UNFPA UNITED NATIONS POPULATION FUND

NIGERIA

FAMILY PLANNING ANALYSIS:
Selected Demographic AND SOCIO-ECONOMIC Variables

2010

Further Contact: UNFPA Nigeria Country Office:
4th Floor, UN House, Plot 617/618 Diplomatic Drive Abuja,
Tel: +234 9 4616574; emails: lawson@unfpa.org, adonri@unfpa.org ogbonna@unfpa.org

Introduction

The Demographic and Health Surveys contain a wealth of information about family planning, maternal health, infant health, as well as, demographics. While, the survey results are usually summarized in a publication, DHS raw data are also obtainable for use in further analysis. The aim is to examine relationships between demographics and other output variables that were not originally analyzed in the published report, thereby developing new insights. Specifically, the further analysis of Nigeria DHS raw data on FP studies the relationship between Contraceptive prevalence rate and demographic and socio-economic variables, as well as, costs, while providing additional information to guide future programming for increased access and utilization of family planning information and services.

Demographic variables

In Nigeria, the 2008 NDHS found that only 10% of married women of reproductive age use contraceptives. This is lower than the current Sub-Saharan Africa average of 17%. Further analysis of the Total Contraceptive Prevalence rate (CPR) indicates wide state variations, ranging from 0.3 in Jigawa to 41.6 in Lagos state, as well as zonal variations ranging from 2.7 in the North West to 28.5 in the South West; as illustrated in Figs 1 and 2.

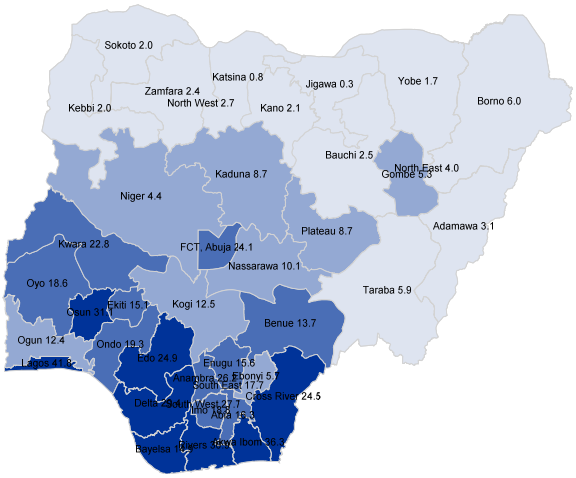


Fig 1: Wide state variations in total CPR

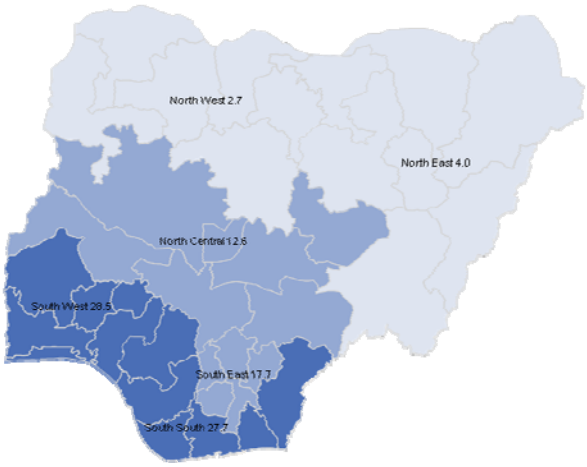
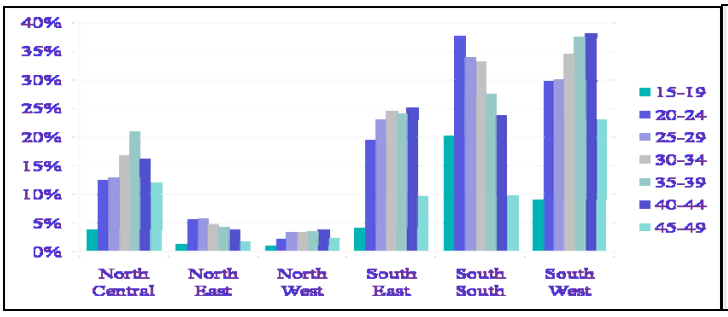


Fig 2: Wide zonal variations in total CPR

In-depth review of the relationship between CPR and age groups within the reproductive years revealed different correlations. On a national scale, CPR was low among teenagers and became fairly constant for the ages within the 20 – 39 range. However, further disaggregation by zone (Fig 3) revealed that apart from the south –south and (to some extent) the North East geopolitical zones, where the highest CPR was recorded in the 20-24 age group, in all the other geopolitical zones the highest CPR was recorded in the 30 -44 age cohort.



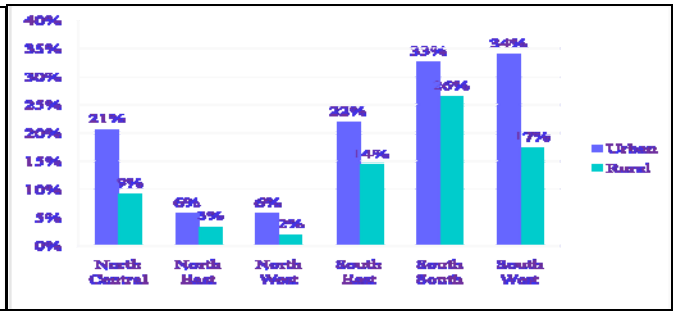


Fig 3: Relationship between CP &, age-groups by geopolitical zones. Fig 4: Rural/Urban differences in CPR by zone.

A closer look at rural/urban dimensions and age groups at the national level showed the largest urban/rural differences in CPR for the 25-39 age range. A review of urban/rural locations on CPR also illustrated differences by zone, with the most pronounced in South West Zone with 34% in urban and 17% in the rural area. Others zonal variations are as depicted in Fig 4 above. State-wide analysis also reveals large variations for urban and rural locations as depicted in Figs 5 (a) and (b)

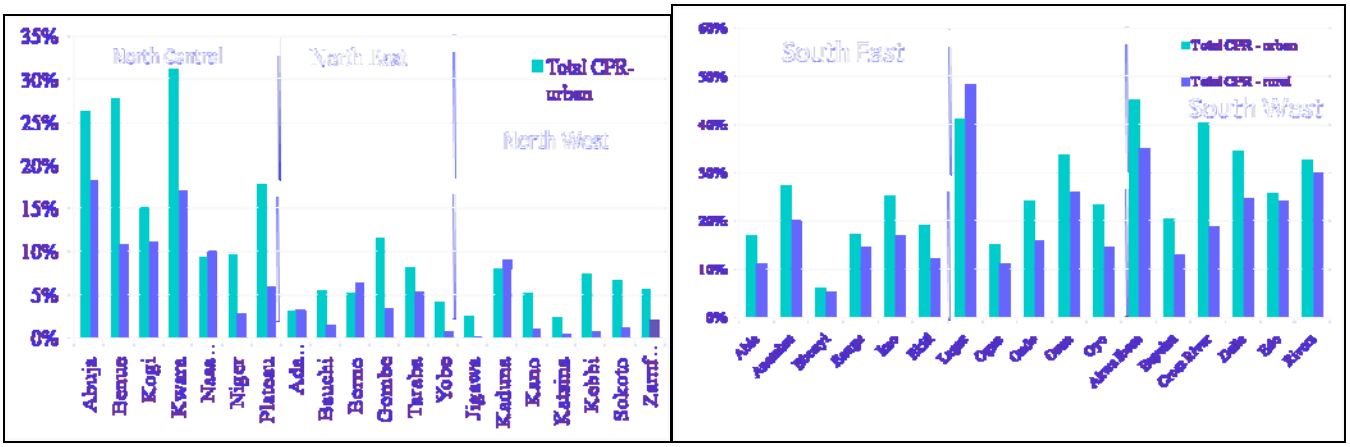


Fig 5a: Urban/Rural variations by States (NC, NE and NW) Fig 5b: Urban/Rural variations by States (S, SW and SS)

Notably, the urban/rural variations for each of the states are pointers for future programming. CPR by marital status in urban and rural locations mirrored similar differences, with married urban women being much more likely to use contraceptives than their rural counterparts as illustrated below. Also the difference between rural women living together with a partner to rural married women is much greater than their urban counterparts, which possibly reflects the different goals of using FP products by location and marital status.

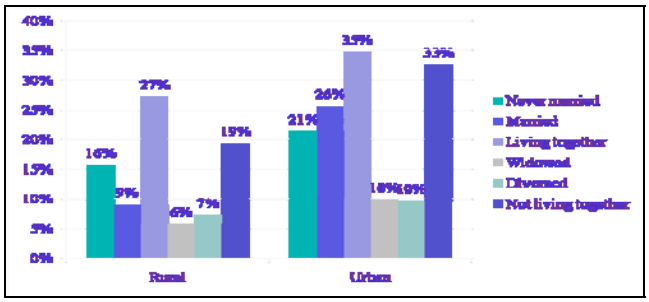


Fig 6: CPR by marital status and urban/rural places of residence.

Summarizing the findings on the relationship between demographics and CPR, disparities among and within zones, age groups and rural/urban locations were found to be pronounced as illustrated by the interplay between CPR and demographic variables. There is therefore the need for specific and focused family planning information and services by zone, state, age groups, urban/rural places of residence and by marital status in Nigeria. This is necessary if Nigeria is to reach target 5B of the MDGs – universal access to sexual reproductive services.

Socio-economic variables

When examining the impact of education and wealth on CPR, one must note the correlation between these two variables, with over 70% of women with higher education qualifications noted to be in the highest wealth quintile.

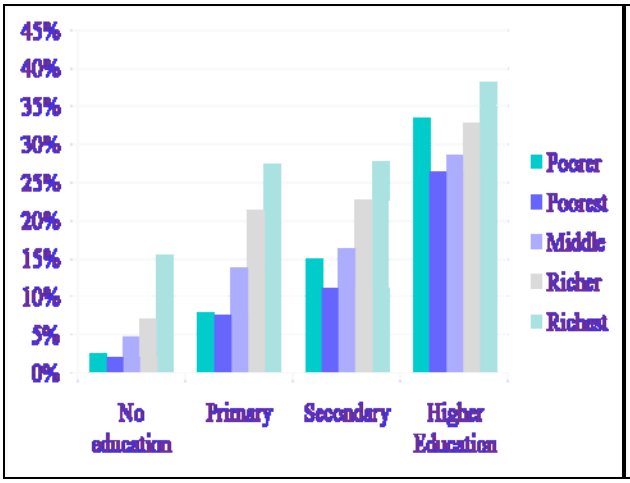


Fig 7: CPR, education and wealth

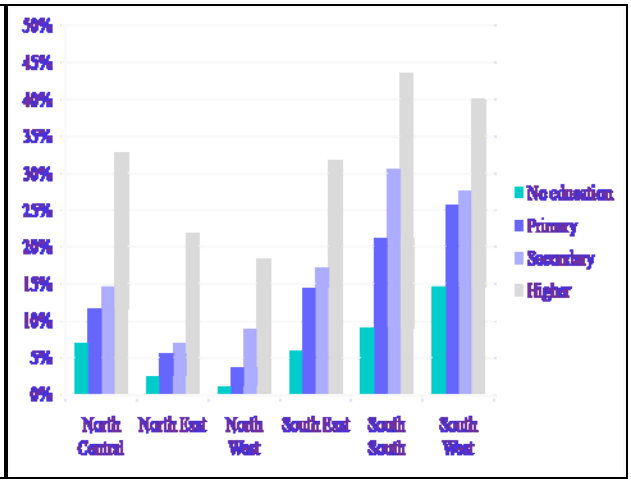


Fig 8: CPR by zone and level of education

Viewed separately, CPR increases with education and literacy levels as expected. Fig 8 below illustrates the zonal variations of education levels and CPR. Fig 9 in turn reflects the relationship between literacy levels and CPR on a national scale.

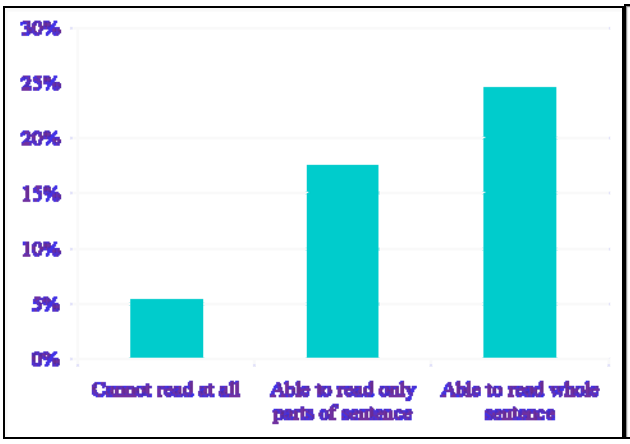


Fig 9: CPR by literacy level

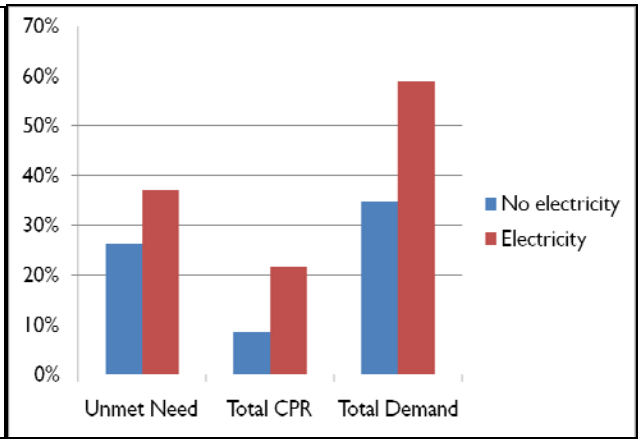


Fig 10: CPR and electricity

CPR as a function of wealth mirrored the relationship seen with levels of education. Availability of electricity was matched with higher CPR, as well as, higher unmet need which is evidence of higher demand for contraceptives. Similar trends for CPR and electricity are found to be true when disaggregated by zone, with the largest differences noted in the South South and the least noted in the North West.

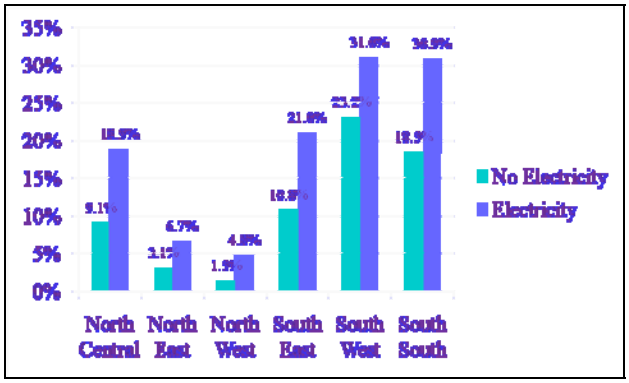
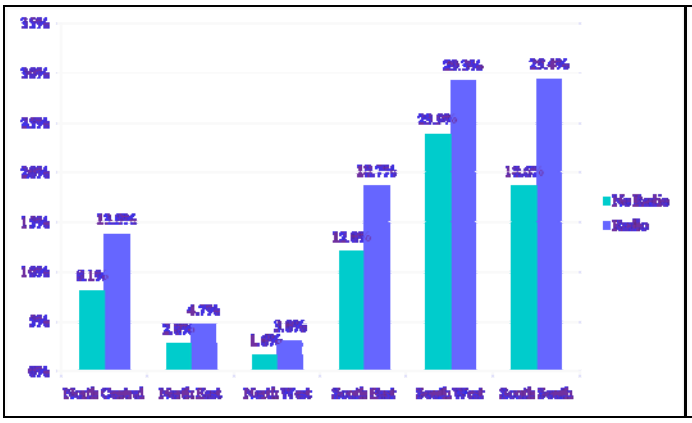
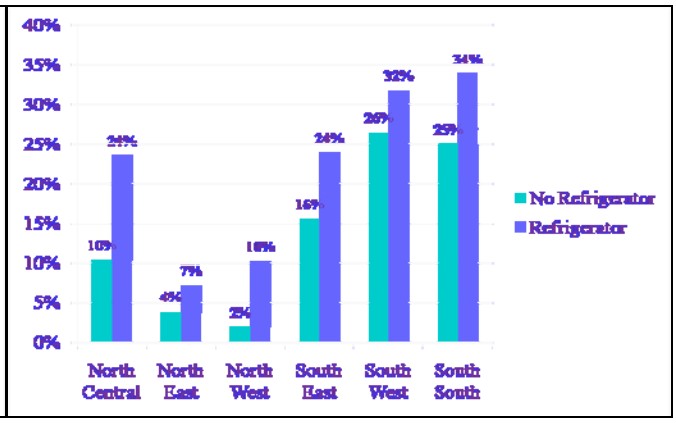


Fig 11: CPR by zone and as a function of electricity

The relationship between CPR and ownership of radio and refrigerators as wealth indicators generally mirrored the established trend that CPR increases with wealth.





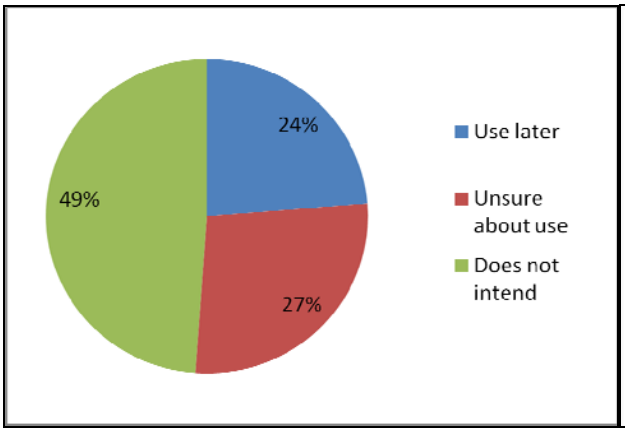
Figs 12a: CPR by Zone and radio ownership

Fig 12b: CPR by zone and Refrigerator ownership

Summarizing the effect of socio-economic variables on CPR, it was found that women who are poor and have little education are observed to have lower CPR, which reflects poor access to services as a result of socio-economic status.

Intentions for future use

About half the number of women (49%) who are currently not using contraceptives in Nigeria, do not intend to use in the future with 27% unsure of future use.



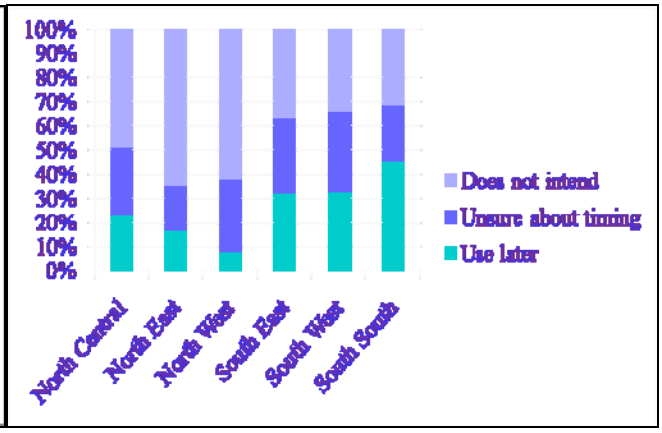
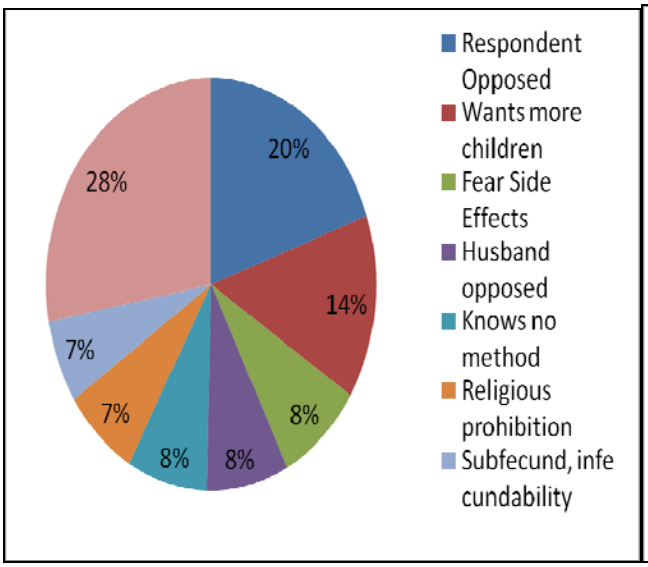


Fig 13: Future use of FP services

Fig 14: Zonal disaggregation of future use

Disaggregation by zone revealed that women in the South South represent the most likely group to use contraceptives in the future. As shown in Fig 15, major reasons for not using contraceptives included lack of knowledge, wanting more children, fear of side effects, husband's disapproval, with 28% indicating other reasons not mentioned.



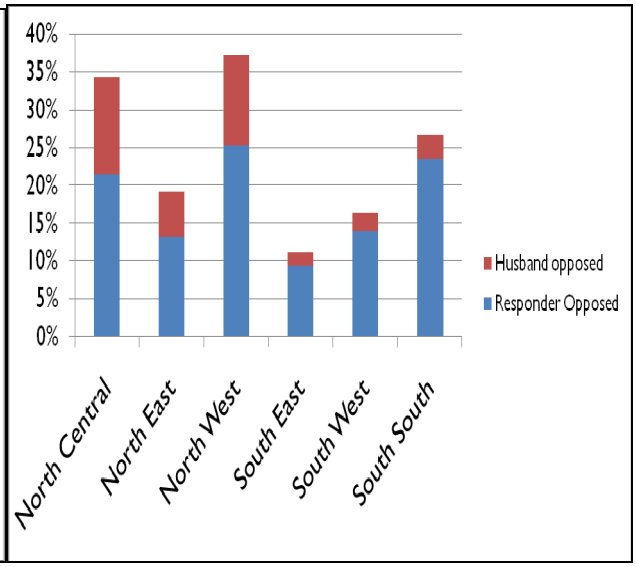


Fig 15: reasons for not using FP services ***Fig 16: Husbands Opposition to FP by zone***

Amongst these reasons, we highlight the role of male involvement in the use of FP services, as further analysis of husbands' opposition revealed zonal differences with Husband's opposition more commonly expressed in the North than in the South as shown in Fig 16 below. Equally, the analysis yielded information that could serve as a guide for awareness and sensitization activities.

Factors influencing Programming for FP services

The UNFPA/Guttmacher Institute Publication on ***Investing in Family Planning, Maternal and Newborn Health*** uses analysis of recent DHS data from Sub-Saharan Africa, Nigeria inclusive. The publication underscores the need for significant investments to strengthen the health systems in order to meet the need for modern family planning, maternal and newborn health services.

a) Cost of Services

Analysis of the DHS data on the cost of services using the market price revealed mean costs in Naira for various FP commodities ranging from N143 for condoms, N320 for the pill, N899 for injectables and N970 for IUDs. It is also important to highlight that while seeking insight for the reasons affecting future use of FP services, less than 1% of respondents indicated costs as a reason for not using FP services. On-going efforts in the country are seeking to further understand the interplay between cost and use of FP services through the conduct of Ability-To-pay and Willingness-To-Pay studies.

b) Value for Money

The UNFPA/Guttmacher Institute Publication using SSA data underscores the need for including family planning services as part of an integrated package. This has been effected within the Minimum Package of health care services as reflected in the National Strategic Health Development Plan, as well as the Federal and State strategic plans. The integration of FP services has been found to be more cost effective than using stand-alone approaches. Within an integrated package, the analysis for the SSA indicates that providing modern contraceptives to all women of reproductive age more than pays for itself, saving $1.30 in the cost of MNH services for every dollar invested. Equally, it has been found that the average cost to save a health year of life or DALY through the use of family planning services is $149. This is found to compare favourably with other high impact and cost effective interventions to prevent HIV/AIDS and tuberculosis to mention a few.

c) Direct Health Benefits

The SSA analysis also shows direct benefits inclusive of a drop of unintended pregnancies by 77%, from 17 million to four million annually in the SSA with a decline of unsafe abortions from 5.2 million to 1.2 million. The number of women requiring medical care for complications of unsafe abortions would also reduce from 2.2 million to 500,000. The multiple country analysis also shows that about 750,000 lives would be saved annually, indicating a 69% decline in MMR and a 45% decline in newborn deaths. These would culminate in a decline by two-thirds in the number of health years of life lost due to disability and premature deaths among women and their newborns. This would mean a decline from 61 million to 22 million Disability-Adjusted Life Years (DALYs) lost.

d) Behavioural Change Communication

To inform programming, further analysis of Nigeria's DHS data on family planning services provides pointers that if applied effectively, would greatly improve access and utilization of services. For instance, CPR rate did not vary much as a function of births in last 5 years, while CPR rates increased as the age of first intercourse increased. A Relative ratio defining the ratio of CPR with contact and CPR without contact, where contact depicts the source through which FP information was obtained, is provided for in the further analysis of Nigeria's DHS data. The contact with FP was from four main sources – radio, newspaper, television and visit by a health worker.

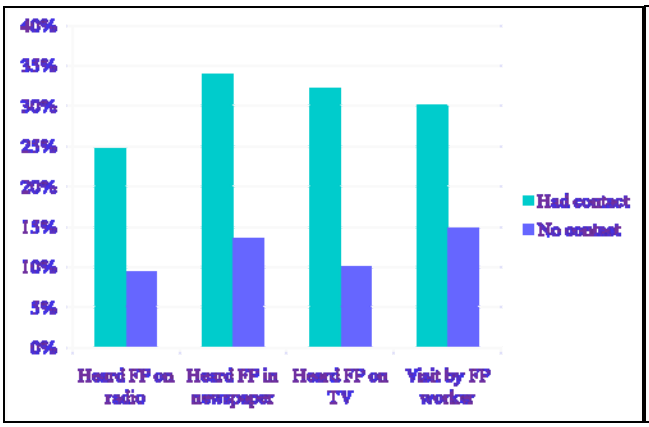


Fig 17: Relative ratios of CPR with contact sources

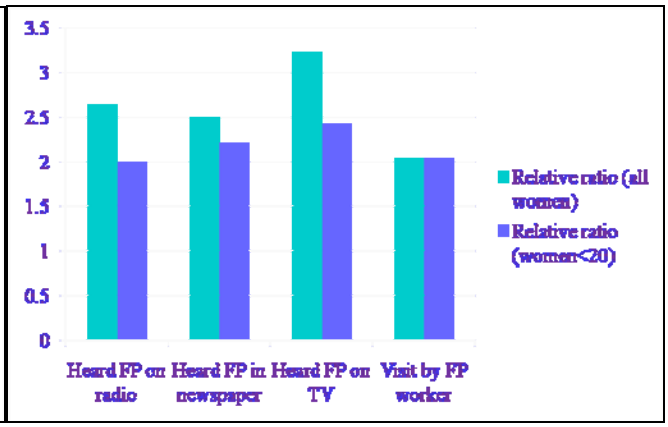
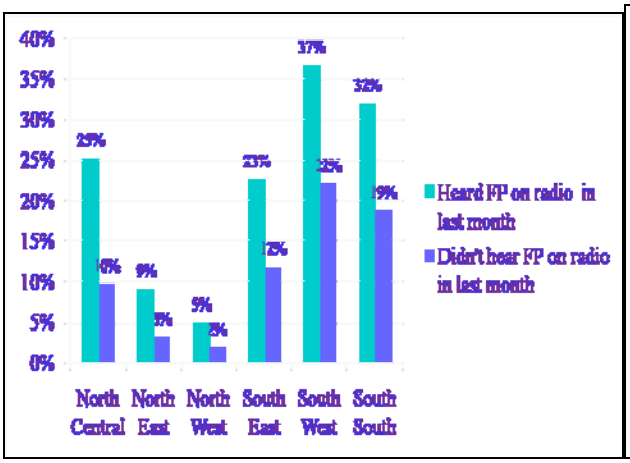


Fig 18: Relative ratios of CPR and contact sources by age.

The relative ratio was noticeably lower for young women contacted through the media, which suggests that these are less effective ways of reaching the youth. Further disaggregation by zone as illustrated in Fig 19 reveals that the relative ratio for radio as a source of FP information was highest in the North and lowest in the South. This confirms findings of previous studies on use of radio in the North as a key source of information for programming.



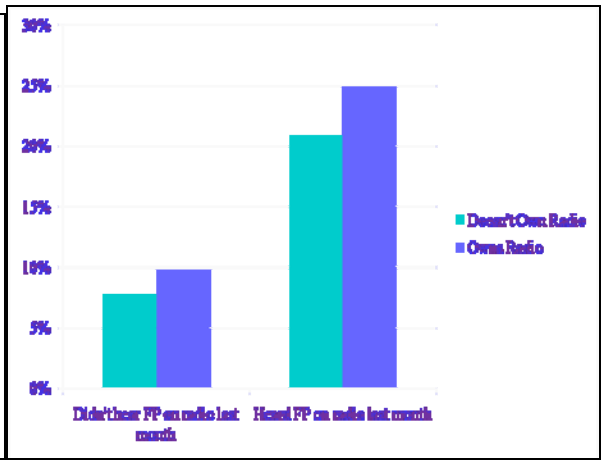


Fig 19: Relative ratios of CPR by Zone ***Fig 20: Relative ratio of CPR, radio contact and ownership***

Interesting insight was provided when radio as a source of contact was analyzed by ownership of radio, which revealed that the higher CPR for those hearing FP information on the radio was not significant of whether they owned a radio, rather underscored the contact through radio irrespective of ownership. This is shown in Fig 20. Regardless of the frequency of reading newspaper, the relative ratio of hearing about FP in a newspaper was similar, indicating the lack of adequate FP information disseminated through the print media. On the other hand, Fig 21 shows that for all zones, those who heard FP on TV had higher CPR with highest relative ratio in the North.

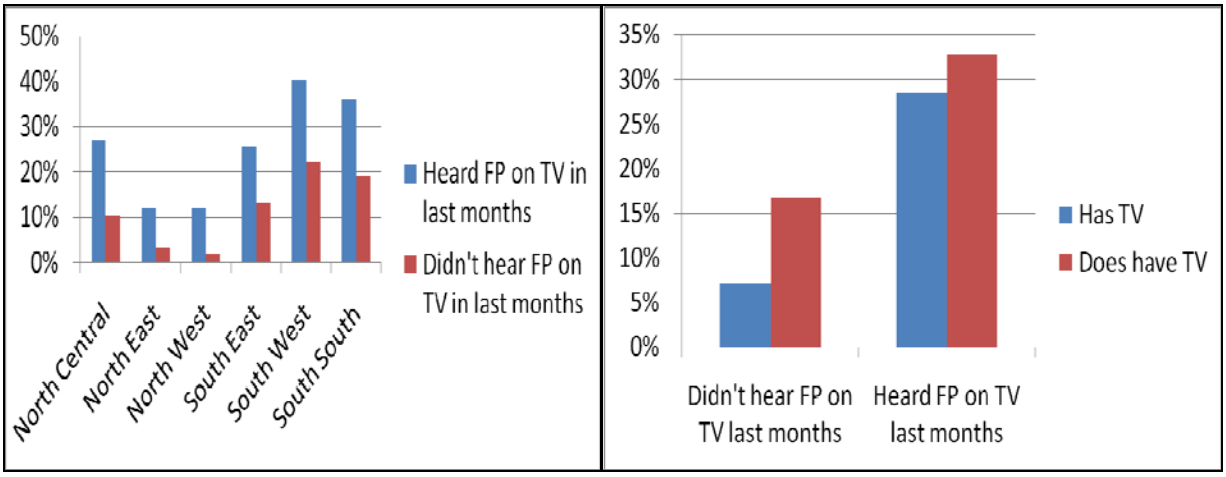


Fig 21: FP contact through television messages ***Fig 22: FP contact through Television and ownership***

Regardless of whether the respondents owned a TV or not, hearing FP messages on the TV was strongly correlated with CPR as shown in Fig 22. On the last source of FP contact, CPR was noted to be significantly higher for women with a visit by a health worker in last 12 months with higher relative ratios in the North. This underscores the need for provision of FP information by health workers through each of the service delivery modes adopted for the Minimum package – family/community; outreach/population oriented and facility-based.

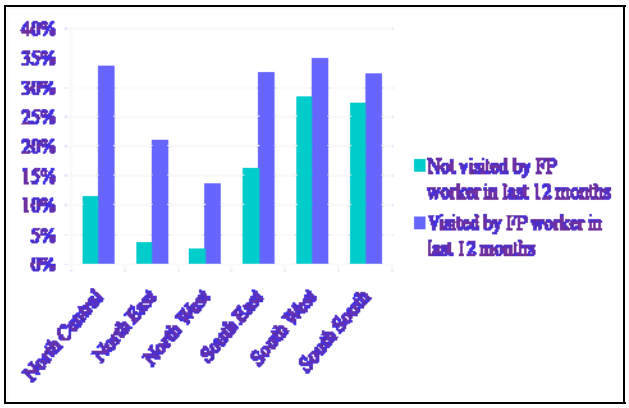


Fig 23: Zonal disaggregation of FP contact by health workers.

Interpretation of these information would support development and dissemination of BCC materials in the country.

Conclusion

Acknowledging that family planning, maternal and newborn health care have substantial and measurable impact on the health of women and their families and by extension the nation, efforts to better understand the interplay of variables

have provided insights that would improve access and utilization of FP/MNH services. Further analysis of FP raw data from the 2008 NDHS has specifically provided additional knowledge and information on the disparities that exist among and within zones, age groups and rural/urban locations as illustrated by the interplay between CPR and demographic variables. Equally, women who are poor and have little education are observed to have lower CPR, indicating the effect of socio-economic variables on FP. A possible inference from the data also point to the fact that for programming in Nigeria, current efforts should target the unmet need and demand in the South, while pursuing advocacy efforts targeted at current potential and non-users in the North.

There is evidence to support that the role of male involvement in the use of FP services, using the data emanating from further analysis of husbands' opposition to use of FP services. Further evidence using triangulation of data from other sources would provide further insight to this important variable. Equally, reasons for not using contraceptives and sources of FP information provide areas of focus for Behavioural Change Communication, particularly as most of the data have been disaggregated by geopolitical zone. Policy and programme implementation aimed at improving access and utilization of sexual reproductive health services, should therefore ensure specific focus by zone, state, age groups, urban/rural places of residence, marital status, level of education and literacy, wealth. A "one size fit all" approach for FP programming should be discouraged.

The information reported in this fact sheet is from further analysis of Nigeria's 2008 DHS raw data, as well as extracts from the special tabulations from the Adding it Up Publication on "The costs and benefits of Investing in family Planning and Maternal Newborn health"

For further contacts:

UNFPA Headquarters: 220 East 42nd Street, New York, NY 10017 USA, Tel: +1 212 297 5000; email: hq@unfpa.org and friedman@unfpa.org; contact name: Howard Friedman.

UNFPA Nigeria Country Office: 4th Floor, UN House, Plot 617/618 Diplomatic Drive Abuja, Tel: +234 9 4616574; email: lawson@unfpa.org, ogbonna@unfpa.org and adonri@unfpa.org

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