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Couple Asymmetries and Modern Contraceptive Use among Young Married Women in Nigeria.

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Abstract

Nigeria is faced with high fertility, maternal and child mortality, and a rapid population growth rate. The uptake of modern methods of contraception is crucial to reduce the high fertility rate, halt population growth, lessen child mortality, and enhance maternal health. This study assessed partners' socio-economic and demographic asymmetries as barriers to modern contraceptive use among young married women in Nigeria. This study used data for 5,772 young married women aged 15-34 years from the Nigerian Demographic and Health Survey 2018. Frequency distributions and binomial logistic regression were carried out using STATA v12. Findings show that 20.4% of young married women use modern contraceptives. Respondents whose partners desire more children were less likely to use modern contraceptives (AOR= 0.712, CI 0.603-0.840). Also, contraceptive use is less likely when the respondent's partner is more educated than the respondent compared to if both have the same level of education (AOR= 0.721, CI 0.607-0.857). Differences in partners' fertility desires and educational status are associated with the use of modern contraceptives among married women aged 15-34 years in Nigeria.

Keywords: Modern contraceptives, young women, partner asymmetries, Nigeria.

Introduction

Nigeria is one of the countries with the lowest contraceptive prevalence rates in the world, with 14.2% of women of reproductive age using modern contraceptives (Ekholuenetale et al., 2021). Further, Nigeria is among the countries with the highest total fertility rates (TFR) in the world, with an average of 5.4 children per woman - higher than sub-Saharan Africa, generally, with an average TFR of 4.7 children per woman (World Bank, 2020). If the current level of contraceptive use and its resultant effect on high fertility in Nigeria persist, by 2050 Nigeria will be the third most populous country in the world (Desa, 2015).

Contraceptive use could avert maternal deaths by enabling women to postpone and space births, avoid unplanned pregnancies and abortion, and stop reproducing when they have reached their desired family size. Furthermore, modern contraceptive users are more likely to exhibit a wider birth interval, which in turn increases child survival (Merali, 2016). Knowledge of contraceptive methods is high among all reproductive-aged women in Nigeria. However, this knowledge is not reflected in the practice of contraception. The level of modern contraceptive use has remained low over the years (NPC & ICF, 2019). Leading to high fertility, increased unsafe abortions resulting from unwanted pregnancies, and birth complications (Haque, Rahman, Mostofa, & Zahan, 2012). These health challenges could be significantly reduced, if not averted totally, by effective modern contraceptive use.

In Nigeria, 49% of married women are married before their 18th birthday (Efobi, Adejumo, & Atata, 2021). Most of these women get married to older men, 98% of women in Nigeria are younger than their partner (Ibisomi, 2014). Wide age gaps are often complemented by differences in maturity, exposures, social status, and financial resources (Longfield, Glick, Waithaka, & Berman, 2004; Luke, 2005). Even when there is no age difference between partners, women are still more disadvantaged than men in access to resources. Gender inequality in access to jobs and other sources of livelihood in the country also persist (Adeosun & Owolabi, 2021).

Moreover, in a patriarchal setting, such as Nigeria, decision-making power is conventionally bestowed on males. This coupled with differences in the socio-economic status of a couple may further affect the woman's decision-making power in the household. Women who are socio-economically advantaged have greater decision-making power in their households, which in turn affects their modern contraceptive use (Kibe, 2017; OlaOlorun & Hindin, 2014). Also, pro-natal views tend to be stronger among males than females. Husband's real or perceived opposition to contraceptives may prevent wives who want to delay or stop childbearing from using it (Barden-O'Fallon & Speizer, 2010).

Since the 1994 International Conference on Population and Development (ICPD), national governments, international agencies, and donor organizations have intensified efforts to ensure an increase in the use of effective methods of contraception in Sub-Saharan Africa and elsewhere (Chandra-Mouli et al., 2015). Despite these efforts, contraceptive use is still low in Nigeria. The country aimed at increasing the national contraceptive prevalence rate to 36% by 2018 (Austin, 2015). This was not achieved. However, the National Family Planning Blueprint (2020-2024)

reported a revision of this goal from 36% to 27% by 2024(FMoH, 2020). Considering the present level of contraceptive use, achieving the Sustainable Development Goal (SDG) 3.7 of ensuring universal access to sexual and reproductive health-care services, including family planning, may also be difficult.

This study is based on the Health Belief Model. The model attempts to explain and predict health behaviours by focusing on the attitudes and beliefs of individuals; and views humans as rational beings who make decisions from different perspectives(Rosenstock, Strecher, & Becker, 1988). This model is appropriate in preventive health behaviour, such as contraceptive behaviour. The Health Belief Model hypothesizes that contraceptive behaviour is a function of the perceived risk of unintended pregnancy, perceived severity, perception of contraceptive benefits and barriers to use. It also states some demographic, social, structural, psychological and reproductive factors called modifying or enabling factors that interact with an individual perception of pregnancy and decision to use contraceptives(Hall, 2012). However, this study considers perceived barriers and modifying factors of the model. Perceived barriers per the model are potential negative aspects of contraceptive behaviour, which may act as a hindrance to contraceptive use. Differences in partners' characteristics may hinder young married women from discussing modern contraception with their partner, and this may reduce their likelihood of contraceptive use.

Hence, this study assessed couple's socio-economic and demographic differences as barriers contributing to the uptake of modern contraceptives among young married women in Nigeria. This is based on the premise that low levels of modern contraceptive use among married women could be due to the differences in partner's socio-economic and demographic differences. These differences might make relationships naturally unequal and, therefore, affect the women's capability to discuss modern methods of contraception. Therefore, ascertaining the relationship between partner's socio-economic differences and low contraceptive use among women aged 15–34, the population within which fertility peaks, will help program managers to design and implement new and existing programs, and evaluate their contributions to improving young women's contraceptive use properly.

Methods

This study used secondary data from the 2018 Nigerian Demographic and Health Survey (NDHS). The 2018 NDHS is a nationally representative survey, carried out by the National Population Commission (NPC), the agency responsible for the collection, collation, analysis and dissemination of population census and survey data at all levels in Nigeria. The survey was funded by the United States Agency for International Development (USAID), the United Kingdom Department for International Development (DFID), the United Nations Population Fund (UNFPA), and the Nigerian government.

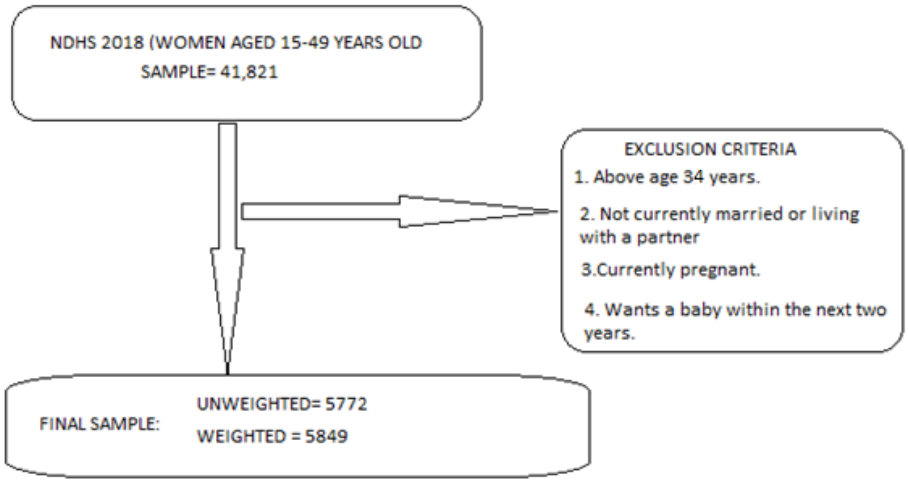
The cross-sectional survey was carried out using a stratified three-stage cluster sample design. The sampling frame used for this survey is the list of Enumeration Areas (EAs), which was designed for the country's 2006 population census prepared by the NPC. The EAs were grouped by state, by local governments within the state, and by localities within the local government areas. All women aged 15-49 years who were either resident of the household sampled or a

visitor in the household on the night before the survey were eligible to be interviewed (NPC & ICF, 2019).

Sample Size

For this study, data for 5,849 (weighted sample) young women between the ages of 15-34 years who are currently married or cohabiting and were not pregnant at the time of the survey or trying for a baby were used. Below is the flowchart of how the sample was selected.

FIGURE 1: Sample selection flow chart.



Study Variables

Outcome Variable

The outcome variable for this study is contraceptive use. This is measured using level of current use, and the actual practice at the time of survey namely "current use by method type". The variable - current use by method type – comprises of folkloric, traditional, and modern methods. For the purposes of this study, this variable was dichotomized into modern method users and non-users of modern contraceptive methods making it a binary variable for this study.

Predictor Variables

The main predictor variables are partner's age difference, employment difference, and fertility intention difference. New variables were created from the NDHS 2018 dataset to measure these predictors individually. Partner's age difference was created using respondent current age and age of partner and was categorised based on the focus of this study. The variable has three categories namely – 'respondent not older than partner', 'same age as partner', and 'respondent younger than partner.

The difference in education attainment was measured using a new variable which combines the respondents' highest level of education and partners' highest level of education. The variable has four categories- 'both have no education', 'same level of education, 'respondent more educated', 'partner more educated'.

For couple's employment difference, a new variable was created from respondent employment status and partner's employment status. The variable has four categories namely- 'both unemployed', 'woman employed but partner unemployed', 'woman unemployed but partner employed' and 'both employed'.

The difference in fertility desire was measured using the original variable the way it is in the dataset. This variable has three categories which are – 'same number', 'partner wants more' and 'partner wants less'.

The other predictor variables are the selected socio-economic characteristics of the respondents which have been found to influence contraceptive use in the literature. These variables are current age, age at first birth, education, religion, ethnicity, number of living children, place of residence, and region.

Data Management and Analysis

The statistical package STATA version 12 was used for the statistical analysis. Weights was applied to the data to control for sampling errors taking the sample design into account and to make the sample representative of the entire population.

Data analysis was done in three levels: namely univariate, bivariate, and multivariate analysis. The univariate analysis was done to describe the background characteristics of the respondents, the predictors using percentage distribution. This is followed by cross-tabulations of each of the predictors with modern contraceptive use. Moreover, the analytical bivariate analysis was conducted using bivariate binomial logistic regression (unadjusted model) to measure the association of each of the predictor variables with modern contraceptive use.

At the third level, multivariate analysis was done using binomial logistic regression (adjusted) which consists of all the study variables i.e., both the partner difference variables and the socio-economic characteristics of the respondents. Diagnostic tests for logistic regression such as multicollinearity test, link test for detecting model specification error, and goodness of fit test for the model were conducted.

Results

Descriptive profile of study sample. Table 1 presents the descriptive characteristics of the respondents and the prevalence of modern contraceptive use among respondents.

The total sample for this study comprises of 5849 married young women aged 15-34 years. As seen in Table 1, the mean age of the respondent is 27.2 years. On average the respondents had their first birth at age 19 years. Most of the respondents (61%) have three or more living children. More than two-fifth of the sample have up to Secondary education. More than half of the women are Muslim (55.9%), 37.6% are Hausa, and 28.9% resides in the North-western region (28.9%). Further, most of the respondents (54.3%) live in rural areas. Close to one-fourth of the respondents (23.3%) are from the richer household wealth quintile.

Most of the respondents (98.3%) are younger than their partner, while just 1% are of the same age as their partner. Most of the respondents (36.8%) have the same level of education as their

partners. Close to half of the participants (41.2%) are married to partners who desire more children than they do. Finally, two-thirds of the respondents are employed and married to employed partners at the time of the survey.

Table 1: Frequency and percentage distribution of respondents and prevalence of modern contraceptive use.

CHARACTERISTICS	FREQUENCY (n= 5,849)	PERCENTAGE	PREVALENCE OF USE (20.4)
Non-User	4,652	79.5	
Modern contraceptive User	**1196**	**20.4**	Mean age of Users=28.1, SD=3.9
AGE (Mean=27.22, SD=4.51)			*p-value 0.000*
15-19	337	5.8	6.3
20-24	1,188	20.3	16.8
25-29	2,014	34.4	22.2
30-34	2,309	39.5	22.8
AGE AT FIRST BIRTH	Mean=19.04	SD= 3.71	Mean age at first birth of Users= 20.0, SD=3.7
NUMBER OF LIVING CHILDREN			*p-value 0.000*
None	82	1.4	13.8
1 child	924	15.8	16.2
2 children	1,273	21.8	22.0
3 or more	3,569	61.0	21.1
HIGHEST LEVEL OF EDUCATION			*p-value 0.000*
No education	2,086	35.7	6.8
Primary education	837	14.3	19.9
Secondary education	2,365	40.4	29.6
Higher education	561	9.6	34.4
RELIGION			*p-value 0.000*
Catholic	492	8.4	26.1
Other Christians	2,055	35.1	27.7

Islam	3,269	55.9	15.2
Traditionalists and Others	33	0.57	3.2
ETHNICITY			*p-value 0.000*
Hausa	2,199	37.6	12.3
Yoruba	1,125	19.2	32.2
Ibo	612	10.5	28.4
Other	1,912	32.7	20.3
REGION			*p-value 0.000*
North-Central	921	15.7	19.9
North-East	803	13.7	13.0
North-West	1,693	28.9	13.3
South-East	492	8.4	24.1
South-South	722	12.3	22.0
South-West	1,217	20.8	33.3
PLACE OF RESIDENCE			*p-value 0.000*
Urban	2,672	45.7	29.4
Rural	2,176	54.3	12.9
WEALTH INDEX			*p-value 0.000*
Poorest	971	16.6	6.3
Poorer	1,095	18.7	10.3
Middle	1,174	20.1	17.9
Richer	1,364	23.3	27.3
Richest	1,243	21.2	35.2
AGE DIFFERENCE			*p-value 0.555*
Respondents older	37	0.6	31.8
Same age	62	1.0	22.0
Partner older	5,750	98.3	20.4
EDUCATION DIFFERENCE			*p-value 0.000*
Both uneducated	1,518	26.0	5.4

Same level of education	2,152	36.8	29.6
Respondent more educated	607	10.4	26.2
Partner more educated	1,571	26.9	20.3
FERTILITY DESIRE DIFFERENCE			*p-value 0.000*
No difference	2,304	39.4	26.2
Partner wants more	2,408	41.2	14.2
Partner wants less	349	6.0	25.9
Don't know partner's desire	787	13.5	20.5
WORK DIFFERENCE			*p-value 0.000*
Both Unemployed	251	4.3	10.0
Respondent unemployed but partner unemployed	1,654	28.3	15.0
Respondent employed with unemployed partner	58	1.0	18.0
Both Employed	3,886	66.4	23.5

***Weighted frequencies may not add up to 5,848 due to decimals*.** **SOURCE: NDHS 2018**

In Table 1 above, the prevalence of modern contraceptive use across selected sociodemographic characteristics and partners' sociodemographic differences were examined. Overall, 20.4% of currently married young women aged 15-34 years are using a modern method of contraceptive. Modern contraceptive use is more prevalent among respondents who are older than their partners (31.8%), have same level of education (29.6%), have same fertility desire (26.2%) and both employed (23.5%).

The prevalence is statistically different ($p<0.05$) across respondent characteristics. Use is most common among the oldest age group, 30-34 years (22.8%). Modern contraceptive use is highest among respondents who have just two living children (22.0%). Christian respondents reported the highest use of modern contraceptives (27.7%). Across level of education, respondents with no formal education reported the lowest use (6.8%), while respondents with tertiary education reported the highest use. Use is highest among respondents in the Southwest (33.3%) and lowest among respondents in the Northeast (13.0%). Also, use is more common among respondents in urban areas (29.4%). Use increases as wealth increases with the highest percentage of users from the richest wealth quintile (35.2%), whilst the lowest percentage of users in the poorest wealth quintile (6.3%). Table 2 presents the unadjusted and adjusted odds ratio and confidence intervals of factors associated with modern contraceptive use.

Table 2: Factors associated with modern contraceptive use among married young women aged 15-34 years old in Nigeria.

VARIABLES	UNADJUSTED	ADJUSTED
AGE DIFFERENCE		
Same age	RC	RC
Respondents older	1.646[0.658-4.121]	1.491[0.565-3.937]
Partner older	0.904[0.493-1.656]	1.252[0.661-2.370]
EDUCATION DIFFERENCE		
Same level of education	RC	RC
Both uneducated	0.135*[0.106-0.172]	0.307*[0.229-0.412]
Respondent more educated	0.842[0.688-1.032]	0.986[0.796-1.221]
Partner more educated	0.605*[0.519-0.706]	0.721*[0.607-0.857]
FERTILITY DESIRE DIFFERENCE		
No difference	RC	
Partner wants more	0.465* [0.401-0.538]	0.712* [0.603-0.840]
Partner wants less	0.984 [0.761-1.273]	0.969 [0.737-1.274]
Don't know partner's desire	0.726* [0.596-0.883]	0.950[0.768-1.176]
WORK DIFFERENCE		
Both Employed	RC	
Both unemployed	0.364* [0.239-0.552]	0.609*[0.382-0.973]
Respondent unemployed but partner employed	0.575*[0.492-0.671]	0.848[0.713-1.010]
Respondent employed with unemployed partner	0.715 [0.364-1.406]	0.767[0.376-1.565]
CURRENT AGE	1.059*[1.044-1.075]	1.025*[1.002-1.049]
AGE AT FIRST BIRTH	1.073*[1.055-1.090]	0.968*[0.945-0.992]
NUMBER OF LIVING CHILDREN		
None	RC	
1 child	1.205[0.628-2.311]	0.288[0.073-1.140]
2 children	1.758 [0.926-3.339]	0.352 [0.089-1.389]

3 or more	1.669 [0.302-0.574]	0.384 [0.097-1.517]
PLACE OF RESIDENCE		
Urban	RC	
Rural	0.357* [0.312-0.408]	0.713*[0.601-0.845]
WEALTH INDEX		
Poorest	RC	
Poorer	1.725* [1.247-2.386]	1.288 [0.918-1.808]
Middle	3.276* [2.428-4.419]	1.877* [1.354-2.602]
Richer	5.638* [4.237-7.502]	2.607* [1.866-3.643]
Richest	8.154* [6.135-10.838]	3.252* [2.296-4.606]
EDUCATION		
No education	RC	**a**
Primary education	3.529* [2.768-4.498]	
Secondary education	5.981* [4.924-7.264]	
Higher education	7.457* [5.831-9.534]	
REGION OF RESIDENCE		
North-Central	RC	
North-East	0.602* [0.463-0.782]	1.130[0.836-1.528]
North-West	0.621* [0.501-0.769]	1.313[0.984-1.753]
South-East	1.281 [0.985-1.665]	0.411*[0.276-0.610]
South-South	1.135[0.894-1.442]	0.560*[0.427-0.733]
South-West	2.013*[1.647-2.461]	1.120[0.828-1.516]
RELIGION		
Catholic	RC	
Other Christians	1.084[0.867-1.355]	1.020[0.793-1.312]
Islam	0.506*[0.405-0.632]	0.745[0.553-1.003]
Traditionalists and Others	0.093*[0.013-0.650	0.158[0.022-1.142]
ETHNICITY		
Hausa	RC	

Yoruba	3.382*[2.30-4.043]	1.213[0.843-1.747]
Ibo	2.825* [2.274-3.509]	1.824* [1.211-2.749]
Other	1.819* [1.536-2.154]	1.390*[1.065-1.816]

*Significant at p<0.05, RC-reference category, **a** -not included in multivariate analysis due to multicollinearity with wealth index

From Table 2 above, there is no association between age difference and modern contraceptive use among currently married young women aged 15-34 years.

Education difference is statistically associated with modern contraceptive use among married young women. The odds of using modern contraceptives for uneducated respondents with uneducated partner is 86.5% lower than the odds of use for respondents who have the same level of education as their partners (OR=0.135, CI 0.106-0.172). The odds remain lower after adjusting for respondents' socio-economic characteristics (AOR=0.307, CI 0.229-0.412). The odds of using modern contraceptives for respondents whose partners are more educated than them is lower than the odds of use for respondents who have the same level of education as their partners (OR=0.605, CI 0.519-0.706). The odds remain statistically lower after controlling for other variables in the multivariate model (AOR=0.721, CI 0.607-0.857).

The odds of using modern contraceptives for respondents who are unemployed with unemployed partner is 64% lower than the odds of use for respondent employed with employed partner (OR=0.364, CI 0.239-0.552). The odds remain statistically lower for the same category after controlling for other variables (AOR=0.609, CI 0.382-0.973). The odds of modern contraceptive use is 29% lower for respondents who are employed with unemployed partner compared to respondents employed with employed partners (OR=0.715, CI 0.364-1.406).

Differences in fertility desire is statistically significant with modern contraceptive use. The likelihood of using modern contraceptives is 54% lower for respondents whose partners want more children compared to respondents whose partners want the same number of children as they do (OR=0.465, CI 0.401-0.538). Controlling for both socioeconomic and other partner difference variables, the odds of use for respondents whose partners want more children is 29% lower compared to respondents who want the same number of children as their partner (AOR=0.712, CI 0.603-0.840).

Discussion of findings

This study examined the partner's socio-economic characteristic differences associated with modern contraceptive use among married young women (15-34 years old) in Nigeria. The prevalence of modern contraceptive use among married women aged 15-34 years in Nigeria is low, with only 20.5% of the women using modern methods at the time of the survey. Partner difference in education status, and fertility desire were significantly associated with modern contraceptive use.

Findings on the prevalence of modern contraceptive among young married women in Nigeria is low compared to the findings of previous studies for some other African countries. A previous

study in Ethiopia aimed to analyse contraceptive use among women with no fertility intention, found that modern contraceptive prevalence among women aged 34.7 on average is 51.1% (Asresie, Fekadu, & Dagnew, 2020). Similarly, another study in Uganda carried out to examine factors associated with modern contraceptive use young and older women found that contraceptive use among sexually active married women age 15-24 is 39% and 50% among 25-34 (Asiimwe, Ndugga, Mushomi, & Ntozi, 2014). Although, previous studies in Nigeria had confirmed that the use of modern methods of contraception in Nigeria is low (Lamidi, 2015; OlaOlorun & Hindin, 2014). Findings from the study affirms the relatively low modern contraceptive use in Nigeria, 13% for all sexually active married and cohabiting women use modern contraceptives. The author suggested relatively low socio-economic status of married and cohabiting women in the country as the reason (Lamidi, 2015). Findings from this study also re-affirm the significance of women's socio-economic status in the uptake of modern contraceptives.

The focus of this study was to examine the relationship between differences in partner's characteristics and modern contraceptive use among young married women in Nigeria. From the results, nearly all the respondents are younger than their spouse. However, this is not significantly associated with modern contraceptive use among the respondents. These findings offer support to earlier research that examined the relationship between spousal age difference and women's contraceptive behaviour in Nigeria. Using DHS couples dataset, it was found that large age difference between partners is associated with low contraceptive use only at the bivariate level of analysis (Ibisomi, 2014). Large age differences in a marital union may not be a threat to reproductive health if the women are socio-economically advantaged as it is in non-marital relationships. Studies have indicated a reduction in age gap between partners as one of the factors associated with improvement in young women's reproductive health (Wildsmith, Manlove, & Steward-Streng, 2015).

Most of the respondents are employed with employed partners, and prevalence of use is highest among this group. When both parties are employed, they are more likely to use modern contraceptive compared to when they are both unemployed. Having a gainful employment may give young married women autonomy and allow them to have a say over their reproductive health. A study in Nigeria showed that women with autonomy and who have a say in decision making are more likely to use modern contraceptives (OlaOlorun & Hindin, 2014). Also, because of the job, the woman may want to avoid or delay pregnancy to keep her job to sustain the family.

Prevalence of use is significantly higher when the respondents have the same level of education as their spouse. The likelihood of modern of use is lower among respondents who have partners that are more educated compared to those with same level of education. A plausible explanation for this could be that balanced level of educational status in a union increases women's autonomy and increases their participation in decision-making in the family. Studies have established a positive association between women autonomy, decision-making power, and contraceptive use (Mboane & Bhatta, 2015). Previous studies have revealed that balanced

relationships encourage communication, increasing the probability of contraceptive use (Manlove, Ryan, & Franzetta, 2007; Wildsmith et al., 2015).

Most of the respondents are married to partners who desire more children than they do. Respondents whose partner desire more children are less likely to use modern contraceptives, even after controlling for other factors. The prevalence of use is also lowest among this group. This finding is similar with the result from a study of trends in contraceptive use among young women in Ethiopia, which reported a decline in the percentage of husbands who want more children than their wives contributing significantly to the increase in modern contraceptive use over the survey period (Worku, Tessema, & Zeleke, 2015). Also, in Mozambique women whose partner wants a higher number of children than them are less likely to use contraceptive compared to when they want the same number of children (Mboane & Bhatta, 2015). This is because, in a patriarchal society, men's opinions are regarded more highly. Hence, husband's disapproval of contraceptives may prevent wives who want to delay or limit births from using contraceptives; the decision of the man overrides that of the women (Barden-O'Fallon & Speizer, 2010).

Conclusion

Modern contraceptive use among married women aged 15-34 years in Nigeria is low, compared to other sub-Saharan African countries. Further, partner's higher fertility desire was found to be negatively associated with modern contraceptive use among young married women. This shows young women also depends on spousal fertility desire. Young women and their spouses need to reach agreement on the number of children and the woman should have a say in the decision.

Educational and employment status homogeneity in union encourages modern use. These findings support the call for women empowerment in both education and employment. This will boost their agency and they will be able to discuss their desire and have a say in issues that concerns them. Also, targeting men for significant commitment to reproductive health programs and reorientation on cultural beliefs towards desiring many children. This is important for the country as modern contraception is an operational public health tool that guarantees women staying healthy, more productive, and more opportunity for education, training, and employment, which in turn, benefits entire families, communities, and the nation.

Therefore, policymakers on family planning should intensify their effort to increase contraceptive rate in the country especially among the socio-economically disadvantaged women. Also, government needs to address gender inequality in education and employment as a means of promoting women sexual and reproductive rights.

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