

CICRED'S SEMINAR

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1. Introduction

Renewed emphasis on the issue of poverty has been rekindled by the unacceptability of its continued prevalence, particularly in Africa. Poverty was the theme of the 1995 World Summit for Social Development in Copenhagen, the 1997 United Nations Human Development Report, and the World Development Report in 2000. This focus on poverty is not misplaced, given its retarding influence on development efforts. That a large and increasing proportion of the population in Nigeria is reported to be poor is not surprising, particularly when viewed against the background of an ailing economy for almost two decades. Nigeria was ranked 40th among the world's poorest countries in 1999 and the share of the country's population below the poverty line is reported to have increased from 42.8% in 1992 to 65.6% in 1996 (World Bank, 1999, 2001). The Federal Office of Statistics (FOS, 1999), using a series of consumer expenditure surveys over a period of sixteen years, from 1980 to 1996, also

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confirms the increasing incidence of poverty in the country. The poverty level in 1980 was 27.2%, it rose to 46.3% in 1985 and declined to 42.7% in 1992 and, by 1996, it reached an all time high of 65.6%. In absolute terms, the population affected was 17.7, 34.7, 39.7 and 67.1 million for 1980, 1985, 1992 and 1996, respectively. Demographic indicators such as infant and child mortality, maternal mortality and life expectancy over the years have not shown considerable improvement, particularly when compared with other developing countries within the subregion or other continents. For example, the life expectancy of 53.2 years estimated for the country using the 1991 census is low when compared with 64 years for Indonesia in 1994. Stunting, a measure of the long-term effect of under-nutrition, is reported to have seemingly increased between 1990 and 1999 by 10 percentage points, from 36% to 46% (NPC, 2000). The incidence of poverty in the country is increasing, despite the various programmes put in place to ameliorate the situation.

The poverty profile as presented by FOS (1999) also indicates that the incidence is higher in the rural than in the urban areas. In 1996, 58% of the urban population, as against 70% of the rural population, are poor. An inverse relationship is observed between poverty and education. Households headed by persons with no education had the highest poverty incidence, whereas those with an educational level above the secondary level had the lowest chance of being poor. The incidence of poverty, on the other hand, is positively related to family size. While most small households were out of poverty, most large households were poor. Households with less than five members had a poverty incidence lower than the national average, while households with five or more members had a higher poverty incidence. In 1996, a little more than half of households with 2 to 4 members were categorized as poor, while three quarters of the households having between 5 to 9 members were poor.

In recognition of the adverse effect of a high population growth rate on national development and individual welfare, the government launched the first *National Policy on Population for Development, Unity, Progress and Self-Reliance*, which is currently being reviewed (FRN, 1988). Prior to this period, a contrary perception of the influence of the country's population growth rate on development efforts prevailed. Among other objectives, the policy sought to improve the living standard and the quality of life of the people and achieve lower growth rates through reduction in birth rates by voluntary fertility regulation methods. This position by the government resulted in an increased participation in the provision of fam-

ily planning services. Hitherto, the initial provision of family planning services in the country was by private organizations and dates back to the early 1960s as a result of concern over the increasing incidence of illegal abortion. At present, the provision of family planning services is mainly through private and public health facilities, even though methods such as the condom and pills may be obtained from patent medicine stores and pharmacies. Although the costs of family planning commodities may be described as low, such costs can, however, be enormous for the poor.

The family planning situation in Nigeria over the years has undoubtedly experienced improvements, although it remains relatively poor when compared with other African countries. Knowledge of contraceptive methods among women rose from 34% in 1981/82 to 44% in 1990 and 64% in 1999. The level of use, however, failed to increase by the same magnitude, with current use of any method of contraception increasing from 6% in 1981/82 and 1990 to 15% in 1999 (FOS, 1992; NPC, 2000). The level of knowledge and use of contraception also vary significantly for regions of the country, urban/rural residence, and with the sociodemographic background of individuals. Data from the 1990 and 1999 *Nigeria Demographic and Health Surveys* (DHS) (FOS, 1992; NPC, 2000) confirm a higher level of knowledge of contraceptive methods among currently married women in the south compared to the north. In 1990, the highest percentage of knowledge of any contraceptive method was 74% in the southwest, compared with 30% in the northwest. Similarly in 1999, although there was a general improvement across the regions regarding knowledge of any method of contraception, the southwest, with 87%, has slightly more than twice the percentage of the northwest. The data for currently married men in 1999 is similar to that of women, except that the percentage among men reporting knowledge of contraceptive methods is higher – 90% of the men in the southwest compared with 65% in the northwest report knowledge of any method of contraceptive. Knowledge of contraception increases with higher education and it is almost 100% among those with higher education for both men and women, with primary education making a great difference among women compared to men using the 1999 data. By residence, knowledge of any method is higher in the urban population than in the rural. In 1990 and 1999, 70% and 83%, respectively, report knowledge of any method among married women compared with 36% in 1990 and 57% in 1999 for women in rural areas. In 1999, 93% of the men in urban areas and 79.5% in rural areas report knowledge of any contraceptive method.

Current use of any method of contraception also displays the same pattern as described for knowledge, both by region and education. The southwest has the highest contraceptive prevalence with 24%, while the north has 3%. Women with no education have 6% and men 12% compared with 45% for women and 53% for men with higher education. By residence, 23% of the women in urban locations compared with 12% in rural locations report current use of contraception, an 11 percentage point difference. For men, the figure is 39% in the urban area compared with 30% in the rural area (NPC, 2000).

The high and stable total fertility rate at six children per woman, with little variation (not more than one child) across regions, is attributable to the value attached to children, buttressed by the traditional customs and dominant religious beliefs of Christianity and Islam. Tradition-wise, barrenness or the inability to replace oneself is scorned. Women or men with one or two children are considered only a step better than the barren, equally demanding some amount of pity, while, conversely, women with large family sizes are honoured with special ceremonies in some cultures. Against this backdrop, it is not surprising to see a high number of people proffer nonnumeric responses (“as God gives”) to questions on the desired number of children or ideal number of children.

Although the value attached to children cannot be alleged to have weakened, it may be argued that the economic distress facing the nation has somewhat influenced childbearing desires, observed to have declined from the standpoint of nonnumeric responses for the ideal number of children from approximately 61% in 1990 to 18% in 1999. The proportion reporting a desire to limit childbearing also increased between the two surveys from 15.4% in 1990 to 19.6% in 1999 for currently married women; and the figure for men is 18.8% in 1999. More urban compared to rural residents, and those in the south generally compared with those in the north, report a desire to stop childbearing in both surveys. Desire to stop childbearing also increases steadily with the increasing number of surviving children (FOS, 1992; NPC, 2000).

In the 1998 population policy, the desire was to achieve a reduction in the total number of children born to a woman to four children, and although the policy is currently under review, it is certain that a policy change is not expected in the opposite direction. One of the major critiques of the 1998 population policy is the restriction of the number of children to women and the difficulty in its implementation in the face of the critical role men play in childbearing issues. The importance of the

male attitude in the determining of sexual and social behaviours among women in patriarchal societies and the need to involve men in family planning programming is established in literature (Ezeh, 1993; Finger, 1992; Isiugo-Abanihe, 2003). In a study of five urban areas in Nigeria by Isiugo-Abanihe (2003), more men compared to their female counterparts agree to the prominence of men in various aspects of reproductive decision-making such as family size determination, when to have sex, duration of abstinence, and practice of family planning. For each of the issues raised, more than two fifths but less than half of the women indicated the prominent role of men, while the proportion for men is more than half in all the instances, except for the practice of family planning, with 48%. Increasingly, couple's joint decision-making on reproductive issues is becoming more common, especially with education. In instances where the female partner participates in childbearing decision-making, the male position is stronger, particularly where there is a disagreement (Isiugo-Abanihe, 2003). The 1999 NDHS reports disapproval of contraception by the spouse as a reason for non-adoption, particularly for women (7%) compared to men (2%) (NPC, 2000).

The importance of spacing births or limiting births for the health of women is of equal importance in a traditional society like Nigeria, where the traditional customs of breastfeeding for a long period and abstinence from sex for long periods, which ensured long birth intervals, have undergone changes. It may, however, be easier to effectively achieve the purpose of limiting childbearing with effective contraception compared to child spacing. This is because of the fear associated with effective contraceptive methods and future fertility desires. This fear may no doubt account for the high unmet need reported for the country. Among currently married women, unmet need estimates were 21% in 1990 and 18% in 1999 (FOS, 1992; NPC, 2000). The importance of the concept of unmet need, which evolved from the "kap-gap" term, is anchored in its ability to influence the development of family planning programmes to better reach groups that are yet to be reached and better serve those currently being served. The measurement of the term has undergone changes over time, both in terms of the population to which it is applicable and in its definition. While the term was first applied to women because of the orientation of most policies and family planning programmes in many developing countries that had married women as the main target for fertility control, the case for men and couples has increasingly been made (Ngom, 1997; Bankole and Ezeh, 1999). The argument for the inclusion

of various groups of persons – male, female, married, unmarried – in the measurement of unmet need is often justified, particularly given observed differences by sex for information on family planning methods since the inclusion of males. Another issue that arises is the need for definition and measurement to be applicable in a similar manner in order to enhance comparison of estimates across groups and to enable the use of one summary statistic for unmet need for an entire country. In this study, married men who report a desire for no more children, when either he or his spouse is not currently using any method of contraception at the time of the survey, are regarded as having unmet need for childbearing.

2. Methodology

The data used in this study come from a 1998 survey of urban households in Nigeria. The cities and towns covered are the ones for which Field Research Stations (FRSs) already existed since 1990 for the purpose of collecting systematic and longitudinal socioeconomic data. The FRSs were created using the longitudinal and latitudinal grid system that divided the country into seven cells consisting of urban and rural FRSs (for more detail on the FRSs, see Odumosu *et al.*, 1998). Only the seven urban sites were covered in this study. A total of 150 heads of households were interviewed in five urban centres in each of the seven cells, making a total of 5,250 households. In the selection of the households, each urban settlement was stratified into broad groups of upper, middle and lower classes on the basis of residential patterns. In each of the stratified clusters, systematic selection of households took place.

The urban bias of this study is relevant to the extent that these areas are better served with health facilities, both public and private, that provide family planning services. The people are also better exposed to information and more likely to limit childbearing. In the analysis of the data for this paper, the FRs were regrouped to reflect the four health zones into which Nigeria is divided for the effective implementation of Primary Health Care (PHC). Family planning services as provided by the government are embedded within the PHC. The distribution of health facilities in the country varies significantly within the health zones, the southwest being the most served (Kiragu *et al.*, 1995). While the population is dense in the south, it is sparsely distributed in the north, with the implication for more travel time to health facilities in the north. Approximately equal

populations obtain in each of the health zones, which also reflect sociocultural groupings in the country. The southeast is Zone A, comprising Imo, Abia, Anambra, Cross River, Akwa-Ibom, Benue, Bayelsa, Ebonyi, Rivers and Enugu States; the southwest is Zone B, comprising Oyo, Lagos, Delta, Edo, Ekiti, Osun, Ogun and Ondo States; the northwest is Zone C, comprising Sokoto, Abuja, Kebbi, Kogi, Kwara, Niger, Zamfara, Kaduna and Katsina States; while the northeast is Zone D, comprising Kano, Gombe, Plateau, Borno, Taraba, Nasarawa, Yobe, Jigawa, Adamawa and Bauchi States.

Structured questionnaires were used to elicit information from the heads of households and details relating to other members of their household. The questions to which answers were sought relate to the socioeconomic background of all members of the households, the respondent's marital history, family size preferences, knowledge of, attitude toward, and practice of family planning, perception of the government's policy of four children per woman and perception of the respondent's quality of life. Due to the fact that men are often the head of households, except where the woman is divorced or widowed, the majority of the respondents were male. For this study, the few women who were interviewed are not part of the analysis. The types of questions asked also limit the possibility of addressing the concept of unmet need for spacing, despite its importance. The responses to three questions, "Would you like to have a (another) child or would you prefer not to have any more children?", "Are you currently using a method to delay or avoid having a child?", and "Is your spouse currently using a method to delay or avoid having a child?", are used to categorize the respondents as either having unmet need for family planning or not having unmet need. These questions were asked without any specific reference to a wife or partner of the respondent for those in polygynous union. For the questions on current use of contraception, only negative responses to both questions (for spouse and self) classify the respondent as not currently using contraception. The question on desire for more children was followed by a question on the number of children desired, and reason for desiring more children. Respondents who did not want more children were also asked why they preferred not to have any more children. For the question on current use of contraception, the reason for non-use was obtained. A total of 1,872 of all men interviewed irrespective of their marital status were identified as not desiring any more children (37.1% of 5,046).

In the first part of the analysis, the background of the respondents (currently married men) is discussed using simple descriptive data. In the second part of the analysis, the level of unmet need is examined by background characteristics, and logistic regression is used to assess the strength of the various variables on unmet need of men for limiting childbearing. Eight variables, which include mainly background variables and health service for family planning commodities, are included in the regression equation. Variables such as education, age, surviving children, religion and zone were chosen because of the prior knowledge of the relationship of these variables with contraceptive use. The variable 'birth within the last 12 months' is controlled due to the non-inclusion of variables that relate to the wives. Distance of place of residence to family planning service points was included, based on the established relationship of use of health facilities and distance to place of residence. Visitation to family planning service points with spouse, either voluntarily or through invitation by service providers, to some extent measures the exposure of men to a reliable source of information.

3. Results

3.1. Characteristics of respondents

The background characteristics of all the respondents as presented in Table 1 show that the majority of the respondents who are currently married were in monogamous union (83%). A mean age of 43.5 years obtains and the majority of them have three children and above, with a mean number of surviving children of 4.0. Approximately 57% were Christians, 41% were Muslims and the balance of other religious belief. The majority of the respondents are educated, with approximately 13% having no formal education. Less than 10% report primary school education, about 22% have secondary education and about 46% have higher education, which includes university and other professional qualifications. The level of education observed among the respondents to some extent reflects the urban location of the study, although an oversampling among persons with higher education and misreporting of the educational status among the respondents may have taken place. About the same percentage of respondents are from the northwest (29.7%), northeast (27.1%) and southwest (28.5%) health zones, with the southeast zone accounting

Table 1
 Characteristics of respondents (married men only)

Characteristics		Percent	N
Type of marriage	Monogamous	83.3	3,879
	Polygynous	16.7	777
Age	<35	19.1	890
	35-39	19.5	908
	40-44	18.1	842
	45-49	16.2	754
	50-54	10.8	503
	55-59	7.0	324
	60+	8.6	401
	No response	0.7	34
	<i>Mean</i>	<i>43.5</i>	<i>4,656</i>
Number of living children	0	2.4	113
	1	10.9	506
	2	16.9	789
	3	17.6	821
	4	16.2	755
	5	10.6	494
	≥6	21.7	1,009
	No response	3.6	169
	<i>Mean</i>	<i>4.0</i>	<i>4,656</i>
Religion	Christian	57.7	2,687
	Muslim	40.7	1,894
	Others	1.6	75
Education	No schooling	13.2	614
	Primary	8.6	401
	Secondary	22.0	1,026
	Higher	45.5	2,118
	No response	10.7	497
Health zone	Northwest	29.7	1,381
	Northeast	27.1	1,263
	Southwest	28.5	1,325
	Southeast	14.8	687
% who have visited FP clinic		37.3	1,738
Distance to FP clinic	Very far	22.1	1,028
	Just far	26.9	1,253
	Not far	38.4	1,790
	No response	12.6	585
Total		100.0	4,656

Source: Field survey, 1998.

for 14.8%. Approximately 37% of the respondents have visited a family planning clinic in the past and 38% describe the distance to a family planning clinic as not far, almost half of the respondents describe it as either very far or just far.

3.2. Bivariate analysis

3.2.1. Desire for more children

The distribution of respondents indicating a desire for more children by background characteristics as presented in Table 2 shows that approximately 54.5% of all married men desire more children. Men in polygynous union are more likely to want more children compared with their counterparts in monogamous union; this may be related to the need for the youngest wife to have a number comparable to her co-wives. The percentage indicating a desire for more children is also observed to decline with increasing age, except at age 60 and above that experiences a slight increase, which may be attributed to the introduction of new wives into the household. The rate of the observed decline is, however, not sharp and may be attributed to the value attached to children. At age 50 to 54, almost two fifths of the men desire more children, while at age 55 to 59, about a quarter desire more children. By the number of surviving children, a negative relationship obtains, but as in age, the desire for more children remains high at four children and above. Muslims (72.8%) are more likely to desire more children compared to Christians (46.3%), probably because they are also more likely to be in polygynous union. The percentage of men that indicates a desire for more children is high across all educational categories, but men with no education are the most likely to desire more children. More than half of the men with primary education and above express a desire for more children. Men in the north compared with those in the south are also more likely to express a desire for more children.

3.2.2. Knowledge and use of contraception

The discussion on knowledge and use of contraception is based on the five major methods that are often used, based on reports obtained among the respondents: periodic abstinence, condom, withdrawal, pill and injection. Information was, however, collected for all the methods of

Table 2
Percentage of men desiring more children by background characteristics

Characteristics		Percent	N
Type of marriage	Monogamous	56.1	3,682
	Polygynous	64.1	738
Age	<35	87.5	815
	35-39	73.5	865
	40-44	59.0	809
	45-49	43.7	721
	50-54	39.0	490
	55-59	24.8	310
	60+	30.2	381
Number of living children	0	100.0	8
	1	94.6	500
	2	77.6	774
	3	60.5	806
	4	40.1	740
	5	37.2	486
	≥6	38.9	979
	Religion	Christian	46.3
Muslim		72.8	1,793
Others		66.2	71
Education	No schooling	72.8	584
	Primary	53.7	391
	Secondary	59.5	985
	Higher	51.6	2,004
Health zone	Northwest	75.0	1,304
	Northeast	58.3	1,174
	Southwest	47.6	1,277
	Southeast	40.0	665
Total		54.5	4,656

Source: Field survey, 1998. — 'No response' cases are ignored.

contraception. Permanent methods – male and female sterilization – have less than 2% of the respondents reporting their use and other methods have a little more than 5% reporting their use.

As presented in Table 3, a high awareness of contraceptive methods obtains among the respondents, with almost all the respondents (about 93%) indicating knowledge of at least one contraceptive method. The condom had the highest percentage (81%) reporting knowledge of it,

Table 3
Knowledge of contraception (%) by background characteristics

Background characteristics	Any method	Pill	Injection	Condom	Withdrawal	Periodic abstin.	Number of men
Education							
No education	80.5	48.0	42.8	55.0	38.9	44.8	614
Primary	92.3	69.3	58.4	76.8	62.8	69.8	401
Secondary	95.9	78.0	66.4	85.7	68.3	75.4	1,026
Higher	96.2	87.7	78.0	89.2	76.6	80.5	2,118
Age							
<35	92.8	79.0	69.1	81.2	62.0	69.9	890
35-39	94.1	80.9	70.9	84.8	71.7	76.5	908
40-44	94.2	78.5	68.8	83.6	66.7	70.7	842
45-49	93.1	78.4	69.5	83.0	66.4	71.0	754
50-54	91.8	77.3	65.6	79.3	67.8	73.2	503
55-59	94.1	74.7	62.3	75.9	69.1	72.5	324
≥60	86.3	62.6	55.1	64.6	57.4	62.1	401
Health zone							
Northeast	90.7	75.3	61.1	77.9	58.9	64.4	1,263
Northwest	87.0	69.8	67.0	67.1	48.6	53.9	1,381
Southeast	97.5	80.2	73.5	88.4	86.2	67.3	687
Southwest	98.0	85.3	70.4	92.9	80.9	87.4	1,325
Religion							
Christian	97.5	85.3	73.6	89.9	78.5	84.2	2,687
Muslim	86.0	66.2	58.9	67.6	48.4	52.5	1,894
Others	90.7	68.0	56.0	69.3	69.3	80.0	75
No. of children							
2 or less	93.8	80.0	67.3	82.6	66.5	72.7	1,408
3-4	94.2	80.9	71.9	85.1	70.1	74.6	1,576
5-6	92.9	76.7	68.6	79.4	64.4	70.6	832
7+	89.1	65.3	56.9	68.7	57.5	61.8	671
Total	92.7	77.2	67.3	80.5	66.1	71.2	4,656

Source: Field survey, 1998. — 'No response' cases are ignored.

while withdrawal had the lowest percentage, with about 66%, among the five methods under consideration – the other methods are the pill, injection and periodic abstinence. These methods are among the most mentioned by the respondents.

By background characteristics, awareness of contraceptive methods is observed to increase with education for all specific methods, and the con-

dom is the most popular method for respondents in any specific educational status. Knowledge is also considerably high for all age groups and does not display a specific pattern. By health zone, knowledge of specific methods is equally high in all the zones, but the south had slightly higher percentages than the north. For all the methods under consideration, Christians are more likely to report knowledge compared to Muslims, even though the figures for the various methods by Muslims are relatively high. The percentage reporting knowledge of any method of contraception or of the specific methods increases to the fourth child and subsequently declines, although the figures remain high.

The report on ever-use of contraception by respondents includes that used by the spouse, and is shown in Table 4. Among all the men, over three fifths indicate the use of any method. Periodic abstinence (40.8%) is the most commonly ever-used method and is followed by the condom, with about 35.1%. Effective methods have the lowest percentage of men reporting their use – the injection has approximately 8% and the pill has 12.5%. These methods are female-specific and some underreporting for ever-use may arise from use by spouses outside marriage. The underreporting for the pill and injection is, however, not expected to be large and the data generally reflects the expected pattern. By background characteristics, report of ever-use of any method improves with increasing education and also for specific methods such as the pill, injection and condom. Ever-use of traditional methods such as withdrawal and periodic abstinence, however, displays very little variation by education. By age, ever-use of any method is high for all ages. For specific methods, the injection is the least likely to be reported for all the age groups, and those aged 60 years and above are the least likely to report ever-use of condom and pill. Ever-use of periodic abstinence is high across all ages and increases with age.

The level of ever-use for any method is higher in the southeast and southwest compared with the other health zones in the north, the northwest having the lowest percentage, with about 47%. The percentage reporting use of the pill and injection is generally lower in the north compared to the south, but this pattern does not obtain for the other methods. The percentage of men who have ever-used any contraception is higher among Christians compared to Muslims. For use of specific methods, such as the pill and injection, a higher percentage of Muslims compared to Christians report their use and the reverse obtains for the other methods – condom, periodic abstinence and withdrawal. Ever-use

Table 4
Ever-use of contraception (%) by background characteristics

Background characteristics	Any method	Pill	Injection	Condom	Withdrawal	Periodic abstin.	Number of men
Education							
No education	37.6	5.0	4.7	12.5	12.1	21.7	614
Primary	63.3	6.7	5.2	26.9	25.4	44.6	401
Secondary	68.8	9.8	5.3	38.5	26.7	48.4	1,026
Higher	70.8	16.7	10.7	43.8	25.3	44.4	2,118
Age							
<35	56.7	13.3	6.2	34.4	18.9	36.3	890
35-39	66.0	13.8	8.0	40.9	25.2	40.7	908
40-44	64.0	14.6	7.5	38.5	22.8	41.9	842
45-49	66.4	13.7	3.6	39.0	26.9	42.3	754
50-54	33.2	12.1	10.9	31.6	23.3	43.3	503
55-59	67.3	8.6	6.8	31.5	21.3	50.3	324
≥60	54.6	4.5	5.7	18.5	20.7	36.2	401
Health zone							
Northeast	59.3	17.3	9.7	34.6	20.7	33.6	1,263
Northwest	46.9	14.3	11.6	21.7	12.5	25.9	1,381
Southeast	75.4	4.9	3.1	41.6	35.4	54.1	687
Southwest	76.6	10.0	4.6	46.3	29.2	56.2	1,325
Religion							
Christian	75.3	13.6	7.6	45.1	29.8	52.5	2,687
Muslim	45.2	11.0	8.3	21.3	12.8	23.9	1,894
Others	33.3	9.3	5.3	26.7	29.3	48.0	75
No. of children							
2 or less	62.1	13.3	8.1	37.4	21.7	39.6	1,408
3-4	67.4	14.5	8.2	39.7	24.7	44.2	1,576
5-6	66.9	12.7	8.3	34.3	25.8	43.1	832
7+	53.4	6.6	6.0	23.2	19.4	35.0	671
Total	62.9	12.5	7.8	35.1	22.9	40.8	4,656

Source: Field survey, 1998. — 'No response' cases are ignored.

of contraception, both for any method and for the specific methods under consideration, in most instances is observed to increase with the increase in the number of children to the sixth child and to decline afterwards. The observed pattern may be attributed to the assumption of reduced fecundity of the wife with increasing age.

3.2.3. Current use of contraception among men desiring to limit childbearing

Among men who desire to limit childbearing (37%), approximately 51% report themselves as not using contraception, either modern or traditional methods (Table 5), and the percentage is expected to be lower if only modern methods are considered. The data therefore suggest a high level of unmet need for contraception for limiting childbearing among men in Nigeria. By background characteristics, the unmet need for contraception is observed to be high for all categories, but higher still for some compared with others. It declines with increasing education, connoting that the poor are likely to have a higher unmet need relative to the rich, given the relationship between education and poverty. Unmet need does not display a specific pattern by age, but the oldest age group has the highest percentage of unmet need, which may be due to the assumption of low risk of conception resulting from the advanced age of the spouse. Christians compared to Muslims have a lower unmet need level. By number of children surviving, unmet need declines with the increasing number of children, but increases at the sixth child and above. The pattern of unmet need observed for the number of surviving children may be interpreted as reflecting caution in the adoption of effective contraception among the respondents, and the increase in unmet need at the sixth child and above may be attributed to the perceived reduction in the risk of pregnancy of the spouse due to advance in age. Men in the southeast zone have the highest percentage of unmet need, with approximately 58%, followed by those in the northeast, with 51%, and those in the northwest and southwest have about the same percentage. Men who have ever visited FP service delivery points have a lower unmet need compared with their counterparts who have not. Also, men who describe the distance of residence to service delivery points as very far have the highest percentage of unmet need compared with those who describe the distance as just far or not far. Expectedly, men who had knowledge and had ever-used any method of contraceptive have a lower unmet need compared with those that have no knowledge and have never-used any contraceptive methods.

Table 5
 Percentage distribution of men with unmet need for family planning
 among currently married men desiring to limit childbearing,
 by background characteristics

Background characteristics		% with unmet need	N
Education	No schooling	74.4	156
	Primary	54.8	177
	Secondary	48.9	393
	University	47.0	939
Age	<35	51.5	97
	35-39	41.8	225
	40-44	48.5	328
	45-49	45.3	395
	50-54	51.7	290
	55-59	49.8	225
	60+	69.0	252
Religion	Christian	48.1	1,321
	Muslim	58.1	480
No. of living children	1	58.6	29
	2	53.8	169
	3	47.1	312
	4	47.8	433
	5	45.8	299
	6+	56.5	570
Health zone	Northwest	46.9	326
	Northeast	50.6	472
	Southwest	48.8	647
	Southeast	57.6	382
Ever visited FP clinic?	Yes	33.8	855
	No	66.2	921
Distance to FP clinic	Very far	59.1	352
	Just far	44.5	501
	Not far	49.4	779
Knowledge of any FP method	Yes	49.7	1,775
	No	88.5	52
Ever-use of any FP method	Yes	43.1	1,373
	No	74.0	454
All		50.8	1,827

Source: Field survey, 1998. — 'No response' cases are ignored.

3.2.4. Reasons for not using contraception

The reasons proffered by men with unmet need for not using contraception are presented in Table 6. The main reasons put forward by men relate to the side effects associated with methods (30%), religion (20%) and perceived inability of the wife to conceive (16%), factors that are relevant for family planning programme improvement. Approximately one quarter did not give any reason. Disapproval of contraception is an unimportant reason for not using contraception, as is often observed for reasons proffered by women. Other reasons that are not important for this sample include knowledge of methods, which does not cover in-depth understanding of the methods, cost of the methods and irregular supply of commodities.

Table 6
Percentage distribution of urban men who desire to limit family size
by reasons for not using contraception

Reasons	Percent
Fear of side effects	29.8
No reason	25.6
Against religion	20.2
Wife at menopause/cannot conceive	16.3
Not sexually active	3.5
Ineffectiveness of method	1.3
Wife disapproves	1.3
Lack knowledge	1.2
Cost of method	0.4
Unavailability of methods	0.4
N	928

Source: Field survey, 1998.

3.3. *Multivariate analysis*

Estimates of logistic regression equations that relate unmet need to selected variables associated with the respondents and family planning service are presented in Table 7. In the first model, selected background variables of the respondents and the health zone of residence are taken

Table 7
Logistic regression of unmet need for family planning,
urban Nigerian men, 1998

Variable	Model 1		Model 2	
	Coeff.	Exp (β)	Coeff.	Exp (β)
Education				
None (r)	---	---	---	---
Primary	-0.3248	0.7227	-0.3835	0.6815
Secondary	-0.4653	0.6280*	-0.4127	0.6618**
Tertiary	-0.4669	0.6270*	-0.2425	0.7847
Age	0.0217	1.0219*	0.0205	1.0207*
No. of surviving children	0.0137	1.0138	0.0064	1.0064
Religion				
Muslim (r)	---	---	---	---
Christian	-0.4680	0.6262*	-0.3321	0.7174**
Other	-0.5231	0.5927	-0.6116	0.5425
Birth in the last 12 months				
Yes (r)	---	---	---	---
No	0.1078	1.1138	0.1051	1.1108
Health zone				
Southeast	0.5482	1.7301*	0.5166	1.6763*
Southwest	0.1366	1.1464	0.0853	1.0890
Northwest	-0.2020	0.8171	-0.2506	0.7784
Northeast (r)	---	---	---	---
Distance to FP service point				
Very far	Na	Na	0.1872	1.2058
Just far			-0.1272	0.8805
Not far (r)			---	---
Ever visited FP clinic				
Yes	Na	Na	-1.2424	0.2887*
No (r)			---	---
Constant	-0.5850	-0.0888		
-2 log likelihood	-2416.32*	-2255.55*		
Model chi-square	0.641	148.807*		
Overall classification	58.68	65.63		
N	1,798	1,798		

r = reference category.

* Significant at $p < 0.0001$ ** Significant at $p < 0.02$.

Source: Field survey, 1998.

together. The zone seeks to represent the zonal distribution of health facilities, both private and public, which are unevenly distributed. Together, the background variables such as education, age, religion and zone are related to unmet need.

Generally, formal education of both men and women is expected to positively influence contraceptive use. This expectation is confirmed in the regression analysis, with men's education observed to be negatively related to unmet need, but is significant for only secondary and tertiary education. Relative to men with no education, those with primary education are 72% less likely, secondary and tertiary are 62% each less likely to have unmet need. Employing education as an indicator of poverty, it would be appropriate to conclude that the poor are more likely to have unmet need.

In a society like Nigeria with low contraceptive prevalence, the likelihood for unmet need to increase with age is expected. In this model, age is positively associated with unmet need and it is significant. An increase in age by one year leads to an increase in unmet need by a factor of 1.02. A similar relationship as obtains for age is expected for surviving children. It is observed that a unit increase in the number of children surviving leads to an increase in unmet need by a factor of 1.01.

No religious tenet hinders the use of contraception, except Catholicism, which restricts members to natural methods. On a regional basis as indicated earlier, contraceptive prevalence is lower in the north compared to the south, and this may be attributed to a lower educational status of both men and women in the north compared to the south. Polygyny is also more prevalent in the north compared to the south because of the dominant religion of Islam and Christianity that obtain, respectively. The expectation therefore is that more Christians compared to Muslims would use contraception. The model confirms this expectation, as Christians are 62% less likely and adherents of traditional and other religions are 59% less likely to have unmet need relative to Muslims. The relationship is significant for Christians.

Men who had no birth in the household within the last 12 months are more likely to have unmet need relative to those who report a birth, although the relationship is not significant. This is expected because such women may be covered by the effect of breastfeeding and may not have resumed sexual relations. By health zone, while the southeast (1.7 times) and southwest (1.5 times) are relatively more likely to have unmet need compared to the northeast, the northwest is 82% less likely to have unmet

need compared to the northeast. The observed difference is significant for the southeast only.

The introduction of the two variables related to family planning service in the second model creates some variations in the results obtained in the first model, which employs only background variables. The significant relationship for the tertiary education category, which was observed earlier, ceased to be, although that of secondary education remained statistically significant. Christianity, which was significant in the first model, remained so, but at a lower level of significance. Respondents who described the distance of their place of residence from the family planning service point as very far from a family planning clinic are 1.21 times more likely to have unmet need as compared with those who described it as not far. Those who described this distance as just far are 88% less likely to have unmet need relative to those not living far away. Visitation to a family planning clinic is also statistically significant. Those who have visited a family planning clinic are 29% less likely to have unmet need as compared with those who have never visited.

4. Discussion of findings and recommendations

Despite the high value attached to children in all the cultures in Nigeria, it is becoming more apparent by the proportion indicating a desire to limit childbearing and the responses to the ideal number of children from various surveys that couples desire to control their fertility. The increasing desire to limit childbearing is strongly associated with economic factors brought about by the long-drawn economic depression with which the country is contending. Despite this fact, however, contraceptive uptake remains very low, notwithstanding the high awareness of contraception that prevails. The non-use of contraception is related to the apprehension of the perceived or associated side effects of both temporary and permanent methods. The existence of a large unmet need for childbearing as shown in this study is therefore not surprising.

The computed unmet need for men, given the limitation of the data, cannot be directly compared with the estimated level for women using the Demographic and Health Survey data. Despite this fact, the estimated unmet need for contraception for men in this study supports the claim that a substantial unmet need obtains in Nigeria. It is also evident that the awareness of methods of contraception is not a sufficient indicator of the

understanding of how the methods work. It is apparent that high levels of unmet need, particularly for limiting childbearing, obtain both among the poor and the rich, using education as an indicator. The level is, however, higher among the very poor compared to the other socioeconomic strata. The data on methods reported for ever-use of contraception indicate that traditional methods are prevalent among those currently using contraception. The risk of failure attached to such methods connotes that even those identified as not having unmet need require more efficient methods.

The direct cost of obtaining contraception in Nigeria is not a major hindering factor, as is observed from the reasons proffered for current non-use of contraception. Other indirect costs such as transportation, waiting time and quality of service, perceived risk of pregnancy and attitude of health providers, may constitute a hindrance, although these are not explored in this study. Fear of the side effects of contraceptive methods and religion are cited as reasons hindering contraceptive uptake. Religion appears now and again as a reason for not using contraception, although none of the major religions is against its use – only the Catholic Church, which prohibits its adherents from the use of methods other than the Billings method or periodic abstinence. Interpretations in religious texts such as the Bible and the Koran are used to support high fertility. While a direct quotation may be cited to support high fertility in the Bible, reference to the possibility of men marrying four wives is often used to support high fertility for adherents of Islam, based on the reasoning that husbands with many wives cannot restrict any wife to a number lower than the highest number of children that obtain for any wife. It is only through informal educational strategies employing religious leaders that this notion can be corrected.

Despite the fact that this group of men has had the desired number of children, the health risk in using effective contraception seems to outweigh the risk of unplanned pregnancy. This is similar to the observation Otoide and associates (2001) made among adolescents who consider the immediate threat of abortion to fertility to be lower than the use of modern contraception, and the risk of side effects also accounts for not using effective contraception among the group. According to Stash (1999) individual's and couple's use of contraceptives is strategically planned by them in order to reduce the chances of experiencing negative social, economic or health outcomes. Although both the poor and rich make this assessment, poverty could heighten the perceived risk of contraceptive use because of the low expectation of any form of assistance from any

source when confronted with difficulties. Such difficulties relate to the indirect cost associated with illness and loss of work, which can be considerable. The fact that the future must be protected from unforeseen accidents of infant mortality may also account for the low recourse to permanent methods such as sterilization by both males and females in Nigeria. This method is likely to have little or no side effects and would be suited for those wishing to limit childbearing.

The high unmet need for limiting childbearing connotes that the four children per woman policy of the government may be difficult to achieve, given the possibility of unplanned pregnancy that exists among individuals who desire to limit childbearing but do not employ effective contraception. The option available to such couples in the case of unplanned pregnancy is either carrying the pregnancy to term or resorting to abortion, which is presently illegal in the country, although available clandestinely (Makinwa-Adebusoye *et al.*, 1997). Both options available to these women have negative implications for the maternal mortality level, which is high at present.

Another conclusion that can be reached in this study is that proximity to a family planning clinic is a major factor affecting unmet need. At present, the approach of waiting for the clients to come to the family planning service points may not effectively reach the needs of the poor, who feel inferior due to several years of lack of appropriate clothing to wear to the clinic or the perceived imagination of how the very neat health workers would ill-treat them. For the very poor, therefore, other strategies may have to be developed.

Formal education is yet another important factor that is observed to lower the existence of unmet need. By deduction, it is implied that informal education in family planning with more in-depth focus than obtains presently should bring about an improvement in the uptake of contraception for the general population, and specifically for those with unmet need for limiting childbearing. These educational programmes should focus on the issue of side effects that is observed to account for a large proportion of the reasons for unmet need.

The definition of unmet need employed in this paper is simple but in no way detracts from its significance. Further research allowing of a more sophisticated definition to ensure the comparability of estimates of unmet need for contraception for men and other groups so as to better understand and articulate programmes is in order. This will contribute in no

small measure to ensuring improved reproductive health for all and participation in development activities.

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