean. In 2015, the IUD was most commonly used in Asia (17 per cent) and levels were 20 per cent or more in 12 countries in the region. Use of the male condom is likely underestimated given that where there is dual method use—one of the benefits of male condoms being to prevent sexually-transmitted infections—the more effective method used is recorded. Male condom use was most prevalent in Europe (17 per cent prevalence in 2015), and reached high levels in countries in Eastern Europe and Southern Europe.

Modern methods continue to constitute most contraceptive use worldwide, but fewer users rely on sterilization and more rely on injectables and male condoms than in 1994. Nine out of every 10 married or in-union women using contraception in the

world in 2015 relied on modern methods of contraception, virtually the same proportion of user as in 1994 (figure 14). While more than half of all users in 2015 relied on either female sterilization (30 per cent) or the IUD (21 per cent), there has been a shift among contraceptive users since 1994 away from female and male sterilization and towards injectables (increasing from 2 per cent to 7 per cent of all use) and male condoms (increasing from 8 to 12 per cent of all use). These shifts worldwide reflect, in part, the changing geographic composition of user's e over the past two decades, as contraceptive use has taken off in sub-Saharan African countries where injectables are a common method. For the world as a whole, the share of total contraceptive use by the pill, implants, IUD, vaginal barrier methods, rhythm and withdrawal has remained relatively stable over the past 20 years.

Methods designed to be used by women account for most contraceptive use among couples. Contraceptive methods that require men's direct participation—male sterilization (vasectomy), the male condom and withdrawal—accounted for 21 per cent of contraceptive practice worldwide in 2015. The share of use was 30 per cent or higher in Europe, Northern America and Oceania, around 20 per cent in Asia and Latin America and the Caribbean, and around 10 per cent in Africa. New methods that became available during the second half of the twentieth century are mainly methods for women. Improvements in methods used by men have been limited to refinements of the male condom and improved techniques for performing vasectomy (Hatcher & others, 2011). Although several potential new methods for men have advanced as far as clinical trials, it is still not clear when they will become widely available.

The lack of new methods for men does not, however, explain the low prevalence of male sterilization, given that vasectomy is more effective, less expensive to perform and has fewer complications on Nigeria's population policy and contraception. The

Federal Government of Nigeria adopted the National Policy on Population for Development, Unity, Progress, and Self-Reliance in 1988. A revised policy in 2004 has included the aim of reduction of maternal deaths by 75% in 2015 in accordance with the Millennium Development Goal Number. National Policy on Population back in 1988 encouraged open discussion and promotion of family planning.

The goals of the policy were to improve the standard of living of Nigerians, promote health and welfare of the people through the reduction of deaths and disease among women and children, achieve a lower population growth rate through voluntary fertility regulation, and stem the population drift to urban areas.<sup>67</sup> The specific targets related to family planning were to:

- Reduce the number of pregnancies in women less than 18 years of age and above 35 years of age by 50% in 1995 and by 90% in 2000.
- Reduce by 50% the proportion of women bearing more than four children in 1995 and by 80% in 2000.
- Extend the coverage of family planning services to 50% of women of child-bearing age by 1995 and to 80% by 2000.
- Reduce total fertility rate to 4.0 by the year 2000 and reduce the population growth rate from about 3.0% per year to 2.5% by 1995 and 2.0 by the year 2000.

An evaluation of the policy and the specific targets of the Nigerian Population Policy (NPP) by Adekunle et al, indicate a total failure of all set targets for the year 2000. The population has continued to grow at an annual rate of approximate 3.0% and is now estimated to be about 148 million.

The contraceptive prevalence rate, currently at 11%–13%, is far from the estimated 80% expected in 2000. The total fertility rate, although decreased from 6.2 in the earlier half of the decade, is still far from the targeted 4.0. The reasons for the policy's failure are an underestimation of the huge financial resources required for its implementation, the lack of political will, poor and uncoordinated organizational strategies, "gender-divide" (reducing women's fertility to four children, while leaving

## **CHAPTER THREE**

### **RESEARCH DESIGN AND METHODOLOGY**

#### **3.0 Introduction**

This chapter focuses on the various methods, techniques and procedures used in conducting this research. It provides important information on the following data sources, variables and measurement, data analysis and study population.

#### **3.1 Research design**

This research was a cross sectional study which made use of secondary data obtained from 2013 Nigeria demographic and health surveys (NDHS), of Nigerian couples recode data set.

The sample of the 2013 NDHS is nationally represented and covers the entire population residing in the country. The sample of the 2013 NDHS was designed to provide population and health indicator estimates in the country. The sample designed allowed for specific indicators such as Nigeria couples and information about their contraceptive usage.

Nigeria is divided into states, and each states is subdivided into local government areas (LGA), furthermore, during the 2006 population census, each locality was divided into convenient areas called census enumeration (EAs). The primary sampling unit (PSU) referred to as a cluster for the 2013 NDHS, is defined on the basis of EA's from the 2006 EA's census frame.



to as a cluster for the 2013 NDHS, is defined on the basis of EA's from the 2006 EA's census frame.

### **3.2 Study location**

The study location is Nigeria, were by the contraceptive usage of couples in Nigeria will be focused on using the 2013 NDHS data. Nigeria came into existence as a geographic or political entity in 1914 following the amalgamation of the northern and southern protectorates by the British colonial authorities. The country obtained independence from the British colonial rule in 1960 and has since passed through various political and economic metamorphoses. The Nigeria federation presently comprises 36 states and the federal capital territory, the states are in turn grouped into six zones namely the North East, North West, North Central, South East and South South. Nigeria lies on the west coast of Africa between latitudes 4°16' and 13°53' north and longitudes 2°40' and 14°41' east. It occupies approximately 923,768 square kilometers of land stretching from the Gulf of Guinea on the Atlantic coast in the south to the fringes of the Sahara Desert in the north. The territorial boundaries are defined by the republics of Niger and Chad in the north, the Republic of Cameroon on the east, and the Republic of Benin on the west. Nigeria is the most populous country in Africa and the 14th largest in land mass.

The country's 2006 Population and Housing Census placed the country's population at 140,431,790 and it is projected to reach 192 million at the end of 2015 (PRB, 2013). Nigeria has great geographical diversity, with its topography characterized by two main land forms: lowlands and highlands. The uplands stretch from 600 to 1,300 meters in the North Central and the east highlands, with lowlands of less than 20 meters in the coastal areas. The lowlands extend from the Sokoto plains to the Borno plains in the North, the coastal lowlands of western Nigeria, and the Cross River basin in the east. The highland areas include the Jos Plateau and the Adamawa Highlands in the north, extending to the Obudu Plateau and the

Oban Hills in the southeast. Other topographic features include the Niger-Benue Trough and the Chad Basin.

Nigeria has a tropical climate with wet and dry seasons associated with the movement of the inter-tropical convergence zone north and south of the equator. Its climate is influenced by the rain-bearing southwesterly winds and the cold, dry, and dusty northeasterly winds, commonly referred to as the Harmattan. The dry season occurs from October to March with a spell of cool, dry, and dusty Harmattan wind felt mostly in the north in December and January. The wet season occurs from April to September.

The temperature in Nigeria oscillates between 25°C and 40°C, and rainfall ranges from 2,650 millimeters in the southeast to less than 600 millimeters in some parts of the north, mainly on the fringes of the Sahara Desert. The vegetation that results from these climatic differences consists of mangrove swamp forest in the Niger Delta and Sahel grassland in the north. With its variety of climatic, vegetation, and soil conditions, Nigeria possesses the potential for growing a wide range of agricultural produce.

### **3.3 Study population**

The population is drawn from 2013 NDHS, it comprises of couples in union, married or living together in the reproductive ages 15-49 years interviewed from the 2013 Nigeria demographic and health survey.

### **3.4 Sampling size and Sampling techniques**

The sampling size used for this study, drawing from the 2013 NDHS was 1,751 couples of ages 15-49, who are in union or married residing in Nigeria at the time of the survey. The 2013 NDHS national sample was selected using a stratified three stage cluster design consisting of 5,874 couples with 4,323 in urban areas and 1,551 in rural areas. In each state, the number of households distributed proportionately among the urban and rural areas. A

complete listing of households and a mapping exercise were carried out for each cluster from December 2012 to January 2013 with the resulting list of household serving as the sampling frame for the selection of households in the second stage. All regular households were listed. The national population commissions were trained to use the global positioning (GPS) receiver to take the coordinate of the 2013 NDHS sample cluster.

### **3.5 Data collection methods**

The population census of 1973 was not acceptable and was therefore cancelled. Since then, there have been considerable improvement in data collection process NDHS (2013). The couple's questionnaire was administered to all married men and women aged 15-49 in every second household in 2013 NDHS sample. All aspects of the NDHS data collection were pretested in November 2012. In addition to, collection of such sensitive information requires the establishment of good communication between the interviewer and the respondent. In due process, interviewers were provided with specialized training on how to obtain information on contraceptive usage of Nigeria couples to enable the field agents to collect data in a secure confidential and ethical manner.

#### **VARIABLES AND MEASURES:**

Dependent variable: contraceptive use

Independent variable: respondent socio demographic characteristics, such as age, religion, highest level of education.

#### **DATA ANALYSIS:**

Stata 12 will be employed for the analysis. This study will conduct analysis at three levels. The first level is univariate, followed by bivariate analysis and multivariate analysis. These three levels of analysis are:

1. Univariate descriptive analysis will be done to show frequency distribution of selected characteristics of the study population.
2. Chi-square test will be carried out to examine the association between the independent and dependent variable.

3. Binomial logistic regression will be done to examine the influence of the adjusted relationship among couples contraceptive usage.

### 3.6 MEASUREMENT AND VARIABLES

**DEPENDENT VARIABLES:** The dependent variable is contraceptive usage

#### 3.6.1 Independent variables:

##### Socio-demographic characteristics:

**Couples age:** The age of couples was measured from the NDHS using the grouped age of respondents in five-year age group 20-24, 25-29, 30-34 and 35-39. The age groups were calculated differently for male respondents and female respondents.

**Couples Place of Residence:** One of the two divisions of the NDHS Place of residence will be used. (Urban).

**Couples Level of Education:** This is a categorical variable, which was divided into four categories; No Education, Primary, Secondary and Higher Education.

**Couples Religion:** The religion of the respondents was measured in three categories; the first groups were Christians, which was the combination of Catholics and other Christians and was coded as 0 = Christian, the second group was Islam, was coded as 1 = Islam, the last group are the traditionalists, which was coded as 2 = Traditional.

**Wealth Index:** The wealth index is a categorical variable, which was divided into three categories; poor, average, Rich.

**Exposure to mass media:** This is measured using variables on the NDHS data that asked questions on whether the couples have heard of family planning on radio, television and newspaper in the last 12 months.

**Employment Status:** Employment status of respondents was measured by either the respondent is working or not. Respondents who are currently employed at the time of the survey was coded as 1, otherwise, 0.

**Partner's Education:** This is a categorical variable, which was divided into four categories; No Education, Primary, Secondary and Higher Education

**Knowledge of Contraceptives:** This is coded as a dichotomous variable, respondents who

VARIABLES	DESCRIPTION	MEASUREMENT
Contraceptive usage	Nigerian couples where asked about their contraceptive use.	For this study contraceptive usage was categorized into 3 categories.  1- Both non using 2- Both using 3- Either using
<b>Other selected background variables</b>		
Couples age	The age of couples was measured from the NDHS using the grouped age of respondent in five years age group and was categorized as 20-24  25-29  30-34  35-39	For the purpose of this study, couples age was categorized into four  20-24  25-29  30-34  35-39  The age groups were calculated differently for male and female respondents.

have any knowledge of a contraceptive method was coded as 1, otherwise, 0

**Decision making:** this is a categorical variable which is divided into three, wife, husband or both.

Couples place of residence	One of the two divisions of the NDHS place of residence will be used (urban).	With respect to this study, place of residence was categorized into two.  1-urban  2- rural
Couples level of education	This is a categorical variable which was divided into four categories  1-No education  2- primary  3- secondary  4- Higher education	With respect to this study, couples level of education was categorized into four  1- No education  2- primary  3-secondary  4- Higher education
Couples religion	The religion of the respondents was measured into three categories, the first group was Christian which was the combination of Catholics and other Christians and it was coded as 0=Christian, the second group was Islam and it was coded as 1=Islam, the last group was the traditional which was coded as 2=traditional.	With respect to this study, religion of respondents was categorized into three.  0=Christian  1= Islam  2= Traditional
Wealth index	The wealth index is a categorical variable which was divided into three categories poor, average and rich.	Wealth index was recorded and re-categorized into 3  1-poor  2-Average  3-Rich

Exposure to mass media	This is measured using variables on the NDHS data that asked questions on whether the couples have heard of family planning on radio, television and newspaper in the last 12 months.	With respect to this study, exposure to mass media was categorized into two.  1-unexposed  2-exposed
Decision making	This is a categorical variable which is divided into three, namely; wife, husband and both.	With respect to this study, decision making was categorized into three.  1=Wife  2=Husband  3=Both

### 3.7 DATA PROCESSING AND ANALYSIS

The NDHS dataset 2013 couples recode was analyzed using STATA application package (STATA 12.0). The data processing was necessary before the proper analysis in order to measure the variables in this study accurately as well as to make the analysis well presentable and easily interpretable. The tools for data manipulation were employed on the STATA application package to achieve this task.

Univariate analysis in this study was carried out using tables of frequency distribution to describe the background characteristics of the respondents and. Bivariate analysis was done using the chi-square ( $\chi^2$ ) to examine the association between the independent and dependent variables sexual and the various socio economic and demographics background characteristics that are categorical variables. Furthermore, binomial logistic regression will be used to examine adjusted relationship among couples contraceptive usage.

#### 3.71 LIMITATIONS OF THE STUDY

The limitation to this study is the fact that it limited the unit of analysis to couples contraceptive usage.

## CHAPTER FOUR

### PRESENTATION AND DISCUSSION OF THE FINDINGS

#### 4.0 Data Presentation and Analysis of Results

This chapter focused on the presentation and discussion of the findings. The analysis was done in line with the research questions and hypothesis. Simple percentages were used to present the univariate and bivariate results while the hypothesis was tested at .05 level of significance using Pearson chi-square and multinomial logistic regression.

#### 4.1 Socio-Demographic Attribute of Respondents

TABLE 4.1 Percentage Distribution of the study population by selected characteristics

Variables	Frequency	Percent
<b>Couples Age</b>		
Husband older with 3 year	7,606	90.1
Same Age	832	8.8
Wife Older	6	0.1
<b>TOTAL</b>	<b>8,444</b>	<b>100.0</b>
<b>Couples Level of Education</b>		
Both uneducated	2,392	28.3
Both educated	4,325	51.2
Only one educated	1,727	20.5
<b>TOTAL</b>	<b>8,444</b>	<b>100.0</b>
<b>Couples Religion</b>		
Christian	3,189	37.8
Islam	4,879	57.8
Traditional	38	0.4
Different religion	338	4.0
<b>TOTAL</b>	<b>8,444</b>	<b>100.0</b>



Urban	2,759	32.7
Rural	5,685	67.3
<b>TOTAL</b>	<b>8,444</b>	<b>100.0</b>
<b>Decision Making</b>		
Wife	108	1.3
Husband	4,460	52.9
Both	3,859	45.8
<b>TOTAL</b>	<b>8427</b>	<b>100.0</b>
<b>Number of Living Children</b>		
0	932	11.0
1-4	5,548	65.7
5+	1,964	23.3
<b>TOTAL</b>	<b>8,444</b>	<b>100.0</b>

*Source: Author's Work, 2018 (Data from NDHS, 2013)*

The above attributes are necessary as it is useful to see what influence couple's decision toward the use of contraceptives.

Table 4.1 shows that majority of husband are 3 years older than the wife (90.1%), the table also revealed that majority of the couples were both educated (51.2%), (57.8%) of couples practice Islam and (44.5%) of couples were poor. (67.3%) of couples lived in the rural areas.(52.9%) of the husbands were the decision maker and (65.7%) of couples had 1-4 numbers of living children.

**TABLE 4.2 Percentage Distributions of Respondents by Couples usage of contraceptives**

Variables	Frequency	Percentage (%)
<b>Contraceptive usage</b>		
Both not Using	6,566	77.8
Both Using	579	6.9
Either Using	1,299	15.3
<b>TOTAL</b>	<b>8,444</b>	<b>100.0</b>

*Source: Author's Work, 2018 (Data from NDHS, 2013)*

Table 4.2 revealed that 77.8% of couples do not use any form of contraception.

**Table 4.3: Bivariate Analysis Showing the Relationship between Socio-Demographic Variable and Couples Contraceptive Usage**

CHARACTERISTIC	CONTRACEPTIVE USAGE % (N)			CHI-SQUARE P-VALUE
	Both not Using	Both Using	Either Using	
<b>Couples Age</b>				
Husband older with 3 year	76.0(5782)	7.5(568)	16.5(1256)	$\chi^2=135.7467$ p=0.000**
Same Age	93.6(779)	1.3(11)	5.1(42)	
Wife Older	83.3(5)	0.0(0)	16.7(1)	
<b>Couples Level of Education</b>				
both uneducated	94.8(2268)	0.6(14)	4.6(110)	$\chi^2=102.0921$ p=0.000**
both educated	63.4(2740)	12.8(552)	23.9(1033)	
only one educated	90.2(1558)	0.8(13)	9.0(156)	
<b>Religion</b>				
Christian	61.4(1959)	13.3(423)	25.3(807)	$\chi^2=833.4598$ p=0.000**
Islam	88.8(4307)	2.7(132)	9.0(440)	
Traditional	97.4(27)	0.0(0)	2.6(1)	
Different religion	77.8(263)	7.1(24)	15.1(51)	
<b>Wealth Index</b>				
Poor	93.0(3497)	0.9(34)	6.1(228)	$\chi^2=103.2114$ p=0.000**
Average	77.0(1178)	5.1(78)	17.9(273)	
Rich	59.9(1891)	14.8(467)	25.3(798)	
<b>Place of Residence</b>				
Urban	62.9(1734)	14.5(401)	22.6(624)	$\chi^2=608.7906$ p=0.000**
Rural	85.0(4832)	3.1(178)	11.9(675)	
<b>Exposure to Mass Media</b>				
Not Exposed	79.0(6339)	6.1(494)	14.8(1187)	$\chi^2=182.2648$ p=0.000**
Exposed	53.5(227)	20.1(85)	15.4(112)	
<b>Force (Domestic and Intimate Partner Violence)</b>				
No	76.5(5670)	7.5(552)	16.0(1188)	$\chi^2=59.5155$ p=0.000**
Yes	86.7(896)	2.6(27)	10.7(111)	
<b>Decision Making</b>				
Wife	52.8(57)	20.4(22)	26.9(29)	$\chi^2=683.5381$ p=0.000**
Husband	88.7(3958)	2.9(130)	8.3(372)	
Both	65.8(2538)	11.0(426)	23.2(895)	
<b>Number of Living Children</b>				
0	93.8(874)	1.3(12)	4.9(46)	$\chi^2=160.7121$ p=0.000**
1-4	75.7(4,201)	7.9(437)	16.4(910)	
5+	75.9(1491)	6.6(130)	17.5(1229)	

Source: Author's Work, 2018 (Data from NDHS, 2013)

Background characteristics of couples Contraceptive Usage. Table 4.3 revealed the contraceptive usage among couples in Nigeria. From the table above, couples with same age

are not using any form of contraceptives (93.6%). Distribution of couples' level of education by contraceptive usage reveals that couples that are not formally educated are not using any form of contraceptives (94.8%). Distribution of Contraceptive usage by religion shows that couples practicing traditional religion had not used any form of contraceptives (97.4%). Distribution of Contraceptive usage by wealth status shows that couples with poor wealth status are not using any form of contraceptives (93.0%). Residential distribution of Contraceptive usage reveals that couples residing in rural area are not using any form of contraceptives (85.0%). Also, the study revealed that husbands are the major decision makers on contraceptives (88.7%). Distribution of Contraceptive usage by force shows that couples that experiences fear of domestic and intimate partner violence are not using any form of contraceptives (86.7%). Lastly, a couple that does not have any number of living children are not using any form of contraceptives (93.8%).

**TABLE 4.4 Logistics Regression showing the effect of background characteristics on couple's contraceptive usage. Reported in odd ratio (Unadjusted)**

Variables	Both using			Either Using		
	Odds Ratio	95% CI		Odds Ratio	95% CI	
<b>Couples Age</b>						
Husband older with 3 year	1.00(RC)			1.00(RC)		
Same Age	0.23	1.28	0.81	0.26	0.72	0.21
Wife Older	12.60	4.23	42.11	1.23	1.17	3.64
<b>Couples Education</b>						
Both Uneducated	1.00(RC)			1.00(RC)		
Both Educated	1.39**	0.70	0.81	0.94**	0.64	1.25
Only One Educated	0.65	1.56	0.26	0.30	0.03	0.63
<b>Wealth Index</b>						
Poor	1.00(RC)			1.00(RC)		
Average	0.91**	0.38	1.44	0.73**	0.48	0.99
Rich	1.38**	0.88	1.89	1.03**	0.75	1.27
<b>Couples place of residence</b>						
Urban	1.00(RC)			1.00(RC)		
Rural	0.79**	1.05	0.53	0.80	0.27	0.83
<b>Exposure to Mass Media</b>						
Not Exposed	1.00(RC)			1.00(RC)		
Exposed	0.16	0.16	0.48	0.08	0.25	0.31
<b>Force (Domestic and Intimate Partner Violence)</b>						

No	1.00(RC)			1.00(RC)		
Yes	0.19	0.72	0.34	0.08	0.15	0.40
<b>Decision Making</b>						
Wife	1.00(RC)			1.00(RC)		
Husband	1.23**	1.86	1.44	0.39**	1.48	0.45
Both	0.56	1.15	1.89	0.22	0.77	0.232
<b>Number of Living Children</b>						
0	1.00(RC)			1.00(RC)		
1-4	1.98	1.25	2.70	1.37**	0.96	1.78
5+	2.27	1.52	3.02	1.70**	1.26	2.13

*Source: Author's Work, 2018 (Data from NDHS, 2013)*

The multivariate analysis using logistic regression was used to show the strength and the direction of the relationship between couples background characteristics and contraceptive usage. The results are presented in odds ratios, associated p-values and confidence interval.

The table above presents the results of logistic regression analysis of the relationship between each of the socio-demographic variables and contraceptive usage.

Considering the first model (Both Using), couples with same age 20% less likely to use any form of contraceptives (OR=0.80,  $p>0.05$ ) and wife older than husband are 52% less likely to use contraceptives (OR=0.53,  $p>0.05$ ). The table revealed that there is strong association between Couple's education and usage of contraceptives. The table indicates that couples that are both formally educated are 43% more likely to use any form of contraceptives than couples with no formal education (OR=1.58,  $p<0.01$ ) and couples in which either one of them has formal education are 0.62% less likely to approve usage of contraceptives than couples with no formal education (OR= 0.62,  $p>0.05$ ). Wealth status revealed that there is association between wealth status and usage of contraceptive among couples in Nigeria. It can be observed from the table that couples with average wealth status are 9% less likely to approve contraceptive usage than the poor (OR=0.91,  $p<0.01$ ) while couples with rich wealth status are 55% more likely to approve contraceptive usage than the poor (OR=1.45,  $p<0.01$ ).

Couples living in rural area are 20% less likely to approve contraceptive usage than urban areas (OR=0.80,  $p<0.01$ ). The association between couples exposure to mass media and

contraceptive usage revealed that couples that have exposure to mass media are 74% less likely to approve the contraceptive usage than couples that have no exposure to exposure (OR=0.26,  $p>0.05$ ).

Households where the use of force is pronounced are 21% less likely to use contraceptives (OR=0.79,  $p>0.05$ ). The household in which husband makes the decision on contraceptive use are 76% more likely to approve contraceptive usage than the wife (OR=1.24,  $p<0.01$ ). Household in which there is joint decision on contraceptive use are 0.57% less likely to approve contraceptive usage than the wife is (OR=0.43,  $p>0.05$ ). Conclusively, the table show that couples that have 1-4 children are 3% more likely to approve usage of contraceptive than couples with no children (OR=1.97,  $p<0.01$ ). Couples that have five or more children are 74% more likely to approve the usage of contraceptive than couples with no children are (OR=2.27,  $p<0.01$ ). The second model (either Using) that Couples of the same age are 74% likely to use contraceptives than couples that husbands are 3 years older (OR= 0.26,  $p>0.05$ ) and wife 3 years older than their husband are 77% more likely to approve the use of contraceptives than those whose husbands are 3 years older (OR= 1.23,  $p>0.05$ ). Couple's education was found to be associated with usage of contraceptives. The table indicates that couples that are both formally educated are 6% less likely to use any form of contraceptives than couples with no formal education (OR=0.94,  $p<0.01$ ) and couples in which either one of them has formal education are 70% less likely to approve usage of contraceptives than couples with no formal education (OR= 0.30,  $p>0.05$ ).

Wealth status is another predictor of contraceptive usage among couples in Nigeria, which shows that there is association between wealth status and usage of contraceptive among couples in Nigeria. It can be observed from the table that couples with average wealth status are 27% less likely to approve contraceptive usage than the poor (OR=0.73,  $p<0.01$ ). Couples

with rich wealth status are 99% more likely to approve contraceptive usage than the poor (OR=1.03,  $p<0.01$ ).

In addition, table 4.4 revealed that couples living in rural area are 90% less likely to approve contraceptive usage than urban areas (OR=0.10,  $p>0.05$ ). The association between couples exposure to mass media and contraceptive usage revealed that couples that have exposure to mass media are 90% less likely to approve the contraceptive usage than couples that have no exposure to exposure (OR=0.07,  $p>0.05$ ). Households where the use of force is pronounced are 21% less likely to use contraceptives (OR=0.79,  $p>0.05$ ). The table also depicts that household in which husband makes the decision on contraceptive use are 4% less likely to approve contraceptive usage than the wife (OR=0.96,  $p<0.01$ ). Household in which there is joint decision on contraceptive use are 0.78% less likely to approve contraceptive usage than the wife is (OR=0.23,  $p>0.05$ ). Conclusively, the table, also shown that couples that have 1-4 children are 63% more likely to approve usage of contraceptive than couples with no children (OR=1.37,  $p<0.01$ ). Couples that have five or more children are 31% more likely to approve the usage of contraceptive than couples with no children a

## CHAPTER FIVE

### DISCUSSION OF FINDINGS, CONCLUSIONS, RECOMMENDATIONS AND REFERENCES

#### 5.1 Discussion of findings

The purpose of this study was to examine the determinants of contraceptive use among Nigerian couples, to achieve this purpose two research questions were postulated to guide the study, Literature to the study was reviewed. A total of 8,444 couples were considered in this study, and majority of husbands are 3 years older than the wife (90.1%), majority of the couples were both educated (51.2%), (57.8%) of couples practice Islam and (44.5%) of couples were poor. (67.3%) of couples lived in the rural areas. (52.9%) of the husbands were the decision maker and (65.7%) of couples had 1-4 numbers of living children.

The second objective of this study was to examine how the backgrounds characteristics of couples influence their choice of contraceptive Use. Table 4.3 revealed the contraceptive usage among couples in Nigeria; couples with same age are not using any form of contraceptives (93.6%). Distribution of couples' level of education by contraceptive usage reveals that couples that are not formally educated are not using any form of contraceptives (94.8%), comparing this result with previous literatures. Over the years researchers have tried to find factors that are related to the non-use of contraceptives, never having been to school remains a strong predictor of contraceptive use. In a study in the Transkei South Africa: 67.0% of educated women were using contraceptives compared to 16.0% of the uneducated women. Ehlers (1999, p.48) stated that if a woman is uneducated she is unlikely to find a worthwhile job, so her hope for survival is to find a husband who will support her, she then performs her household duties whilst the man decides on the size of the family and whether she can use contraceptives or not. The findings obtained in this study and the literatures stated by several authors concerning the level of education of Nigerian couples as a determinant of

their contraceptive use are similar with little or no difference. Distribution of Contraceptive use by religion shows that couples practicing traditional religion had not used any form of contraceptives (97.4%), Ehlers (1999, p.54) indicated that religion could sometimes hamper the effective use of contraceptives while Bankole et al (1998, p.127) stated that because religious values oppose contraceptives, women tend to use methods with high failure rates such as the rhythm method. The literatures stated concerning the religion of couples are a bit different from the result obtained for this study because the findings is specific about couples practicing traditional religion (Islam, Christianity, traditional and others) causing their non-use of contraceptives while the previous literatures talks about all religion opposing the use of contraceptives because of beliefs associated with these religions without any specificity. Distribution of Contraceptive usage by wealth status shows that couples with poor wealth status are not using any form of contraceptives (93.0%). Residential distribution of Contraceptive usage reveals that couples residing in rural area are not using any form of contraceptives (85.0%). Also, the study revealed that husbands are the major decision makers. Erasmus and Bekker (1996, p.38) stated that in nurturing their egos, and in combating their wives' potential unfaithfulness, African men prefer to have their wives "permanently pregnant". If no children can be procreated in a marriage, it is a woman's fault, leaving the women feeling unhappy, guilty and depressed in fear that contraceptives could lead to infertility. Traditionally men are regarded as providers and head of their families, even after all the socio-economic changes (pretorius, 1999, p.419). both the previous literatures and findings from this research about decision making power of couples as a determinant of contraceptive use shows that the men/husbands are still the highest decision makers even when it comes to their wives' reproductive health.



## 5.2 Conclusion

The main purpose of this study was to assess the determinants of contraceptive use among Nigerian couples. The findings support that the influence of men on contraceptive use indicates the need to include men in family planning initiatives and programs focusing on men's attitudes towards contraception could improve communication and trust within couples, leading to less unintended pregnancies and reducing maternal child mortality associated with unintended pregnancy, furthermore, these results suggests the necessity of incorporating men's unmet need for contraception and reproductive health program in low income, under resourced countries.

Overall, our results contribute to the current literature by providing an in-depth examination of modern, folkloric and no contraceptive use in the context of couples' characteristics. Specifically, we found that decision making roles and power dynamics in couples are important predictors of contraception. Among couples in which male partners hold primary decision making power, women were less likely to use modern contraception. Accounting for male partners and dynamics within couples as policies and practices move forward to address the issue of contraception is essential, as focusing solely on individual women is not sufficient to increase contraceptive uptake and use. Though larger cultural and social norms cannot be ignored, accounting for the significance of male partners in spousal contraceptive decisions can enable current and future reproductive health programs to work towards addressing unmet needs for contraception.

## 5.3 Recommendations

To increase the rate of contraceptives in Nigeria there is need to intensify governmental and non-governmental family planning programs targeted at couples who want more children. Doing this will guarantee increased uptake and continued usage of family planning with respect of reducing couples fertility intention. Findings in this study call for further research which should preferably include a large proportion of qualitative based study to fully understand other determinants of contraceptive use among couples Nigerian couples.

Health agencies in collaboration with state government should ensure that all the needed family planning programme and health services (counseling, health education, prevention, treatment, family planning and referral) are available in all the state irrespective of location and other militating factors. This will contribute effectively in determining contraceptive use among Nigerian couples.

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