

Original Research Article

Predictors of Unmet Need for Contraception among Urban and Rural Women in Anambra State, Nigeria: A Mixed Method Survey.

ABSTRACT

Aims: To compare the levels of unmet need for contraception and the various factors that influence these levels between rural and urban populations of currently married women of reproductive age in Anambra State, Nigeria.

Study design: Mixed method survey

Place and Duration of Study: Anambra State in South-Eastern Nigeria. The study was carried out from March 2017 to July 2017.

Methodology: Multistage sampling technique was used to select 208 urban and 210 rural married women of reproductive age and quantitative data obtained using pre-tested, interviewer administered questionnaires. Qualitative data was obtained from focus group discussions (FGD) among current non-users of contraception and key informant interviews (KII) among Primary Health Care staff in selected Local Government Areas. Binary logistic regression was done for quantitative data analysis using SPSS software and content analysis of qualitative data was done using the Atlas.ti software. Quotes from the participants that best described some of the themes were also stated.

Results: Response rate was 96.8%. There was a significantly high level of awareness of at least 3 modern methods of contraception among urban (97%) and rural women (87%) ($P < 0.001$). The overall contraceptive prevalence in the State was 44.5% (29.7% for modern methods and 14.8% for traditional methods) and the overall level of unmet need for contraception was very high (26.3%), but much higher was the unmet need for modern contraception (41%). The independent predictors of unmet need for contraception among urban women were health insurance and cost of contraceptives; while that among rural women was perceived risk of pregnancy. The commonest reasons for contraceptive non-use were side effects-related for urban women and opposition to use for rural women.

Conclusion: The level of unmet need for contraception remains very high and its predictors vary between urban and rural women in Anambra State, Nigeria.

Keywords: Contraception, family planning, Unmet need, Determinants, Rural, Urban.

1. INTRODUCTION

Overall, Nigerian women have about one child more than the number they want. This implies that the total fertility rate of 5.5 is 15% higher than it would be if all unwanted births were avoided. [1] The term “unmet need” was coined in the late 1970s, to describe the seemingly discrepant behaviour of women who want to avoid pregnancy but are not using any contraceptive method. [2] It estimates the proportion of women not using contraceptive methods, who either want to cease further childbearing (unmet need for limiting) or who want to postpone the next birth by at least 2 years (unmet need for spacing). The total unmet need is a sum of the unmet need for spacing and unmet need for limiting. [1,2]

At the 2012 London Summit on Family Planning, Nigeria committed to achieving the goal of a contraceptive prevalence rate (CPR) of 36% by 2018. [3] Following the commitment, the Federal Ministry of Health developed a 5-year costed scale-up plan, intended to guide programming, resource allocation and commitments to achieve the national goal. [4] However, despite the good policy environment, less than 45% of the target for unmet need for contraception was met by the end of the 2015 target year for the Millennium Development Goals (weak progress according to Nigeria MDG report 2015), [5]

According to World Health Statistics 2017, while nine out of 10 women in the WHO Western Pacific Region had their family planning need satisfied, only half of women in the WHO African Region did. [6] Nigeria Demographic and Health Survey (NDHS) 2013, reported that the total unmet need for contraception in Nigeria was 16% (12% for spacing and 4% for limiting) and CPR for all methods was 15% (10% for modern methods and 5% for traditional methods); being much higher in urban areas (26.8%) than rural areas (8.5%). [1] Only about one third of the potential demand for contraception was being met; thus if all married women who said they wanted to space or limit their children were to have used contraceptives, CPR would have increased to 31%.

The Population Reference Bureau reports that Nigeria is currently the 7th most populous country in the world with an estimated population of 182 million persons and it is projected that by the year 2050, Nigeria will be the 4th most populous country in the world, with an estimated population of 397 million persons. [7] This has grave social, economic and health implications for the already limited resources of the country. Also, the slow uptake of contraceptive methods has contributed to the high levels of unintended pregnancies, unsafe abortions and maternal deaths. About a quarter of Nigeria's 9.2 million pregnancies in 2012, were unintended; and in spite of Nigeria's restrictive abortion laws, an estimated 1.25 million induced abortions occurred in 2012, with 31 abortions per 1000 women of reproductive age occurring in the South-Eastern part of the country. [8] Finally, according to World Health Statistics 2017, worldwide approximately 830 women died every single day due to complications during pregnancy or childbirth in 2015; with 814 maternal deaths per 100,000 live births occurring in Nigeria [6] (an increase of more than 40% from the NDHS 2013 report of 576/100,000 live births).

Thus, there remains an unfinished agenda to ensure that all people have access to comprehensive Sexual and Reproductive Health (SRH) services in the post-2015 period [9]; and this is indicated in the outcome document of the United Nations Summit for the Adoption of the Post-2015 Development Agenda, by Goal 3 (targets 3.1 and 3.7) of the Sustainable Development Goals (SDG). [10] Unmet need for contraception can be influenced unequally among different settings mainly due to the effect of socioeconomic and demographic variables; thus its predictors are area-specific. [11] Therefore, this study was done for a comparative assessment of the level of unmet need for contraception and the pattern of its determinants among currently married women of reproductive age in the rural and urban areas of Anambra State, Nigeria. It is expected to form an evidence base for establishing informed policy priorities and efficient and equitable resource allocation.

2. METHODOLOGY

2.1 Study Area:

Anambra State is in the South-Eastern part of Nigeria. According to the last census, the state has a total population of 4,177,828 persons, comprising 2,117,984 males and

2,059,844 females, with a land size of 4,816.21km². [12] In 2011, the state registered 110,282 live births, which represents a 28% increase in the 2009 value of 79,550 live births and a 46% increase in the 2010 value of 59,419 live births. [13] Currently, the State is the second most densely populated State in Nigeria, with a population density of 867.5 persons per km², a Total Fertility Rate of 4.2 per woman and an annual population growth rate of 2.2% per annum. [14] There are 21 Local Government Areas (LGAs) in the state, Christianity is the predominant religion and the predominant occupations are civil service and trade.

2.2 Study Design:

The study was a mixed method survey, community-based.

2.3 Study Population:

The study population comprised currently married women of reproductive age (15-49 years) who had resided in the LGA of interest for at least one year prior to the survey and who consented to participate in the study. Excluded from the study were women who were homeless, living in institutional homes or were too sick to participate in the survey.

2.4 Sample Size Calculation:

The minimum sample size to determine a difference in the level of unmet need between women dwelling in rural and urban areas of the state that was significant at 5% confidence level with a power of 90% was calculated using the formula for comparison of two proportions. [15] The level of unmet need used for the calculation was 32.7% for rural women and 18.4% for urban women [11]; with a non-response rate of 10%. Therefore a minimum sample of 432 respondents was used (216 from the rural LGAs and 216 from the urban LGAs).

2.5 Sampling Technique:

2.5.1 Quantitative Sampling Technique:

Multi-stage sampling technique was used for the sampling. In stage 1, stratified sampling with proportional allocation was used for the selection of LGAs to be studied. From information obtained from the National Population Commission, Awka, Anambra State, the state was stratified into 7 urban and 14 rural LGAs (giving a ratio of 1:2); therefore 2 urban and 4 rural LGAs were selected by simple random sampling (employing simple balloting) from the strata. Thus, Onitsha North and Nnewi North LGAs were selected in the urban stratum while Dunukofia, Anaocha, Aguata and Oyi LGAs were selected in the rural stratum.

The LGAs in the state are sub-divided into political wards; thus, in stage 2, simple random sampling (by simple balloting) was used to select 2 political wards from each of the selected rural and urban LGAs. The number of women studied in each ward was proportionally allocated, depending on the proportion of women of reproductive age in the ward (as obtained from the LGA 2017 projected population for each ward).

In each of the selected wards, a bottle was spun at the centre of the cluster of houses and it was allowed to make at least 3 revolutions before stopping. The first house in the direction the bottle neck was facing when it stopped spinning served as the starting point and households in the ward were selected consecutively till the sample size for the ward was

achieved. One eligible woman was interviewed in each household. If there were two or more eligible women in a household, one of the women was selected by simple random sampling employing simple balloting. The interviews were conducted by trained research assistants after a written informed consent was signed by each participant.

2.5.2 Qualitative Sampling Technique:

Four Focus Group Discussion sessions were conducted among current non-users of contraceptives identified and recruited during the quantitative study. Participants were recruited purposively into the FGD sessions based on availability and willingness to participate in the sessions and were stratified based on location and age. Six key informant interviews were conducted among Primary Health Care staff in each of the selected rural and urban LGAs. The participants were, purposively selected based on availability and willingness to participate. The processes were clearly explained to participants, they were assured of confidentiality and their right to opt out at any point clearly stated. A written informed consent was obtained from each participant prior to the onset of the discussions/interviews.

2.6 Study Variables:

The conceptual framework for this study was adapted from the revised behavioural model of health services use developed by Ronald Andersen in 1995. [16] The evaluated health status was the unmet need status (Yes or No) which was the dependent variable. The standard definition of unmet need for contraception as revised by Bradley et al [2], was applied in this study and women who were married or in union were assumed to be sexually active. [2] The independent variables were the Predisposing factors, Enabling factors, Need factors and Health system factors.

Women's decision-making autonomy was measured using five decision-making domains, from which a composite variable was developed as described by Kisaakye. [17] It was inferred that if a woman has autonomy in these decisions, then she has autonomy in the child-bearing sphere as well.

2.7 Data Management:

Collected data were entered into SPSS version 20. Variables that were statistically significant at the bivariate level (using Chi square test) were subjected to multivariate analysis using binary logistic regression. Level of statistical significance was set at $P \leq .05$. Coding and content analysis of the FGD and KII transcripts were done using the Atlas.ti software version 8. The code-primary document cross-tabulation analysis was used [18] and quotes from the participants that best described some of the themes were stated verbatim.

3. RESULTS:

A total of 432 questionnaires were administered out of which 418 questionnaires were retrieved, (response rate of 96.8%). There were 208 urban and 210 rural respondents in the study.

3.1 Socio-demographic Characteristics:

Table 1 shows that the mean age of the respondents was 34.7 ± 7.5 and the rural women were significantly younger than the urban women ($t = 5.944$, $P < 0.001$).

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Table 1: Socio-demographic characteristics of respondents by location

Variable	Urban (n=208) n (%)	Rural (210) n (%)	Total (418) n (%)	χ^2 (P-value)
Age Category				
15 – 24	4 (1.9)	33 (15.7)	37 (8.9)	41.497 (0.000)*
25 – 34	65 (31.2)	93 (44.3)	158 (37.8)	
35 – 44	110 (52.9)	64 (30.5)	174 (41.6)	
45 – 49	29 (13.9)	20 (9.5)	49 (11.7)	
Total	208 (100.0)	210 (100.0)	418 (100.0)	
Mean age $\pm$ SD	36.8 $\pm$ 6.5	32.7 $\pm$ 7.9	34.7 $\pm$ 7.5	
Religion				
Roman catholic	104 (50.0)	130 (61.9)	234 (56.0)	12.276 (0.015)*
Protestant	67 (32.2)	39 (18.6)	106 (25.4)	
Pentecostal	34 (16.3)	34 (16.2)	68 (16.3)	
Islam	2 (1.0)	3 (1.4)	5 (1.2)	
Traditional religion	1 (0.5)	4 (1.9)	5 (1.2)	
Total	208 (100.0)	210 (100.0)	418 (100.0)	
Educational Status				
No formal education	2 (1.0)	0 (0.0)	2 (0.5)	69.312 (0.000)*
Primary	17 (8.2)	29 (13.8)	46 (11)	
Secondary	67 (32.2)	139 (66.2)	206 (49.3)	
Tertiary	122 (58.7)	42 (20.0)	164 (39.2)	
Total	208 (100.0)	210 (100.0)	418 (100.0)	
Occupation				
Civil servant/professional	97 (46.6)	30 (14.3)	127 (30.4)	64.443 (0.000)*
Farmer	0 (0.0)	14 (6.7)	14 (3.3)	
Self employed	49 (23.6)	73 (34.8)	122 (29.2)	
Artisan	6 (2.9)	2 (1.0)	8 (1.9)	
Unemployed	17 (8.2)	26 (12.4)	43 (10.3)	
Trader/business woman	39 (18.8)	65 (31.0)	104 (24.9)	
Total	208 (100.0)	210 (100.0)	418 (100.0)	
Number of living children				
0	11 (5.3)	15 (7.1)	26 (6.2)	4.820 (0.185)
1 – 2	46 (22.1)	53 (25.2)	99 (23.7)	
3 – 4	102 (49.0)	81 (38.6)	183 (43.8)	
5 and above	49 (23.6)	61 (29.0)	110 (26.3)	
Total	208 (100.0)	210 (100.0)	418 (100.0)	

* Statistically significant ($P \leq 0.05$)

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3.2 Contraceptive Awareness:

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Table 2 below shows that the level of awareness of at least 3 modern methods of contraception was significantly higher among urban women (97.1%) compared to rural women (87.1%) ($P < 0.001$).

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Table 2: Contraceptive awareness of respondents by location

Variable	Urban n (%)	Rural n (%)	Total n (%)	χ^2 (Pvalue)
Contraceptive Knowledge				
Knows no method	2 (1.0)	4 (1.9)	6 (1.4)	21.235 (0.000)*
Knows only traditional methods	2 (1.0)	0 (0.0)	2 (0.5)	
Knows 1-2 modern methods	2 (1.0)	23 (11.0)	25 (6.0)	
Knows $\geq$ 3 modern methods	202 (97.1)	183 (87.1)	385 (92.1)	
Total	208 (100.0)	210 (100.0)	418 (100.0)	

Methods known	(N = 206)	(N = 206)	(N = 412)
Pills	185 (89.8)	162 (78.6)	347 (84.2)
Lactational amenorrhea	152 (73.8)	110 (53.4)	262 (63.6)
Injectables	173 (84.0)	159 (77.2)	332 (80.6)
Emergency contraception	96 (46.6)	87 (42.2)	183 (44.4)
Male Condom	201 (97.6)	192 (93.2)	392 (95.4)
Female Condom	104 (50.5)	88 (42.7)	192 (46.6)
Implants	169 (82.0)	125 (60.7)	294 (71.4)
Intrauterine device	166 (80.6)	131 (63.6)	297 (72.1)
Male sterilization	60 (29.1)	26 (12.6)	86 (20.9)
Female sterilization	83 (40.3)	47 (22.8)	130 (31.6)
Rhythm	196 (95.1)	149 (72.3)	345 (83.7)
Withdrawal	190 (92.2)	154 (74.8)	344 (83.5)

195 ***Statistical significance ($P \leq 0.05$)**

196 The FGD also showed that participants were well aware of contraception, its methods and its
 197 benefits - which they opined to include child health benefits, economic benefits, maternal
 198 health benefits and improved sexual intimacy.

199 *"Family planning is good in that you do not have to be carrying a baby while backing*
 200 *another. It enables the children to grow to some extent before you have another baby. For*
 201 *example, if you want to have children every 2 years, family planning will help you"* [A 35 year
 202 old rural woman]

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 204 The concept of contraception was however shrouded in myths and misconceptions among
 205 both urban and rural FGD participants which included real and perceived side effects,
 206 infertility, maternal death, neonate born with device in hand and increased promiscuity.

207 *".....Some people say that in your next world you will not be able to have a child if you do*
 208 *family planning....."* [A 34 year old urban woman]

209 *".....It causes them to be promiscuous and lack self control in terms of meeting a man due to*
 210 *their belief that it will protect them; even if they have intercourse ten times with men, they will*
 211 *not get pregnant....."* [A 35 year old rural woman]

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 213 From the table above also, it is evident that natural methods are more commonly known than
 214 artificial methods; the least known methods among both groups of women being male and
 215 female sterilization. Worthy of note also is the finding that some heads of facilities do not
 216 create awareness for artificial methods of contraception in their health centres because of
 217 their personal values. This is as stated by an urban OIC who said;

218 *"Hope you know that there are some heads of facilities in health centres who said that it is*
 219 *against their faith, that they do not do artificial family planning, that it is only the natural ones*
 220 *that they will teach."*

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224 **3.3 Contraceptive Prevalence:**

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226 Table 3 below shows that majority of both urban and rural women do not use any form of
 227 contraception.

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Table 3: Current contraceptive use of respondents by location.

Variable	Urban n (%)	Rural n (%)	Total n (%)	χ^2 (P-value)
Contraceptive use	(N = 208)	(N = 210)	(N = 418)	
No method	110 (52.9)	122 (58.1)	232 (55.5)	2.224
Traditional method only	36 (17.3)	26 (12.4)	62 (14.8)	(0.329)
Modern method	62 (29.8)	62 (29.5)	124 (29.7)	
Total	208 (100.0)	210 (100.0)	418 (100.0)	
Methods in Use	(N = 98)	(N = 88)	(N = 186)	
Pills	8 (8.2)	8 (9.1)	16 (8.6)	
Lactational amenorrhea	3 (3.1)	15 (17)	18 (9.7)	
Injectables	7 (7.1)	8 (9.1)	15 (8.1)	
Emergency contraception	1 (1.0)	1 (1.1)	2 (1.1)	
Male condom	28 (28.6)	16 (18.2)	44 (24.7)	
Female condom	0 (0.0)	1 (1.1)	1 (0.5)	
Implants	13 (13.3)	13 (14.8)	26 (14)	
Intrauterine device	6 (6.1)	4 (4.5)	10 (5.4)	
Male sterilization	0 (0.0)	0 (0.0)	0 (0.0)	
Female sterilization	1 (1.0)	1 (1.0)	1 (0.5)	
Rhythm	31 (31.6)	21 (23.9)	52 (28)	
Withdrawal	35 (35.7)	19 (21.6)	54 (29)	

*Statistical significance ($P \leq 0.05$)

The CPR among urban women was found to be 47.1% while that among rural women was 41.9%; only 29.8% of both urban and rural women use at least one modern method of contraception. However, these differences were not statistically significant ($p = 0.33$). The most commonly used methods of contraception among both groups of women were rhythm method, withdrawal method and male condom; while the least commonly used methods were male sterilization and female sterilization.

3.4 UNMET NEED FOR CONTRACEPTION:

Figures 1 and 2 below show that out of the 208 urban respondents, 52.9% were currently not using any contraceptive method; out of the 110 (52.9%) urban current non-users of contraception, 52 (25%) had an unmet need for contraception (11.5% for spacing and 13.5% for limiting). Likewise, out of the 210 rural respondents, 58.1% were currently not using any contraceptive method and out of the 122 (58.1%) rural current non-users of contraception, 58 (27.6%) had an unmet need for contraception (15.2% for spacing and 12.4% for limiting).

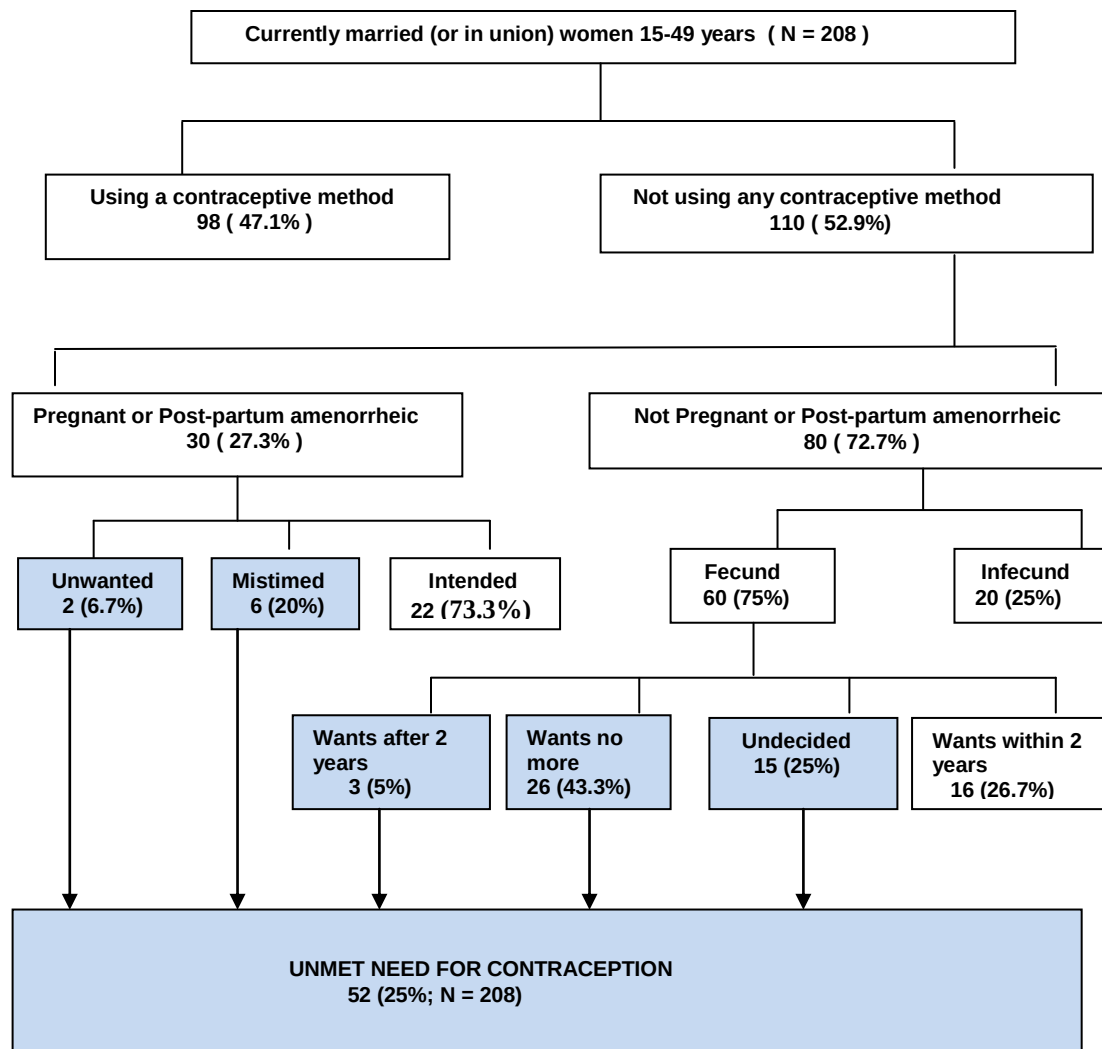


Figure 1: Flowchart for unmet need for contraception in urban area

The level of unmet need for contraception among urban women was 25% while that among rural women was 27.6%; however this difference in unmet need between women in the two locations was not statistically significant ($P=0.054$). From the study, 42.3% of urban and 40% of rural women had an unmet need for modern contraception and the total demand for contraception among urban and rural women was 72% and 69.5% respectively. Sixty five percent (65.3%) and 60.3% of this demand was satisfied by any method among urban and rural women respectively while 54.4% of this demand was satisfied by only modern methods of contraception in each of the two groups of women.

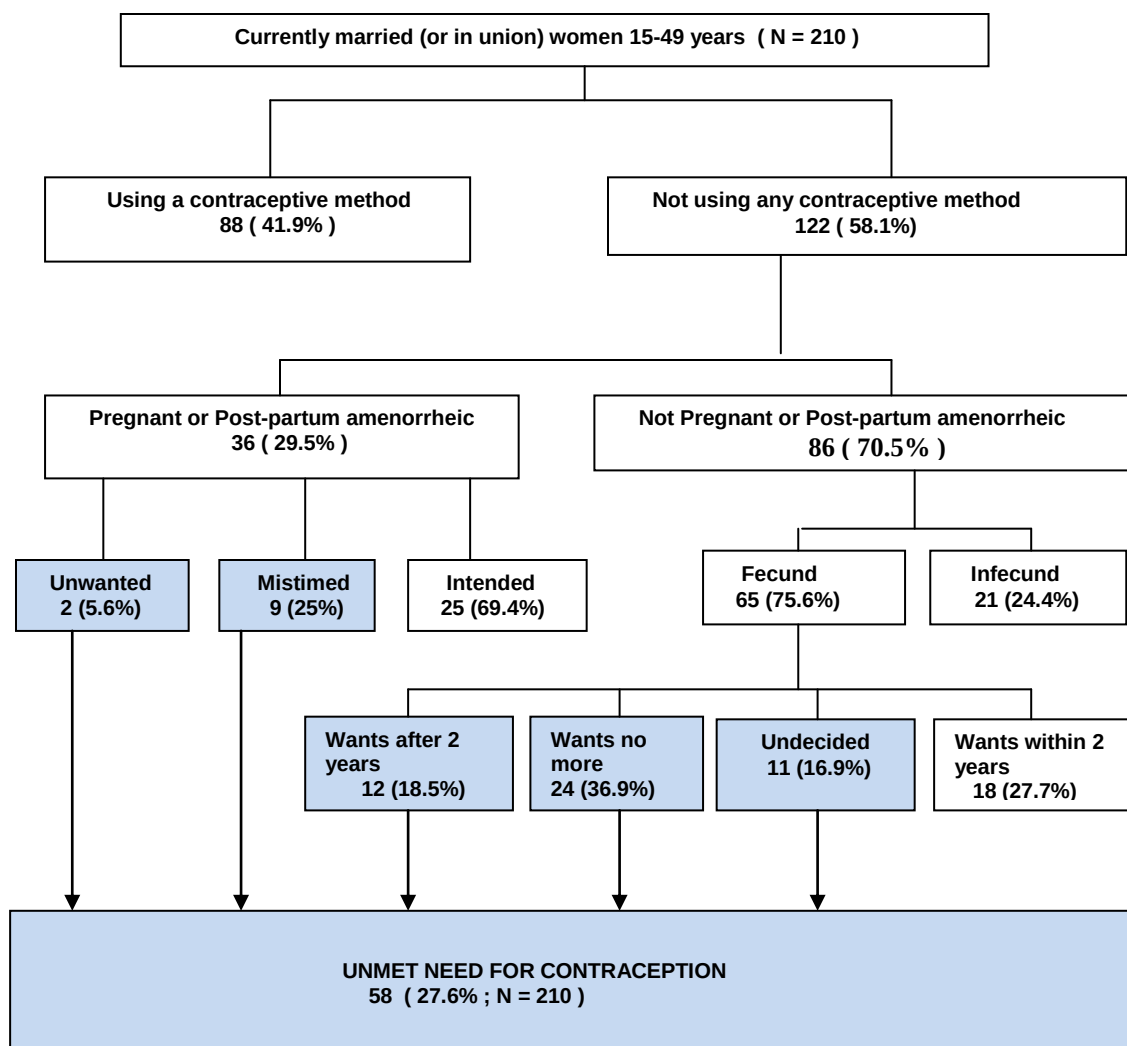


Figure 2: Flowchart for unmet need for contraception in rural areas.

The reasons for non-use of contraception was explored among the FGD participants and showed that majority of urban women gave side effect-related reasons for current non-use of contraception, while majority of the rural women gave opposition to use (from the women themselves, their partners or their relatives) as their reason for current non-use.

"I know of a woman that used to have 2 weeks menstrual flow instead of 4 days after she put it and when she removed it, she could not get pregnant again so it discouraged me. I do not want it. Even if I have 10 children, it does not matter." [A 35 year old urban woman]

"My husband and I do not want it. As long as my body is ok, any number of children that come is ok". [A 35 year old rural woman].

These are in keeping with the findings of the KII in which the commonest reasons for non-use identified by the urban OICs were side effect-related while that identified by the rural OICs was opposition to contraceptive use.

"The first and most important is that once it ceases a woman's period, she gets worried and cries out that all the bad blood is being stored in her body, that she will not use the method again. Even if you counsel her, she will refuse". [An urban OIC]

".....Some say that their husbands disapprove. For example, about 2-3 of them secretly come for it, saying their husbands do not approve but that they want it" [A rural OIC]

3.5 DETERMINANTS OF UNMET NEED FOR CONTRACEPTION:

Table 4 below shows that at bivariate level, number of living children was a significant predictor of unmet need for contraception in both groups of women; while educational status and employment status predicted unmet need for contraception in rural women only.

Table 4: Socio-demographic determinants of unmet need for contraception among urban and rural women.

Variables	UNMET NEED					
	URBAN (N = 208)			RURAL (N = 210)		
	n (%)		P-value	n (%)		P-value
	No	Yes		No	Yes	
SOCIO-DEMOGRAPHIC						
Age Category			0.951			0.739
15-24	3(1.9)	1(1.9)		22(14.5)	11(19.0)	
25-34	48(30.8)	17(32.7)		66(43.4)	27(46.6)	
35-44	82(52.6)	28(53.8)		49(32.2)	15(25.9)	
45-49	23(14.7)	6(11.5)		15(9.9)	5(8.6)	
Total	156(100)	52(100)		152(100)	58(100)	
Number of living children			0.002*			0.007*
0	11(7.1)	0 (0.0)		15(9.9)	0 (0.0)	
1-2	42(26.9)	4(7.7)		43(28.3)	10(17.2)	
3-4	72(46.2)	30(57.7)		57(37.5)	24(41.4)	
5 and above	31(19.9)	18(34.6)		37(24.3)	24(41.4)	
Total	156(100)	52(100)		152(100)	58(100)	
Highest educational status			0.405			0.007*
No formal education	1 (0.6)	1 (1.9)		0 (0.0)	0 (0.0)	
Primary	11(7.1)	6(11.5)		15(9.9)	14(24.1)	
Secondary	48(30.8)	19(36.5)		101(66.4)	38(65.5)	
Tertiary	96(61.5)	26(50.0)		36(23.7)	6(10.3)	
Total	156(100)	52(100)		152(100)	58(100)	
Employment status			0.523			0.036*
None	16(10.3)	7(13.5)		38(25.0)	23(39.7)	
Yes	140(89.7)	45(86.5)		114(75.0)	35(60.3)	
Total	156(100)	52(100)		152(100)	58(100)	

***Statistically significant ($P \leq 0.05$)**

Worthy of note is the finding from table 5 below that women's decision-making autonomy was not a significant predictor of unmet need for contraception in both urban and rural women.

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Table 5: Cultural factors that predict unmet need for contraception

UNMET NEED						
Variables:	URBAN (N=208)			RURAL (N=210)		
	No	Yes	Pvalue	No	Yes	P-value
CULTURAL FACTORS						
Women autonomy			0.874			0.425
Low	17(10.9)	5(9.6)		14(9.2)	9(15.5)	
Medium	54(34.6)	20(38.5)		56(36.8)	20(34.5)	
High	85(54.5)	27(51.9)		82(53.9)	29(50.0)	
Total	156(100)	52(100)		152(100)	58(100)	
Women approval			0.000*			0.048*
No	19(12.2)	20(38.5)		28(18.4)	18(31.0)	
Yes	137(87.8)	32(61.5)		124(81.6)	40(69.0)	
Total	156(100)	52(100)		152(100)	58(100)	
Spousal communication			0.000*			0.440
Never	45(28.8)	31(59.6)		68(44.7)	30(51.7)	
1/2 times	38(24.4)	12(23.1)		25(16.4)	11(19.0)	
≥ 3 times	73(46.8)	9(17.3)		59(38.8)	17(29.3)	
Total	156(100)	52(100)		152(100)	58(100)	
Partner approval			0.000*			0.001
No	46(29.5)	32(61.5)		48(31.6)	33(56.9)	
Yes	105(67.3)	18(34.6)		97(63.8)	21(36.2)	
I do not know	5(3.2)	2(3.8)		7(4.6)	4(6.9)	
Total	156(100)	52(100)		152(100)	58(100)	
Religion			0.015*			0.326
Roman catholic	80(51.3)	24(46.2)		90(59.2)	40(69.0)	
Protestant	55(35.3)	12(23.1)		33(21.7)	6(10.3)	
Pentecostal	19(12.2)	15(28.8)		25(16.4)	9(15.5)	
Islam	2(1.3)	0(0.0)		2(1.3)	1(1.7)	
Traditional religion	0(0.0)	1(1.9)		2(1.3)	2(3.4)	
Total	156(100)	52(100)		152(100)	58(100)	

***Statistically significant ($P \leq 0.05$)**

Unmet need for contraception was found to be significantly associated with spousal communication ($P < 0.001$) and religion ($P = 0.02$) among urban women but not among rural women. Roman Catholics were also more likely to have unmet need than other religious groups in the urban area ($p < 0.05$). Partner approval of contraception was significantly associated with unmet need in both groups of women ($P < 0.001$).

Table 6 below shows unmet need for contraception to be significantly associated with having a form of health insurance among urban women ($P = 0.002$); while among rural women, contraceptive knowledge, income category and perceived risk of pregnancy were significantly associated with unmet need for contraception ($p < 0.05$)

408 **Table 6: Knowledge and information, enabling and need factors by location**
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Variable:	UNMET NEED					
	URBAN (N = 208) n (%)			RURAL (N = 210) n (%)		
	NO	YES	Pvalue	NO	YES	P-value
KNOWLEDGE AND INFORMATION						
Contraceptive Knowledge			0.571			0.037*
Knows no method	2(1.3)	0(0.0)		1(0.7)	3(5.2)	
Knows only traditional	1(0.6)	1(1.9)		0(0.0)	0(0.0)	
Knows 1-2 modern method	2(1.3)	0(0.0)		14(9.2)	9(15.5)	
Knows ≥ 3 modern methods	151(96.8)	51(98.1)		137(90.1)	46(79.3)	
Total	156 (100)	52 (100)		152 (100)	58 (100)	
Mass Media Message			0.348			0.064
No	19(12.2)	9(17.3)		70(46.1)	35(60.3)	
Yes	137(87.8)	43(82.7)		82(53.9)	23(39.7)	
Total	156 (100)	52 (100)		152 (100)	58 (100)	
ENABLING FACTORS:						
Income Category			0.930			0.013*
₦0 - < ₦5000	25(16.0)	9(17.3)		59(38.8)	32(55.2)	
₦5000 – ₦24,999	42(26.9)	16(30.8)		58(38.2)	23(39.7)	
₦25000 – ₦44,999	54(34.6)	16(30.8)		26(17.1)	1(1.7)	
≥ ₦45,000	35(22.4)	11(21.2)		9(5.9)	2(3.4)	
Total	156 (100)	52 (100)		152 (100)	58 (100)	
Health Insurance			0.002*			0.380
No	112(71.8)	48(92.3)		150(98.7)	58(100.0)	
Yes	44(28.2)	4(7.7)		2(1.3)	0(0.0)	
Total	156 (100)	52 (100)		152 (100)	58 (100)	
NEED FACTORS						
Perceived risk of pregnancy			0.795			0.005*
No risk	71(45.5)	22(42.3)		73(48.0)	13(22.4)	
Low risk	27(17.3)	9(17.3)		33(21.7)	15(25.9)	
High risk	22(14.1)	5(9.6)		19(12.5)	17(29.3)	
I do not know	17(10.9)	7(13.5)		8(5.3)	5(8.6)	
Currently pregnant	19(12.2)	9(17.3)		19(12.5)	8(13.8)	
Total	156 (100)	52 (100)		152 (100)	58 (100)	

410 ***Statistically significant ($P \leq 0.05$)**

411
412 Worthy of note however, is the finding that only 2 rural women had a form of health
413 insurance and all the rural women who had an unmet need for contraception had no form of
414 health insurance; while majority of the urban women who had a form of health insurance had
415 no unmet need for contraception ($P = 0.002$).

416
417 Table 7 below shows that in both urban and rural women, highest unit cost of contraceptive
418 in the preceding 12 months, perceived contraceptive effectiveness and perceived
419 contraceptive side effects were found to be significantly associated with unmet need for
420 contraception; while perceived contraceptive availability was found to be significantly
421 associated with unmet need for contraception among urban women alone but not among
422 rural women ($p < 0.05$).

423
424

Table 7: Health system factors that predict unmet need for contraception

Variable:	UNMET NEED					
	URBAN (N = 208)			RURAL (N = 210)		
	n (%)		Pvalue	n (%)		P-value
	NO	YES		NO	YES	
Health System Factors						
Distance from source			0.905			0.477
< 15 mins	52(33.3)	19(36.5)		55(36.2)	18(31.0)	
15 – 30 mins	98(62.8)	31(59.6)		61(40.1)	22(37.9)	
> 30 mins	5(3.2)	2(3.8)		27(17.8)	11(19)	
I do not know	1(0.6)	0(0)		9(5.9)	7(12.1)	
Total	156 (100)	52 (100)		152 (100)	58 (100)	
Counseled by health worker			0.842			0.925
No	32(20.5)	10(19.2)		35(23.0)	13(22.4)	
Yes	124(79.5)	42(80.8)		117(77)	45(77.6)	
Total	156 (100)	52 (100)		152 (100)	58 (100)	
Cost of transport			0.419			0.056
< ₦50	20(12.8)	3(5.8)		58(38.2)	20(34.5)	
₦50 – ₦100	23(78.8)	43(82.7)		60(39.5)	25(43.1)	
₦ > 100	12(7.7)	6(11.5)		25(16.4)	4(6.9)	
I do not know	1(0.6)	0(0.0)		9(5.9)	9(15.5)	
Total	156 (100)	52 (100)		152 (100)	58 (100)	
Highest unit cost			0.000*			0.002*
None	97(62.2)	50(96.2)		92(60.5)	51(87.9)	
≤ ₦100	12(7.7)	1(1.9)		20(13.2)	3(5.2)	
₦ 101 – ₦ 500	47(30.1)	1(1.9)		39(25.7)	4(6.9)	
> ₦500	0 (0.0)	0 (0.0)		1(0.7)	0 (0.0)	
Total	156 (100)	52 (100)		152 (100)	58 (100)	
Perceived availability			0.040*			0.463
Not available	2 (1.3)	0 (0.0)		1 (0.7)	0 (0.0)	
Not readily available	14(9.0)	1 (1.9)		18(11.8)	10(17.2)	
Readily available	128(82.1)	41(78.8)		97(63.8)	31(53.4)	
I do not know	12(7.7)	10(19.2)		36(23.7)	17(29.3)	
Total	156 (100)	52 (100)		152 (100)	58 (100)	
Perceived effectiveness			0.000*			0.000*
Ineffective	9 (5.8)	1 (1.9)		5 (3.3)	1 (1.7)	
Effective	115(73.7)	23(44.2)		107(70.4)	23(39.7)	
I do not know	32(20.5)	28(53.8)		40(26.3)	34(58.6)	
Total	156 (100)	52 (100)		152 (100)	58 (100)	
Perceived side effects			0.000*			0.003*
None	59(37.8)	4(7.7)		39(25.7)	9(15.5)	
Mild-moderate	48(30.8)	12(23.1)		63(41.4)	14(24.1)	
Severe	12(7.7)	6(11.5)		9(5.9)	9(15.5)	
I do not know	37(23.7)	30(57.7)		41(27.0)	26(44.8)	
Total	156 (100)	52 (100)		152 (100)	58 (100)	

*Statistically significant ($P \leq 0.05$)

Table 8 below shows women who had no form of health insurance were 4.7 times more likely to have an unmet need for contraception than those who did ($P = 0.01$); and those who had not purchased contraceptives in the 12 months preceding the study were 24 times more likely to have unmet need for contraception than those who had spent between N101-N500 to purchase one unit of contraceptive in the preceding 12 months ($P=0.03$).

437 **Table 8: Crude and adjusted odds ratio for predictors of unmet need for contraception**
 438 **among urban women.**
 439

Variables	TOTAL UNMET NEED		Overall P-value for AOR
	COR (95% CI)	AOR (95% CI)	
Women approval			0.423
No	4.507(2.158 – 9.412)*	1.506(0.554 – 4.097)	
Yes (reference)			
Spousal communication			0.873
Never	5.588(2.437 – 12.813)*	1.336(0.415 – 4.306)	
1/2 times	2.561(0.992 – 6.617)	1.101(0.354 – 3.420)	
≥ 3 times (reference)			
Partner approval			0.857
No (reference)			
Yes	0.246(0.126 – 0.483)*	0.869(0.303 – 2.490)	
I do not know	0.575(0.105 – 3.150)	1.656(0.186 – 14.758)	
Health insurance			0.011*
No	4.714(1.604 – 13.854)*	4.722(1.438 – 15.512)*	
Yes (reference)			
Highest unit cost			0.029*
None	24.227(3.247 – 180.791)*	15.714(1.943 – 127.093)*	
≤ ₦100	3.917(0.228 – 67.263)		
₦101 – ₦500 (reference)		6.569(0.341 – 126.452)	
Perceived effectiveness			0.491
Ineffective	0.127(0.015 – 1.066)	0.242(0.023 – 2.501)	
Effective	0.229(0.116 – 0.450)*	0.856(0.294 – 2.497)	
I do not know (reference)			
Perceived side effects			0.056
None (reference)			
Mild – moderate	3.687(1.117 – 12.170)*	4.863(1.357 – 17.423)*	
Severe	7.375(1.802 – 30.183)*	4.083(0.869 – 19.179)	
I do not know	11.959(3.897 – 36.702)*	6.030(1.474 – 24.660)*	

440 ***Statistically significant ($P \leq 0.05$)**

441 **Note: reference category for the dependent variable is “No unmet need”**

442

443 After adjusting for potential confounders in the logistic model, having a form of health
 444 insurance ($P=0.01$) and highest unit cost of contraceptives ($P=0.03$) were found to
 445 independently predict unmet need for contraception among urban women. Worthy of note
 446 also is the finding that at multivariate level, religion ceases to be significantly associated with
 447 unmet need for contraception among urban women.

448

449 Table 9 below shows that the odds of having an unmet need for contraception significantly
 450 decreased with increasing educational status among rural women ($P=0.003$); and women
 451 who had no form of employment in the preceding 12 months of the study were found to be
 452 twice more likely to have an unmet need for contraception than those who had some form of
 453 employment ($P=0.04$).

454

455

456

457 **Table 9: Crude and adjusted odds ratio for predictors of unmet need for contraception**
 458 **among rural women.**
 459

Variables	TOTAL UNMET NEED		Overall P-value for AOR
	COR (95% CI)	AOR (95% CI)	
Educational status			0.097
Primary (reference)			
Secondary	0.403(0.178 – 0.914)*	0.421(0.148 – 1.198)	
Tertiary	0.179(0.058 – 0.553)*	0.227(0.058 – 0.889)*	
Employment status			0.270
None	1.97(1.038 – 3.745)*	1.559(0.708 – 3.430)	
Yes (reference)			
Partner approval			0.245
No (reference)			
Yes	0.315(0.165 – 0.602)*	0.501(0.216 – 1.159)	
I do not know	0.831(0.225 – 3.068)	0.530(0.101 – 2.781)	
Risk of pregnancy			0.018*
No risk (reference)			
Low risk	2.552(1.092 – 5.965)*	3.138(1.154 – 8.535)*	
High risk	5.024(2.082 – 12.126)*	6.076(2.105 – 17.535)*	
I do not know	3.510(0.992 – 12.417)	2.622(0.619 – 11.098)	
Currently pregnant	2.364(0.857 – 6.525)	2.162(0.672 – 6.959)	
Cost of contraceptive			0.179
None (reference)			
≤ ₦100	0.271(0.077 – 0.955)*	0.285(0.065 – 1.256)	
₦101 – ₦500	0.185(0.063 – 0.547)*	0.322(0.091 – 1.148)	
Perceived effectiveness			0.167
I do not know (reference)			
Ineffective	0.235(0.026 – 2.113)	0.783(0.066 – 9.229)	
Effective	0.253(0.133 – 0.480)*	2.212(0.173 – 28.239)	
Perceived side effects			0.116
None (reference)			
Mild – moderate	0.963(0.381 – 2.435)	0.416(0.138 – 1.250)	
Severe	4.333(1.339 – 14.022)*	1.184(0.263 – 5.334)	
I do not know	2.748(1.145 – 6.596)*	0.330(0.086 – 1.266)	

460 ***Statistically significant ($P \leq 0.05$)**

461 **Note: reference category for the dependent variable is “No unmet need”**

462
 463 After adjusting for potential confounders, perceived risk of pregnancy was found to be an
 464 independent predictor of unmet need for contraception among rural women.

465
 466 Some of the findings in table 8 and 9 above correspond to the results of the FGD which
 467 showed that majority of both urban and rural women who are current non-users of
 468 contraception have unsupportive partners and relatives.

469 *“My husband, mother and mother-in-law are not in support at all because they said the*
 470 *disadvantages are too much both in the natural and artificial methods. They do not support*
 471 *anyone at all and it has discouraged me from using anyone”* [A 35 year old rural woman]

472
 473 Although the FGD revealed that majority of both urban and rural women had not heard about
 474 health insurance and had no idea what the concept is, following a brief explanation, a few
 475 urban non-users expressed absolute disinterest in the scheme. However, majority of both

urban and rural participants agreed that where such a scheme exists, it will encourage women to use contraceptive services/commodities.
"It will encourage a woman to use contraceptives because she can get it and it will be paid for even if she does not have the money at a particular time when she wants to renew the method she is using". [A 28 year old rural woman]

4. DISCUSSION

The rural women were significantly younger than the urban women and this difference was remarkable in the 15-24 years age category. This could be explained by the relatively later age of marriage of urban women as reported by the Nigeria DHS. [1] Although much more needs to be done, the CPR for modern methods in the state was found to be higher than that recorded in the 2013 Nigeria DHS. This shows that more women in the state are adopting modern contraceptive methods unlike in previous years when traditional methods were preferred. These gains in CPR could be as a result of increased efforts and effectiveness of family planning programmes in the state and the deteriorating economic situation of many families in our society today, which forces many couples to seek more effective ways of limiting and spacing child birth.

Worthy of note is the KII finding that some facility heads discourage use of modern contraceptives in their facilities. This implies that women that access such facilities for health care, who ordinarily would have opted for artificial methods of contraception are denied the opportunity; thus introducing provider bias into the system and narrowing the contraceptive method mix. [19] Such facility heads should thus be re-oriented by contraceptive programme managers, in order to achieve value change in them; however if this proves abortive, they should be replaced or paired with a second facility head who would encourage and offer artificial contraceptive methods to clients.

Male and female sterilization were the least used methods among both urban and rural women. Some studies among Nigerian men have also shown low level of awareness of vasectomy and low intention to adopt it as a contraceptive method [20-22]; as it is viewed by some men as castration. [21] Therefore men and women who have successfully adopted these methods of contraception can be identified to serve as male motivators and mentor mothers to other people, demystify the permanent contraceptive methods and dispelling myths around them.

Health insurance and the highest unit cost of contraception were found to be independent predictors of unmet need for contraception among urban women. This could be because having a form of health insurance implies that women have more access to contraceptive information and education which is included in the benefit package for most of the social health insurance programmes (SHIPs). [23] This association has also been demonstrated by similar studies. [24-26] Therefore, the government should consider including long-acting reversible and permanent methods of contraception in the benefit package of the SHIPs and intensify efforts towards demand creation for the various forms of the SHIPs in both urban and rural areas; encouraging and supporting state and local government buy-ins and enrolment of the informal sector and vulnerable groups into the scheme.

Despite the efforts of the Federal Ministry of Health, Department for International Development and other International agencies to eliminate cost as a barrier to contraceptive use through the free contraceptive policy [27,28], user fees paid by women in public health facilities for the logistics and consumables, remain an economic barrier to contraception. Government and programme managers should thus strive to make provision for these so as

to overcome the barrier. Community health workers should also be trained (by qualified family planning providers) on the provision of some of the long acting reversible contraceptive methods in Primary Health Centres, in order to improve access to these more effective modern methods.

The study showed that the higher the risk perception, the higher the odds of having an unmet need for contraception; but this differs from that of other studies done in Cairo and the States [29,30], in which the women with unmet need for contraception had low perceived risk of pregnancy. This contrast in findings implies that the rural women in Anambra State are well aware of their risk of pregnancy (unlike the women in the latter studies), but their non-use of contraceptives stems most importantly from opposition to use (among other factors) as shown by the FGD and KII findings. Therefore more spousal and family support for contraception needs to be promoted in the communities.

5. CONCLUSION

This study has elucidated the fact that although there is high awareness of the various methods of contraception, there persists a knowledge-use gap in the practice of the more effective modern contraceptive methods, which if promptly and properly addressed, promises to control the explosive population growth and its consequences on the limited resources of the country, while improving maternal and child health.

COMPETING INTERESTS

Authors have declared that no competing interests exist. No funding was received towards the conduct and completion of this research work.

ETHICAL APPROVAL

Ethical approval for this study was obtained from the ethics committee of Nnamdi Azikiwe University Teaching Hospital, Nnewi, Anambra State.

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ETHICS COMMITTEE APPROVAL

RE: COMPARATIVE ASSESSMENT OF UNMET NEED FOR FAMILY PLANNING AND ITS DETERMINANTS AMONG CURRENTLY MARRIED WOMEN OF REPRODUCTIVE AGE IN RURAL AND URBAN AREAS OF ANAMBRA STATE, NIGERIA

We write to inform you that after due consideration of your research proposal, approval is hereby conveyed for you to commence the study.

The principal investigator is required to send a progress report to the Ethics Committee at the expiration of three (3) months after ethical clearance to enable the Committee carry out her oversight function.

Please note that this approval is subject to revocation if you fail to obtain proper authorization from your study site/unit.

Dr. Joy Ebenebe
Chairman, NAUTH Ethics Committee

Udemezue N.O (Mrs)
Sec., NAUTH Ethics Committee