POWER DYNAMICS AND THE USE OF CONTRACEPTIVES AMONG COUPLES IN NIGERIA

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CERTIFICATION

This is to certify that this research work – Power Dynamics and the use of Contraceptives among Couples in Nigeria – was carried out by **OLADELE, OLUWAROTIMI SAMUEL** with Matriculation Number **DSS/11/0140** of the Department of Demography and Social Statistics, Faculty of Humanities and Social Sciences, Federal University Oye Ekiti, Ekiti State, Nigeria.

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DEDICATION

This research work is dedicated to God Almighty, the Alpha and the Omega, the source of all wisdom and understanding to whom I give all glory, for giving all I needed to see through my first degree.

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Abstract

Previous researches have ignored couple's contraceptive use based on existing power dynamics at the household level. This study was undertaken to provide insight into power dynamics and use of contraceptive among Nigerian couples. The Social Dominance Theory was employed as theoretical framework. The theory suggests that while men may be the dominant decision makers at the household level they rarely make decision on contraceptive use. Couple's data from the Nigeria Demographic and Health Survey from 2003-2013 were pooled and used. Three levels of analysis were employed for the study while Chi-Square, Cramer's V and Logistic Regression were used to test the hypothesis. The analysis of data shows that couple's decision making power have a significant impact on contraceptive use in Nigeria (P<0.05). Couples who desire more than two children are less likely to use contraceptive (OR: 0.22, CI: 0.14-0.37) when compared with the reference category (OR: 1.0), which are couples who desire less than two children. In addition, women who report intimate partners' violence are more likely to use a contraceptive (OR: 0.52, CI: 0.42-0.62) compared to women who do not report intimate partner's violence (OR: 1.0). The study concludes that men should be involved in family planning programs. This is believed to have a positive relationship to couples use of contraceptives.

CHAPTER ONE

INTRODUCTION

1.1   Background to the Study

The Africa population is currently growing faster than any other continents in the world. In fact, projections suggest that the continent will account for 21 percent of the world's population by the year 2050 (Population Reference Bureau, 2013). The National Population Commission (2012) reported that Nigeria grows by 3.5 million people population annually. The unrestrained growth rate will ensure that the nation's population would be doubled within the next 24 years. The use of contraceptives has been identified as an important tool for controlling this rapid population growth and protecting women's health. The total fertility rate among married couples is still on the high side, and one of the reasons for this is the low usage of contraceptives in Nigeria (Odusina, Akinyemi and Bisiriyu, 2014). Throughout the world, contraceptives use has also helped prevent an estimated 2.7 million infant deaths (Darroch, Singh, and Nadeau, 2008).

Recent research estimates that 222 million women in developing countries have unmet contraceptives needs (Darroch and Singh, 2013) where unmet needs is an indicator of the violation of women's right and absence of empowerment (Ahlburg, Kelly and Manson 1996). The social dominance theory explains the factors responsible for the violation of women's right as a function of power relations between gender categories in the society and its influence on the use of contraceptives (Jalal, 2014). This theory indicated four bases for the power difference among couples in the society. These are consensual ideologies, resource control, force and social obligation. The consensual ideologies explains gender roles and any other beliefs or expectation about men and women that are generally agreed upon in a society or culture that often put women in a weaker position in comparison to men (Rosenthal and Levy 2010). This is referred to as

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benevolent sexism (Glick et al. 2000). Such benevolent sexism puts women in a weaker position and helps to maintain low decision making power and enhance gender inequality in the household (Anurag, 2014). In areas where wives' decision making is limited, the use of contraceptives is not extensive (Kurimoto and Mai Do, 2012). Control of resources by the household is also significant to the use of contraceptives. Whoever controls the cash earnings of the family most times has more decision making power on contraceptives use. Generally however control over productive resources (e.g. income, assets, e.tc.) usually favours men than women worldwide, and thus allows men's dominance in decision making regarding women reproductive health and contraceptive use (Connell 2005).

Ogunjuyigbe and Adeyemi (2005) in a study of married women in Yorubaland stated that the culture required that women be submissive to their husbands in fertility-related matters. They thus need their husband's permission before undertaking fertility decisions through contraceptives or other means. This is reflected in the popular proverb "*Oko lolori aya*", which means "the husband is the head of the wife". Such a belief limits the decision making power of the women in the family The fear of domestic and intimate partner violence (force) has been reported in many settings as a barrier to contraceptive use, the use of some contraceptives method, such as the pill, may raise the male partner's suspicion of infidelity, as well as challenge his authority, which may result in physical and domestic violence (Williams, Larsen and McCloskey, 2008). In sub-Saharan Africa, evidence of the relationship between domestic or physical violence and contraceptive use remains scarce. Female victims of domestic violence are not likely to use any form of contraceptives. Alio (2009) however observed that women who had experienced intimate partner violence were more likely to report contraceptive use.

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Furthermore, social obligations in many African societies place women in a weaker position regarding their contraceptives use desires by their responsibilities of childbearing and child caregiving (Jalal 2014). One study revealed that women in sub-Saharan Africa are expected to begin childbearing shortly after marriage to fulfill their roles as wives and mothers (Hindin 2000). It is therefore necessary to examine the power relations and contraceptives use among couples.

1.2   Statement of Problem

Approximately two out of five pregnancies worldwide are unintended, and this is as a result of the low usage of contraceptives (Darroch and Singh 2013). Population Reference Bureau (2014), reports that 63 percent of women in union between the ages 15-49 use any form of contraceptives worldwide, while 72 percent of this women are in the more developed countries, 62 percent in the less developed countries and 34 percent in the least developed countries. Nigeria Demographic and Health Survey (2013) also reports that about 15 percent of currently married women use contraceptives in Nigeria, out of the 15 percent, 10 percent currently use a modern method of contraceptives, and an additional 5 percent use traditional form of contraceptives, which is an increase of only 2 percent from the 2003 NDHS report (NDHS, 2013).

This low usage of contraceptives can be attributed to the low level of decision making autonomy among women in the household. Despite the importance of women's participation in family decision-making, women's decision-making power on the use of contraceptives is limited to some extent in third world countries (Sultan, 2012). If given the power, women's decision making ability will not only increase the use of contraceptives, but will facilitate access to material resources such as land, income, food and other forms of wealth and social resources within the family and community. In practice, women's attitudes to contraceptives use do not depend only

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on their individual characteristics or socioeconomic status, but also on their husbands' characteristics. This is because evidence from several studies have shown that if a family planning program targets men as potential clients, it will achieve more success than if it targets women alone (Cleland, 2005). One of the major reason for this is that men have more decision making power than women in many developing countries. If men are ignored, it will slow down the fertility transition. Decision making about contraceptive use and childbearing may be confounded by unequal power relations, especially in more patriarchal societies (Poonam, 2014). This study aims at examining power relations and the use of family planning among couples in Nigeria.

1.3. Research questions

1. What are the factors determining the use of contraceptives among couples in Nigeria?

2. Is there any relationship between couples' decision making and contraceptives use?

3. Do social obligations (Desired number of children and Number of living children) influence the use of contraceptives among couples in Nigeria?

1.4. Research objectives

The main objective of this research is to explore the relationship entwine power relations and the use of contraceptives among couples in Nigeria.

Specific objectives

1. To examine factors determining the use of contraceptives (Age, education, religion, place of residence, wealth index, region and exposure to mass media) among couples.

2. To investigate the extent at which couples decision making influence contraceptives use.

3. To ascertain if social obligations (Desired number of children and Number of living children) influence couples contraceptives use.

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1.5. Justification of study

Men are most times the reason for the use of contraceptives among women (National Institute of Population Research and Training. Dhaka 2005). Men receive power, position, and privilege due to existing gender differentiation in society. Society has rewarded men's work and gives more power and prestige to men, as compared to women, who rarely have the opportunity to control resources (Dodoo. 1998). Theoretically, the assumption is that in a relationship, if both partners behave rationally, have sufficient skills in bargaining, and are aware of each other's tastes and preferences, it would increase individual mutual benefits in multiple ways. If they have a common goal and equal bargaining power, a solution that is satisfactory to both can be attained (Dodoo. 1998). The equation would not be the same if there were unequal bargaining powers or skills.

However, the elements that give men a more active role than women are rooted in culture through patriarchy and religion. Typically, male dominance is observed in the family where men are considered to be the head of the household and the breadwinner, they control the family resources and assets. Male dominance is categorically reflected in their right to polygamy, unilateral divorce, double share of inheritance, and guardianship over wife and children (Jalal. 2014). Women are often considered as men's property, their sexuality, income, and labor are being systematically controlled by the men in the family (Jalal. 2014). This is the reason why men have high decision making power and most times in the developing counties the women are subjected to their whims and caprices resulting in physical violence (force) when there is an objection to their decision.

Apart from patriarchal gender norms, some fixed social obligations place women in a weaker position regarding their ability to use contraceptives, make decisions and regulate fertility, one of such obligations include early marriage (Jalal. 2014). This study examines power relations

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and the use of contraceptives in Nigeria. A research effort channeled towards power relations and the use of contraceptives in Nigeria cannot be effort in futility. Besides, the study will contribute immensely to the existing knowledge on couples' power relations in household decision- making and empowerment both at household and society at large.

CHAPTER TWO

LITERATURE REVIEW

2.1   The Concept of Contraceptives

Contraceptive is any device used to prevent conception or pregnancy. This can either be mechanical or chemical barrier. The Longman Dictionary (1978) defines contraceptive as 'any drug or object or material used inside or outside the sex organ as a means of preventing an act of sex from resulting in the birth of a child.' Contraceptives have long been in existence as history reveals that people either make use of contraceptive unconsciously or consciously. In the olden days a lot of things have been used as device to prevent unwanted pregnancy and space births among couples. In traditional African society these include the use of rings (oruka), substances from locally available herbs, salt, potash etc. Traditional methods of contraceptive have been used throughout history and are still in use today despite the availability of modern contraceptive. One of the earliest methods of barrier dated back to 1550BC in the ancient Egyptian society. The mild acidity of the Arabic gum was believed to be a barrier to the spermicide. The substance such as oil of cedar recommended by Aristotle might have been partly successful. In Rome, women sometimes wiped the semen with soft wool and oil in order to stop conception. Each of these methods varied from place to place. The 19th century witnessed further development of modern contraceptives and this was marked with by invention of condom.

This study discusses contraceptives that are deemed appropriate for couples. This is because certain contraceptive methods are not suitable for couples in Nigeria e.g. sterilization. Types of contraceptives for the purpose of this study are:

i.   **Condoms:** They are thin latex sheaths that are placed on the male organ as a means of containing semen after ejaculation.

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ii. **Intra Uterine Device (I.U.D):** It is a plastic object that gynecologists insert into the uterine cavity. I.U.D comes in various sizes, manufactured to fit various sized uterine cavities.

iii. **Douche:** It is a clearing of the vaginal canal by using syringe and stream of water. The belief is that semen can be removed from the vaginal by clearing it. The disadvantage of this method is that it is not a reliable method of contraceptive.

iv. **Contraceptive Jellies, Forms, Tablets and Suppositions:** Are commercial products that are highly effective in destroying sperm within the vagina.

v. **Vaginal diaphragm:** It is a circular device that fits tightly in the vaginal and completely covers the cervix.

Other methods include:

i. **Oral contraceptive (pills)** – These are pills which are taken orally. They are an ovulatory in the sense that they inhibit ovulation or egg formation.

ii. **Rhythm method** – It is a partial form of abstinence using the supposition that there is a certain time in each month when the woman is likely to become pregnant. During this period a man and woman refrain from sexual intercourse (sexual abstinence).

iii. **Coitus interruption (Withdrawal method)** – This is deliberate removal of male reproductive organs before ejaculation. It is not also a reliable method of contraception because semen may escape into the vaginal before the male organ is removed.

With all these methods listed, the rate at which people use of all forms of contraceptives in Nigeria is just 16 percent (NDHS, 2013) and contraceptives are used more by married couples than single people in Nigeria (PRB, 2013). Previous research has tended to ignore women's ability to use contraceptives based on existing power relations at the household level in Nigeria, where persistent seclusion, religious norms, patriarchal family structure challenge women in acquiring

power. Social obligations further compounded women's decision making autonomy by the perception of husbands who may see their wives use of contraceptives as undermining their roles as household heads or as likely to encourage promiscuity (Oni and McCarthy, 1991). In that respect, contraceptives decisions exclude the wife who not only succumbs to marital expectations, but also to communal ideas of valuation of child birth.

2.2. Gender Power, Decision Making and Contraceptives Use

Power refers to acting or behaving according to one's own wish and being able to influence or have control over the actions of others (Wingood and DiClemente, 2000). Understanding the linkages between power bases and women's ability to influence family planning choices requires a gender based power dynamics perspectives. Thus demographers have begun to apply issues of power to theorizing women's agency in contraceptives use (Jalal, 2014).

The use of contraceptives promotes a wide range of health and socioeconomic benefits to women, men, and their families. Still, many barriers prevent women from using contraception. Such barriers include the decision making power of the family, which lies majorly in the hands of the husband in many African societies. Despite efforts to increase awareness and improve access to these methods of contraception, household resource control, use of force and social obligation remain the factors contributing to its use and no-use in developing countries. Specifically, disagreements between a husband and wife about family planning may influence decisions about contraceptive use. Common sources of disagreements between partners are preferences for whether or not to use contraceptive, what contraceptive method to use and mismatches in ideal family size (Belohlav & Mahesh, 2013)

Where a spouse's voice differs in preferences and attitudes toward family planning, there is speculation that many women might not use modern contraceptives because their partners

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disapprove of such methods. Or, alternatively, that they might obtain family planning services secretly and use concealable methods of contraception. Secret use of contraceptives has drawbacks for a marriage that may or may not outweigh the family planning benefits for women. Secret use of contraceptives may introduce mistrust in the marriage, though it could also improve the welfare of women and their children by, for example, increasing the amount of time between each birth. Using contraception in secret, or completely forgoing its use, may detract from agreements that couples have about spacing and limits on family size, with the result that the couple either has more children or has them more frequently than either one wants (Kate Belohlav & Mahesh Karra, 2013).

In Africa, the decision on the number of children that a couple will have is typically made by men. In Nigeria, there is a high value placed on children and hence the use of family planning methods is significantly determined by the number of living children of a couple. According to Musalia (2003), it is a taboo to be childless in many African cultures. The tragedy that befalls a childless couple is so great that any childless marriage will by and large fail. Women's participation in domestic decision-making is increasingly being recognized as affecting their ability to make reproductive decisions. Demographic literature suggests that active involvement in domestic decision-making indicates the power of women within the household and, consequently, their ability to control their fertility (Hogan DP, Berhanu B, Hailemarian A, 1999). Several studies have found that woman with little autonomy in the household are less likely to make innovative decisions. The influence of gender-based power dynamics in sexual relationship between men and women on reproductive outcomes is becoming increasingly recognized. The empowerment of women as reflected in their socio-economic and employment status, educational levels, household organization, the dynamics of their marital relations and their involvement in

domestic decision-making is an important factor in the decline of fertility levels in developing countries (Idda Mosha, Ruerd Ruben and Deodatus Kakoko. 2013). The connection between the employment and demographic behavior of couples has been found to be strong, particularly in its impact on contraception and fertility. The rationale behind this connection is that the financial contribution to the household by women with paid employment is higher, hence enabling them to control resources and household expenditures, as well as their reproduction.

As family planning programs challenge complex societal norms, they may also challenge traditional gender roles and dynamics and reshape social norms, for example, by endorsing women's right to refuse sex, and by encouraging couples to discuss and jointly decide on an appropriate contraceptive method (Jacobson, 2000). Men play powerful — even dominant – roles in reproductive decisions. Without considering their partners' wishes or the health consequences for themselves or their partners, however, their actions can have unhealthy and even dangerous results. In contrast, couples who talk to each other about family planning and reproductive health reach healthier decisions. These couples are more likely to use contraception and use it wisely and effectively (Beckman 2002, De-Silva 2000).

Men's contraceptive use is lower than might be expected, given their levels of knowledge and approval of family planning, according to surveys of men in developing countries mostly in sub-Saharan Africa. In Nigeria, men's attitudes and behaviors toward family planning and re-productive behaviour appear negative and un-encouraging. Nigerian men prefer allowing their wives to attend clinics and hospital where provision for family planning is available. For example, between one quarter and two-thirds of these men say they do not want to have more children, but neither they nor their wives are using contraception (Ezeh. 1996). By comparison, in countries

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surveyed, about one-fifth of married women say they do not want to become pregnant but are not using any method of contraception (Oladeji, 2008.)

Opposition from male partners has been cited as an important factor that affects Contraceptives use. In Ghana for example, ancestral customs give men rights over women's procreative power. In fact women in poorer countries with lower levels of education show the highest rates of unmet needs for Family Planning. In addition, men have traditionally been portrayed as either explicitly or implicitly unconcerned or unknowledgeable about reproductive health. Generally, men have been regarded as formidable barriers to women's decision-making about fertility, contraceptive use and health care utilization (Idda Mosha, Ruerd Ruben and Deodatus Kakoko, 2013).

Despite the ready availability of contraceptives methods and high contraceptive knowledge, the use of Family Planning methods remains low. For the purpose of this study, the use of modern contraception refers to current use of contraceptives as defined by the National Demographic and Health Survey (NDHS). It is not well-established how people make family decisions on contraceptives use, neither have their perceptions on contraceptives use been well established. These are important issues to be addressed so as to enhance further contraceptive use and lower fertility levels in the Nigeria. Odusina et al (2014), in their study on determinants of concordance and discordance reporting of contraceptives, found out that couples decision making was significant to their contraceptives use.

2.3. Socioeconomic Characteristics of Couples

Age

A common determinant of contraceptives use among couples is the age. The difference between the ages of the couples shows and tells more about the level of their communication in a typical African society. As far as the husband-wife communication and current use of contraception is concerned, there exists a positive relationship between these two variables i.e. as communication increased contraceptive use will also increase. It is generally argued that a large age gap between the sexes is a necessary mechanism for giving husband sufficient dominance to resist their wives sexual Demand (Caldwell, Reddy and Caldwell, 1983). A study conducted in 18 countries in Africa shows that when the age difference between spouses is low, the likelihood of ever having used modern contraception is 2.4 times higher than when the age difference is high, and around one-third higher than when the age difference is moderate (Barbieri and Hertrich, 2005).

In Nigeria, it is a common phenomenon that older men often get married to younger women. This cuts across all major ethnic groups in the country. The disparity in age permits the husband to autonomously make household decision including those on the use of contraceptives. Older age gives the husband considerable advantage in terms of status, experience and power. Even in a society where men and women share complete equality in education and occupational opportunities, men could always maintain their superior position as long as their status increases with age (Barbieri and Hertrich, 2005).

Education

The Educational level among couples is a determinant for power dynamics and the use of contraceptives. In households where the couples are both educated, there tend to be equal decision

making power among them. These couples often times sit together to take decisions that would be of benefit to both of them. The education enlightens them about gender equity and the need for both parties to equally participate in the decision making of the household (Klassen and Lamanna, 2009). In some households where one of the couples is educated, there is often a power shift in the family. If the wife is the only one who is educated, most times the husband in such family may feel inferior to the wife, and let the wife take many of the decisions in the family, especially when the woman is a career woman, she will most times decide on reproductive issues in the family.

Religion

Religion play important role in the contraceptives use among couples in Nigeria, it is a general belief among the Muslims that the Holy Koran allows them to practice polygamy as stated in *Quran 4:3* "*...then marry those that please you of other women, two or three or four. But if you fear that you will not be just, then marry only one or those your right hand possesses*". This verse of the Holy Quran allows many Muslims in Nigeria to engage in polygamy. It is very difficult to use contraceptives in a polygamous family where every woman in the house wants to birth many children so that their strand of the family will have the largest share of the inheritance. More so, in the Christian fold, the Holy Bible supports procreation as quoted in *Genesis 1:28* "*...Be fruitful, and multiply, and replenish the earth, and subdue it*". This verse of the Bible makes the Christians kick against the use of contraceptives, the Christian doctrines is populationist in outlook but condemns polygamy, divorce, abortion and infanticide, they glorified virginity and continence and frowned upon second marriage. Their views on procreation makes the Vatican City kick against the use of contraceptives as proposed in the 1984 International Population Conference in Mexico City.

Place of residence

The place of residence is considered as a determining factor for the use of contraceptives. It is believed that residents of urban centres are more exposed and educated than people who live in rural areas. They also have better access to modern contraceptive method than those in rural areas and are more likely to use a modern contraceptives method (Rahman 2012; Cleland 1996). Studies have shown that households in the urban centers are exposed to small family norms and often enjoy far better access to health and family planning than those in rural areas (Khan et al. 2008 ; Cleland, Kamal and Sloggett, 1996).

Exposure to Family planning information on Mass media

According to a baseline survey conducted in 2010 and 2011 across 6 towns in each regions of Nigeria, by the Nigerian Urban Reproductive Health Initiative (NURHI) among women, found out that the mass media (radio, television and newspaper) is an important source of family planning. More than 57 percent of women with knowledge of contraceptives receive the message through the mass media. There are several programs on radio and television on family planning, but most of these programs are targeted at urban residents.

2.4   Theoretical Framework: The Social Dominance Theory

The Social Dominance Theory (SDT) has been used to justify the position of women on decision making on contraceptives use, reproductive health and gendered power in the household. The Theory suggests that the society is hierarchized on social categories such as gender, social status and lack equivalent levels of power because of their group membership. Pratto and Walker (2004) propounded four bases of gendered power that provide those who hold more advantaged statuses better access to power. These include: consensual ideologies, social obligations, resource control, and force. As a whole, these four bases are useful in outlining the ways that gendered power dynamics in the household contribute to their contraceptives use (Jalal, 2014).

Consensual Ideologies

Consensual ideologies include "gender roles and any other beliefs or expectations about men and women that are generally agreed upon in a society or culture, that place women in weaker positions in comparison to men" (Rosenthal and Levy 2010: 26). In Nigeria, the widely held view is that the husband controls the sexuality of their wives and decides on the use of contraceptives (Isiugo-Abanihe, 1994a). Wives must then comply with their husband's sexual demands since refusal may break the family or lead the husband to marry more wives or keep "outside wives" (Karanja, 1987). Women are thus placed in a weaker position and are required to negotiate the use of contraception (Bently 2008: Ogunjuyigbe & Adeyemi, 2005).

Women in one study described certain gendered norms, including the requirement of the society that married women should bear many children, as reasons why their husbands did not want them to use contraception (Nalwadda etal.2010). Another study comparing the influence of male dominance on fertility in rural versus urban areas found that in rural areas, where traditional norms provides men with greater power, their fertility desires is dominant more than the desires of their wives, in contrast to urban areas where traditional ideologies were less pervasive and women's desires held more sway (Dodoo and Tempenis 2002). Similarly, households where both couples are educated or where the husband was more educated, were more likely to use a contraceptive method because his ideology did not put women in as weak a position, further suggesting the importance of ideology (Rosenthal and Levy, 2010)

One form of consensual ideology that can place women at a disadvantage involves gender roles that provide men with more decision-making power (Jalal, 2014). Thus, consensual ideologies – gender roles, norms, or expectations that limit the decision-making power of women

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within the home and regarding sexual encounters with their partners diminish women's ability to negotiate the use of contraception.

Social Obligation

This is the responsibilities that individuals have toward others (Rosenthal and Levy 2010). These social obligations may place women in a weaker position regarding their desire to use contraceptives. Some of these obligations include marital obligations which are childbirth and childcare; women in the sub-Saharan Africa are expected to begin giving birth shortly after marriage to fulfill their roles as wives and mothers (Hindin and Fatusi 2009). Thus, married women may have less power to negotiate the use of contraception because they feel obligated to giving birth to children as part of their marital responsibilities. With this, the higher the number of living children a women has the more likely the couple should be to use contraception because women with more children feel they have fulfilled their social obligation as wives and are subsequently able to use contraception as they desire (Pratto 2004).

The obligation regarding childbearing is obvious with wives in polygynous relationship as they are less likely to use contraception. However, childbearing may also involve dual social obligations as "reproductive output to a large extent guides subsequent male investment [in the wife]," suggesting that polygynous wives may bear children to access resources husbands provide in view of the presence of offspring (Bove and Valeggia 2009: 24). In addition, in polygynous marriages, couples may be less committed. The likelihood of husbands having affairs is higher and couples communicate less and have looser emotional ties (Bove and Valeggia 2009). If, as this suggests, polygynous husbands are less committed and less communicative with their wives, they may be less likely to listen to her desires regarding contraception use. Thus, polygynous wives are expected to be less likely to use contraception compared to non-polygynous wives.

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Another such obligation is faithfulness. Woman report that requesting the use of contraceptives can lead their partners to believe they have been unfaithful (Hebling and Guimarães, 2005). This implies that women are expected to show trust toward their partners. However, when women suggest the use of a condom, research indicates that partners perceive this as an accusation of unfaithfulness or lack of trust (Montgomery et al. 2008). Indeed, studies suggest that women in long-term committed relationships (Amaro and Raj 2000) or marital relationships (Maharaj and Cleland 2005) are less likely to use condoms to protect themselves. So, due to the social obligations outlined above, the length of marital relationships is likely to negatively influence the use of condoms. Higher rates of contraction of sexually transmitted diseases among polygynous couples (Bove and Valeggia 2009) suggest women in polygynous relationships may be less likely to use contraceptive, a tendency which may result from the different social obligations inherent in this type of relationship (Bove, Riley and Valeggia, 2009).

Force

Force involves any act or threat of violence that undermines women's power (Rosenthal and Levy 2010). Evidence shows that violence or the threat of violence is associated with lower use of contraception and reduces the ability of women to negotiate protection against disease (Pratto, 2014). Regarding contraception, one study (Bawah et al. 1999) performed using focus groups in Ghana found that women cited violence as a form of retaliation for using or even attempting to discuss the use of contraception. Another study using clients from a nongovernmental organization (i.e., NGO) in Zimbabwe found low contraception use for women who feared violence in response to discussing contraception with their partners or in hiding their pills or other contraceptive methods if their efforts would be discovered (Njovana and Watts 1996). Further, childhood abuse, sexual assault, and intimate partner violence are all associated with

greater risk for contracting HIV/AIDS (Rosenthal and Levy 2010), suggesting that the use of force or the threat of violence (i.e., experiencing force as a power differential) discourages the use of protective measures like condoms. Thus, the use or threat of force may diminish women's ability to advocate for the use of contraception and condoms to prevent disease. With this, we expect with hypothesis three when women who report a high degree of support for the right of men to use force against women will be less likely to report ever using contraception. A survey in Nigeria stated that about 64.4 percent of 45 women interviewed informed that they had been beaten by a partner, boyfriend or husband. In addition, 56.2 percent of 48 market women had experienced the same kind of violence (Project Alert on Violence against Women, 2001).

Resource Control

Resource control is defined here as access to employment. Unequal access to employment can leave women economically vulnerable and dependent upon their partners (Rosenthal and Levy 2010). On a macro scale, employment is usually associated with reductions in national fertility rate, presumably through increasing women's status within the home and their ability to advocate for their own fertility desires through the use of contraception (Lagerlof, 2003; Soares and Falcao, 2008; Klassen and Lamanna, 2009). Several studies on an individual or household-level support this assumption as women's employment tends to increase the likelihood of contraception use (Hindin 2000; Beekle and McCabe 2006; Bently and Kavanagh 2008). A similar relationship exists in the use of disease prevention measures, with more economically vulnerable women at higher risk for engaging in unprotected sex (Salem and Bobak 2005; Rosenthal and Levy 2010).

The relevance of this theory is found in its measurement of the power dynamics in the household in terms of decision making. The theory affords the reasons power dynamics among

couples affects decision-making on contraceptives use. The four bases of power dynamic as propounded by the Social Dominance Theory are useful in predicting contraceptives use among couples. The four bases are; consensual ideology, resource control, force and social obligation.

2.5   Conceptual Framework

SOCIOECONOMIC VARIABLES	DEPENDENT VARIABLE	CONTROL VARIABLES
Age Education Wealth index Religion Place of Residence Region etc.	Contraceptives Use	Consensual ideologies Force Social Obligation Resource Control Exposure to mass media
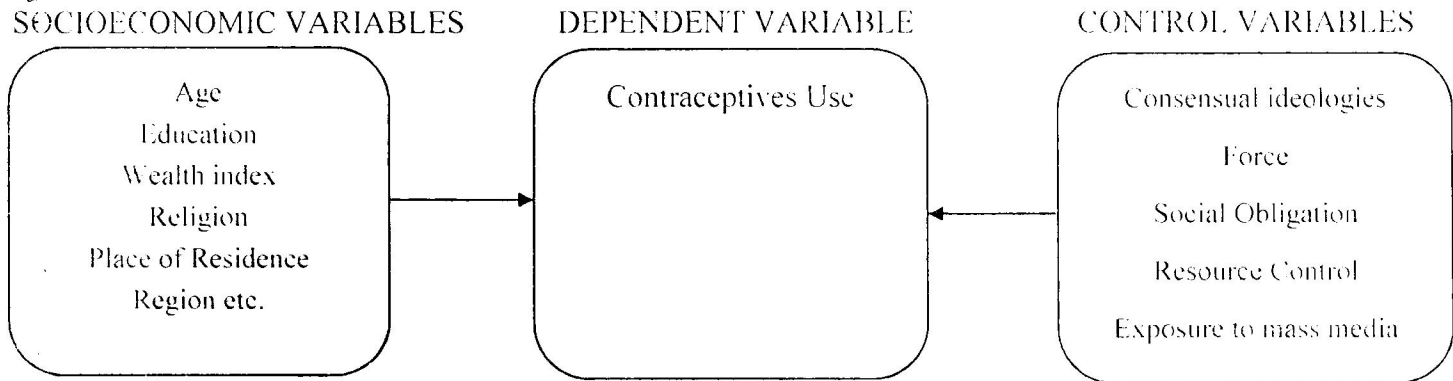
Source: Author's Construct, 2013

2.6   Hypothesis

1. H_0: There is no significant relationship between socioeconomic status and the use of contraceptives among couples in Nigeria.

   H_1: There is a significant relationship between socioeconomic status and the use of contraceptives among couples in Nigeria.

2. H_0: There is no significant relationship between couples' decision making and contraceptives use in Nigeria.

   H_1: There is a significant relationship between couples' decision making and contraceptives use in Nigeria.

3. H_0: There is no significant relationship between social obligations and the use of contraceptives among couples in Nigeria.

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H$_1$: There is a significant relationship between social obligations and the use of contraceptives among couples in Nigeria.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0   Introduction

This chapter seeks to explain the plan and approach for executing the research work. It covers the description of the study area, target population, source of data, sampling design and sample size, method of data collection, measurement of variables, method of data analysis and limitations of the study.

3.1   Description of the Study Area

Nigeria is a West African country located between latitudes 4°16' and 13°53' north and longitudes 2°40' and 14°41' east. It is extends from Gulf of Guinea in the south to the fringes of the Sahara Desert in the north. The country is bordered by Niger Republic and Chad in the north, Cameroon on the east, and the Republic of Benin on the west. With a population of 140,431,790 (NPC, 2006), Nigeria is the most populous country in Africa and the 14th largest in land mass (World Bank, 2012). Nigeria has great geographical diversity, with its topography characterized by two main land forms: lowlands and highlands. The uplands stretch from 600 to 1,300 meters in the North Central and the east highlands, with lowlands of less than 20 meters in the coastal areas. The lowlands extend from the Sokoto plains to the Borno plains in the North, the coastal lowlands of western Nigeria, and the Cross River basin in the east. The highland areas include the Jos Plateau and the Adamawa Highlands in the north, extending to the Obudu Plateau and the Oban Hills in the southeast. Other topographic features include the Niger-Benue Trough and the Chad Basin.

Nigeria has a tropical climate with wet and dry seasons. Its climate is influenced by the rain-bearing southwesterly winds and the cold, dry, and dusty northeasterly winds, commonly referred to as the Harmattan. The dry season occurs from October to March with a spell of cool,

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dry, and dusty Harmattan wind felt mostly in the north in December and January. The wet season occurs from April to September. Nigeria marked its centenary in 2014, having begun its existence as a nation-state in 1914 through the amalgamation of the northern and southern protectorates. Before this time, there were various cultural, ethnic, and linguistic groups, such as the Oyo, Benin, Nupe, Jukun, Kanem-Bornu, and Hausa-Fulani empires. These groups lived in kingdoms and emirates with sophisticated systems of government. There were also other strong ethnic groups such as the Igbos, Ibibios, Ijaws, and Tivs. The establishment and expansion of British influence in both northern and southern Nigeria and the imposition of British rule resulted in the amalgamation of the protectorates of southern and northern Nigeria in 1914.

3.2   Target Population

The category of people considered as eligible respondents in this study are couples from all the 6 geo-political regions of Nigeria, which was qualify and were used as a criterion for the study.

3.3   Sources of Data

3.3.1   Quantitative Data Source

This study analyses data from the couple's recode data of the NDHS datasets form 2003, 2008 and 2013. The three datasets was pooled together.

3.4.   Sample Design for the 2013 NDHS

The 2013 NDHS was nationally representative. The survey used as a sampling frame the list of enumeration areas (EAs) prepared for the 2006 Population Census of the Federal Republic of Nigeria, provided by the National Population Commission. It also provided population and

health indicator estimates. The sample design allowed for specific indicators to be calculated for each of the six zones, 36 states, and the Federal Capital Territory, Abuja.

All women age 15-49 who were either permanent residents of the households in the 2013 NDHS sample or visitors present in the households on the night before the survey were eligible to be interviewed. In a subsample of half of the households, all men age 15-49 that were either permanent residents of the households in the sample or visitors present in the households on the night before the survey were eligible to be interviewed. Also, a subsample of one eligible woman in each household was randomly selected to be asked additional questions regarding domestic violence.

3.4.1   Sample Design for the 2008 NDHS

The sample for the 2008 NDHS also provided population and health indicators at the national, zonal, and state levels. The sample design allowed for specific indicators, such as contraceptive use, to be calculated for each of the 6 zones and 36 states plus the Federal Capital Territory, Abuja. The sampling frame also consisted of the 2006 Population and Housing Census (NPC, 2006).

The primary sampling unit (PSU), referred to as a cluster for the 2008 NDHS, is defined on the basis of EAs from the 2006 EA census frame. The 2008 NDHS sample was selected using a stratified two-stage cluster design consisting of 888 clusters, 286 in the urban and 602 in the rural areas. A representative sample of **36,800** households was selected for the 2008 NDHS survey, with a minimum target of 950 completed interviews per state. In each state, the number of households was distributed proportionately among its urban and rural areas.

3.4.2   Sample Design for the 2003 NDHS

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The sample for the 2003 NDHS was designed to provide estimates of population and health indicators (including fertility and mortality rates) for Nigeria, including urban and rural areas, and six major subdivisions. A representative probability sample of 7,864 households was selected for the 2003 NDHS sample. The sample was selected in two stages. In the first stage, 365 clusters were selected from a list of enumeration areas developed from the 1991 population census. In the second stage, a complete listing of households was carried out in each selected cluster. Households were then systematically selected for participation in the survey. All women age 15-49 who were either permanent residents of the households in the 2003 NDHS sample or visitors present in the household on the night before the survey were eligible to be interviewed. In addition, in a subsample of one-third of all households selected for the survey, all men age 15-59 were eligible to be interviewed if they were either permanent residents or visitors present in the household on the night before the survey.

3.5   Measurement of Variables

The analysis examined the power relations and the use of contraceptives among couples in Nigeria. the general binary logistic regression model used for the multivariate analysis is:

$$Log = \beta_0 + \beta_1 x_1 + \beta_2 x_2 + \dots \beta_n x_n$$

Where p = probability of contraceptives use, when Y=1

x_1-x_n = predictor variables

$\beta_0, \beta_1 - \beta_n$ = regression coefficients

3.5.1. Dependent variable: Contraceptives Use

This study use the NDHS concepts of contraceptives use. there are about 13 different types of contraceptives as explained by the NHDS, these are pills, condoms, injectable, IUD, diaphragm, Female sterilization, periodic abstinence, withdrawal, Female condom, implants, Lactational

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Amenorrhea Method (LAM), other modern methods and standard days methods. Those couples who are not using any form of contraceptives are coded No = 0, and those who are currently using are coded Yes = 1.

3.5.1 Independent variables

<u>Socioeconomic characteristics</u>

Age of Couples: The age of couples was measured from the NDHS using the grouped age of respondents in five year age group 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, and 50-54. The age groups were calculated differently for male respondents and female respondents.

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

Level of Education: This is a categorical variable that is divided into four categories. These are No Education, Primary, Secondary and Higher Education. The levels of education of the couples were combined together as uneducated, where both of the respondents have no education, and were coded as 0. If both of them have Primary education and above, it was coded as 1 = both uneducated and where one of the respondents have no education, it was coded as 2 =either one of them is educated.

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

Wealth Index: The wealth index is a categorical variable, which was divided into three categories: Poor, Middle, Rich.

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

Couples decision making

This study measured the extent of couple's participation in household decision making in the following areas: (a) who makes decision on health care. (b) who makes the decision on family visits. Response for the couples were recoded as 1 "Wife alone", 2 " Husband alone", 3 "Joint decision"

Resource control variables

This was measured by the resource control among couples, which includes control over large household purchases and control over household's cash earnings. The responses were recoded as 1 "Wife alone", 2 " Husband alone", 3 "Joint decision"

Force Variables

Force variable for this study is measured in form of physical violence among couples. This reveals the level of intimacy between couples. The variable is measured under five hypothetical scenarios – this is if the husband is justified to hitting/beating his wife in the following situations. (a) if she goes out without telling him (b) if she neglects the children (c) if she argues with him (d) if she refuses to have sex with him (e) if she burns the food (NDHS, 2013). The responses are classified into three. If the respondents say No, it was coded as '0', if yes it was coded as '1'.

Social Obligation

Social obligation for this study was measured with the desired number of children of respondents and the number of living children they have this will greatly influence contraceptives use, couples who desire large number of children might want to show to the society that they are

fertile so they will not want to use any form of contraceptives, and those who have a large number of living children might also want to use a contraceptive method to prevent pregnancy. Number of living children is a continuous variable and desired number of children is also a continuous variable.

3.6   Data Processing and Analysis

The NDHS datasets from 2003, 2008 and 2013 couples recode was pooled, processed and analyzed using STATA application package (STATA 12.0). The data processing was necessary before the proper analysis in order to measure the variables in this study accurately as well as to make the analysis well presentable and easily interpretable. The tools for data manipulation were employed on the STATA application package to achieve this task.

Univariate analysis was carried out using tables of frequency distribution to describe the background characteristics of the respondents and the bivariate analysis was done using the chi-square (χ^2) and Cramer's V test to show the association between use of contraceptives and the various socio economic and demographic characteristics that are categorical variables in the datasets. Furthermore, binary logistic regression is used in the multivariate analysis to identify the strength of association and examine predictors of contraceptives use in the study area.

3.7   Limitations of the Study

This study has several limitations regarding data analysis and measurement of concepts. A shortcoming is that it is reliant on data from three different categories such as how makes final decision on family visits, household purchases and health care. This study also has limitations with respect to constructing an index for decision making on contraceptives use. The data from the

NDHS is defective in measuring who among the couples makes decision on contraceptives use. In addition, some independents variables are difficult to measure.

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.1: Distribution of Respondents by Socio-demographic Characteristics by weighted percentage

Characteristics	2003	2008	2013
Age of wife			
15-19	12.94	8.52	10.80
20-24	17.04	17.10	19.83
25-29	23.95	23.82	26.61
30-34	15.54	18.10	19.49
35-39	15.67	15.48	14.84
40-44	9.20	9.89	6.56
45+	5.66	7.10	1.87
Age of husband			
15-19	0.38	0.15	0.28
20-24	3.76	3.47	4.14
25-29	10.30	10.97	12.90
30-34	19.57	16.62	19.16
35-39	16.30	19.16	22.22
40-44	16.92	16.40	20.54
45-49	32.76	33.23	20.77
Couples Education			
Both Uneducated	32.00	30.94	30.87
Both Educated	41.47	48.35	48.22
Only one Educated	26.53	20.71	20.91
Couples Religion			
Christianity	15.52	38.03	33.83
Islam	6.15	56.09	61.87
Traditionalist	66.57	0.74	0.42
Different Religion	11.76	5.14	3.89
Wealth Index			
Poor	44.50	45.50	45.98
Moderate	21.62	18.03	17.05
Rich	33.88	36.47	36.96
Region			
North Central	14.35	14.30	14.99
North East	24.44	16.69	16.57
North West	35.77	32.31	39.55
South East	6.10	7.40	5.96

South South	9.80	10.62	9.33
South West	9.53	18.67	13.60
Decision Making			
Wife alone	2.01	1.41	1.38
Husband alone	73.28	48.10	54.05
Joint decisions	24.70	50.49	44.57
Resource Control			
Wife alone	67.84	65.76	67.95
Husband alone	11.34	14.01	10.80
Joint decisions	20.82	20.22	21.25
Force			
No	69.39	86.06	88.33
Yes	30.61	13.94	11.67
Desired No of Children			
1-2 Children	1.00	1.03	0.81
3-4 Children	13.50	19.58	18.82
5+ Children	85.51	79.39	80.37
No of living Children			
0	13.36	10.47	11.63
1-2	33.85	31.86	35.76
3-4	27.99	32.06	30.24
5+	24.79	25.60	22.36
Type of Residence			
Urban	28.64	30.99	34.07
Rural	71.36	69.01	65.93
Contraceptives Use			
No	89.02	85.35	85.46
Yes	10.98	14.65	14.54
Exposure to mass media			
Not exposed	94.02	92.74	95.13
Exposed	5.98	7.26	4.87

Source: NDHS, 2003, 2008 and 2013

In the 2003, 2008 and 2013 data set, women within the ages 25-29 have the highest percentages, 23.95%, 23.82% and 26.61% respectively, reasons why there are high percentage of women in this age group is because the age group have the highest number of women who are currently in their reproductive ages. Those who are educated and the non-educated women are in that age group, it is believed that even if a woman went through a university education, she's believed to have graduated from the university and then start child bearing at that age.

Meanwhile, women between the age 45 and above have the lowest percentage of women of reproductive ages in all the three data sets. Reasons for this reduction might be because of the exposure of so many of this women to maternal mortality during their active reproductive ages.

There are low percentage of men in the age group 15-19 and 20-24 in all the three data sets. The age group 15-19 have 0.38%, 0.15% and 0.28% of men respectively while the age group 20-24 have 3.76%, 3.47% and 4.14% respectively in all the three data sets. meanwhile there are large percentage of men in age group of 45-49. 2003 (32.76%), 2008 (33.23%) and 2013, (20.79%). This might be as a result of migration effect among early stages of their lives and their return back when they are getting old. According to Development Research on Migration, Globalization and Poverty (DRC), based on the 2000 Census Round, indicate that 1,041,284 Nigerian nationals live abroad (DRC, 2007) indicating high numbers of men migrant.

Couples who are both educated have the highest percentage of 41.47% in 2003, 48.35% in 2008 and 48.22% in 2013. This implies that a higher percentage of Nigerians have at least, a primary education. putting Nigeria's literacy rate at 51.1 % (World Bank, 2015)

The respondents were predominantly Muslims in all the three data sets. 2003 (66.57%), 2008 (56.09%) and 2013 (61.87%). The United Nation estimates supports this assertion that over 52 % of Nigerians are Muslims (UN, 2014).

According to the NDHS wealth index, 44.50% of the population belong to the poor category in 2003, 45.50 in 2008 and 45.98% in 2013 supporting the assertion of Nigerian Bureau of Statistics 2010 that 60.9 % of Nigerians live below the poverty line of $1 per day.

The North West region of Nigeria have the highest percentage of couples in all the three data sets. 2003, (35.77%), 2008 (32.31%) and 2013 (39.55%).

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Households where the husband alone makes decision makes up (73.28% in 2003, 2008 48.14%) and 2013 (54.05%). This is because Nigeria is a patriarchal society, where in most cases the wife depends on the husband for her needs and the cultural norms i.e. all the ethnic groups in Nigeria supports male dominance in the household.

In terms of the household resource control, in households where the women alone control the household resources makes up are 67.84%, 65.76% and 64.95% respectively in the three data sets. Reasons for this is because the man makes the money and are not always at home because the women's job is majorly to keep the house in most cases, they know what the needs of the household is, and makes decisions on what to spend the husband earnings on.

Women who reported that they are not exposed to beating by their husband are 69.39% in 2003, 86.06% in 2008 and 88.33% respectively.

1.00% of couples desire 1 to 2 living children in 2003, 2008 (1.03%) and 2013 (0.81%), a larger percentage of couples desire more than 5 children, 2003 (85.51%), 2008 (79.39%) and 2013 (80.37%).

Couples who have 3 to 4 living children make up 30% in 2003, 2008 (32.06%) and 2013 (30.24%).

Larger percentage of couples live in rural areas in the three datasets, 2003 (71.36%), 2008 (69.01%) and 2013 (65.93%).

Only 5.98% of the couples were exposed to family planning information on mass media in 2003, 2008 (7.26%) and 2013 (4.87%).

GRAPHICAL ANALYSIS

CONTRACEPTIVES USE OF COUPLES BY YEAR
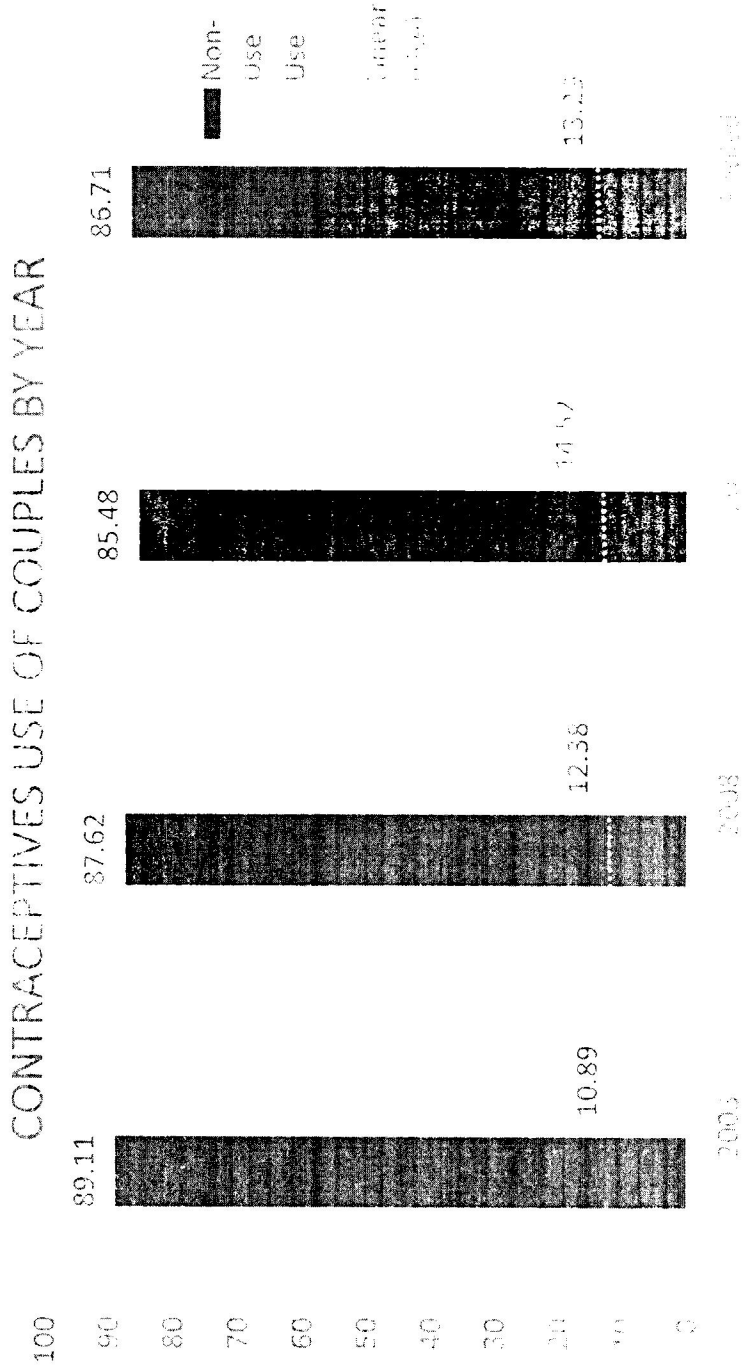
Source: NDHS, 2003, 2008 and 2013.

HOUSEHOLD DECISION MAKING

80			
70	73.28		
60			54.05
50		48.1 50.49	44.57
40			
30	24.7		
20			
10	2.01	1.41	1.38
0	2003	2008	2013

Wife   Husbans   Joints Decisions
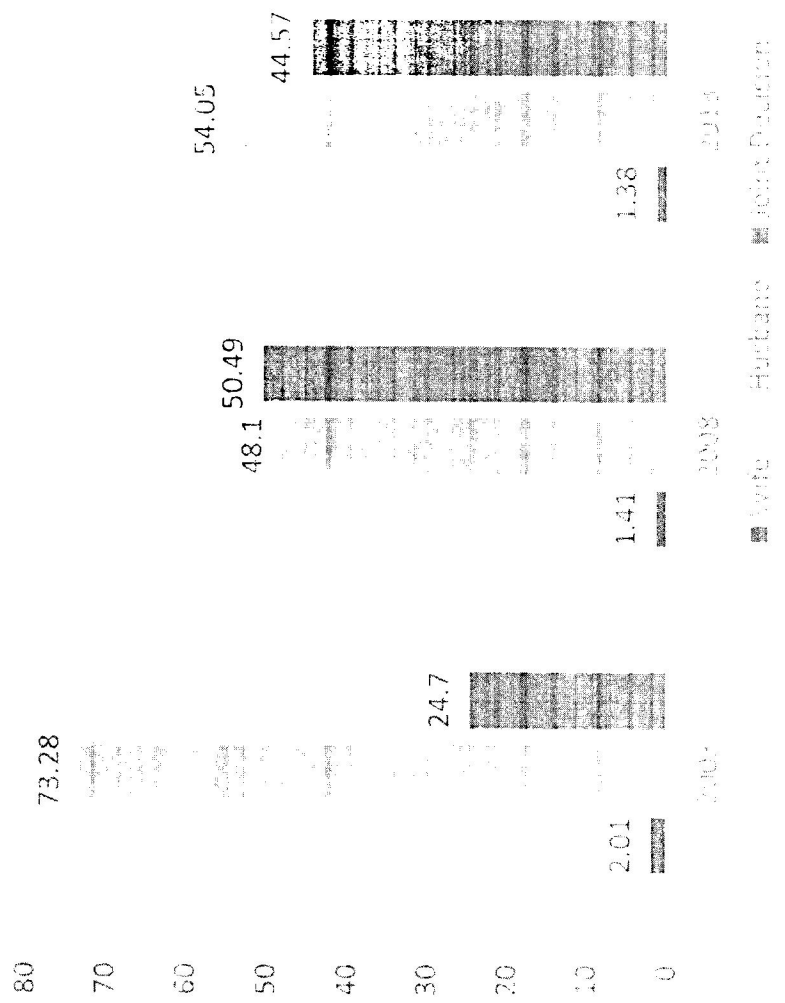
Source: NDHS, 2003, 2008 and 2013

4.2: Distribution of Respondents Socioeconomic characteristic by Contraceptive Use

Characteristics	Contraceptives Use							
	2003		2008		2013		Pooled	
	No	Yes	No	Yes	No	Yes	No	Yes
Age of wife								
15-19	3.76**	96.24	2.66*	97.34	2.39*	97.61	2.61*	97.39
20-24	10.00	90.00	7.47	92.53	8.37	91.63	8.06	91.94
25-29	11.48	88.52	11.63	88.37	13.50	86.50	12.56	87.44
30-34	10.38	89.62	16.07	83.93	18.43	81.57	16.94	83.06
35-39	14.59	85.41	17.29	82.71	21.71	78.29	19.19	80.81
40-44	16.52	83.48	17.98	82.02	24.20	75.80	20.29	79.71
45+	6.94	93.06	11.99	88.01	19.54	80.46	13.13	86.87
Age of husband								
15-19	0.00	100.00	0.00*	100.00	0.00*	100.00	0.00*	100.00
20-24	4.88	95.12	5.19	94.81	6.39	93.61	5.74	94.26
25-29	7.89	92.11	9.43	90.57	9.23	90.77	9.25	90.75
30-34	15.61	84.39	9.93	90.07	13.25	86.75	11.94	88.06
35-39	10.00	90.00	13.63	86.37	15.45	84.55	14.40	85.60
40-44	11.00	89.00	15.06	84.94	17.61	82.39	16.17	83.83

45-49	89.60	10.40	86.48	13.52	83.60	16.40	85.69	14.31
Couples Education								
Both Uneducated	97.59	2.41*	97.41	2.59*	98.49	1.51*	97.88	2.12*
Both Educated	79.42	20.58	76.74	23.26	74.03	25.97	75.52	24.48
Only one Educated	94.22	5.78	94.54	5.46	96.12	3.88	95.22	4.78
Couples Religion								
Christianity	78.65	21.35*	77.43	22.57*	71.97	28.03*	74.75	25.25*
Islam	79.17	20.83	94.13	5.87	94.38	5.62	94.15	5.85
Traditionalist	94.79	5.21	94.94	5.06	100.00	0.00	95.04	4.96
Different Religion	80.14	19.86	85.51	14.49	82.84	17.16	83.63	16.37
Wealth Index								
Poor	94.31	5.69*	95.66	4.34*	96.70	3.30*	96.04	3.96*
Moderate	92.64	7.36	90.54	9.46	87.12	12.88	89.12	10.88
Rich	80.59	19.41	72.93	27.07	71.32	28.68	72.61	27.39
Region								
North Central	89.64	10.36*	86.27	13.73*	82.01	17.99*	84.61	15.39*
North East	94.79	5.21	96.21	3.79	96.56	3.44	96.26	3.74
North West	95.91	4.09	97.14	2.86	96.21	3.79	96.59	3.41
South East	78.82	21.18	77.47	22.53	72.92	27.08	75.53	24.47
South South	76.54	23.46	74.04	25.96	74.68	25.32	74.49	25.51

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South West	71.64	28.36	68.50	31.50	61.26	38.74	65.30	34.70

Decision Making

Wife alone	88.46	11.54**	86.40	13.60*	59.26	40.74*	75.29	24.71*
Husband alone	90.64	9.36	91.97	8.03	93.25	6.75	92.47	7.53
Joint decisions	84.80	15.20	83.41	16.59	77.20	22.80	80.57	19.43

Resource Control

Wife alone	88.28	11.72	86.20	13.80*	84.59	15.41*	85.48	14.52*
Husband alone	83.61	16.39	86.42	13.58	83.91	16.09	85.18	14.82
Joint decisions	84.17	15.83	74.19	25.81	72.55	27.45	73.98	26.02

Force

No	86.32	13.68*	86.55	13.45*	84.41	15.59*	85.50	14.50*
Yes	95.44	4.56	93.95	6.05	93.13	6.87	93.82	6.18

Desired No of Children

1-2 Children	83.33	16.67*	80.68	19.32*	64.00	36.00*	73.71	26.29*
3-4 Children	74.83	25.17	72.25	27.75	70.23	29.77	71.34	28.66
5+ Children	91.42	8.58	90.77	9.23	89.42	10.58	90.19	9.81

No of living Children

0	99.28	0.72*	97.25	2.75*	98.07	1.93*	97.79	2.21*
1-2	89.66	10.34	89.75	10.25	87.34	12.66	88.55	11.45
3-4	89.10	10.90	84.31	15.69	80.58	19.42	82.85	17.15

5+							
83.92	16.08	85.18	14.82	83.15	16.85	84.20	15.80

Type of Residence

Urban	80.83	19.17*	77.19	22.81*	73.43	26.57*	75.54	24.46*
Rural	93.31	6.69	91.53	8.47	91.33	8.67	91.55	8.45

Exposure to mass media

Not exposed	90.11	9.89*	88.96	11.04*	86.61	13.39*	87.92	12.08*
Exposed	75.00	25.00	66.26	33.74	64.15	35.85	66.03	33.97

Source: NDHS, 2003, 2008 and 2013 *p-value<0.01 and **p-value<0.05; No symbol refers to no significant association

From the bivariate analysis, women who belong to the age group 40-44 use more of contraceptives than other women of reproductive ages, 2003 (16.52%), 2008 (17.98%) and 2013 (24.20%), when the dataset is pooled, (20.29%). The reason for the high contraceptives usage among this age group is because most women in this age group do not want another child, so they use contraceptives to prevent unwanted pregnancy.

There are variations in the contraceptives use of men among the age group. In 2003, men who belong to the age group 30-34 use more of contraceptives and they account for 15.61%, while in 2008 and 2013, men who belong to the age group 40-44 use more of contraceptives, 15.06% and 17.61% respectively.

Educated couples use more of contraceptives than couples who are not educated and couples where either the man or the woman is educated. The contraceptives use among educated couples makes up 20.58% in 2003, 2008 (23.26%) and 2013 (25.97%), this high usage of contraceptives among the educated couples is because of their exposure to the relevance of contraceptives, and moreover, couples who are educated often give birth to less children compared to uneducated couples. There is also a trend in the contraceptives use of educated couples over the years.

Although there are large percentage of couples who practice Islam, but there is a high prevalence of contraceptives use among the Christians. In the 2003 dataset, (21.35%) of Christian couples use contraceptives, 2008 (22.57%) and 2013 (28.03%). When the dataset is pooled, (25.25%).

There is a high prevalence of contraceptives use among also among rich couples, (19.41%) in 2003, (27.07%) in 2008 and (28.68%) in 2013. These couples because of their wealth status, have access to any form of contraceptives that suits them. More so, there is also a trend in the contraceptives use among rich couples.

The South West region, though with a low percentage of couples, have the highest percentage of couples using contraceptives, (28.36%) in the 2003 dataset, (31.50%) in 2008, and 2013, (34.70%). This explains why the total fertility rate of the region remain as low as 4.6 (NDHS, 2013).

The highest percentage of contraceptives usage is among household where the husband and wife makes joint decisions, (15.20%) of couples who make joint decisions use contraceptive in 2003, (16.59%) in 2008, and (22.80) in 2013. There is also a trend in the contraceptive use among couples who make joint decisions, which explains the influence of consensual ideology among the couples over the years.

In the same vein, couples who jointly control the household resources use more of contraceptives, (15.83%), (25.81%) and (27.45%) respectively in the three datasets.

Women who do not experience physical violence from their partners use more of contraceptives, (13.68%), (13.45%) and (15.59%) respectively, compared to women who experience physical violence from partners.

Couples who desire 1 to 2 children use more of contraceptives, 2003 (16.67%), 2008 (19.32%) and 2013, (36.00%). When the dataset is pooled, (24.46%).

Couples who have more than 4 living children use more of contraceptives, 16.08% in 2003, 14.82% in 2008 and 16.85% in 2013, compared to couples who have lesser children.

Couples who live in urban centers use more of contraceptives than couples who live in rural areas. 19.17% in 2003, 22.81% in 2008 and 26.57% in 2013.

Couples who are exposed to family planning information on mass media use more of contraceptives than couples who are not exposed to family planning information on mass media. (25%) in the 2003 dataset, (33.74%) in 2008 and (33.85%) in the 2013 dataset.

4.5: Chi-square and Cramer's V values of selected independent variables and contraceptives use

Characteristics	Contraceptives Use			
	2003	2008	2013	Pooled
	χ^2 and Cramer's V	χ^2 and Cramer's V	χ^2 and Cramer's V	χ^2 and Cramer's V
Decision	$Chi^2 (2) = 7.66**$	$Chi^2 (2) = 138.5*$	$Chi^2 (2) = 489.7*$	$Chi^2 (2) = 568.5*$
	0.08	0.12	0.24	0.17
Resource Control	$Chi^2 (2) = 2.21$	$Chi^2 (2) = 76.5*$	$Chi^2 (2) = 86.3*$	$Chi^2 (2) = 160.2*$
	0.05	0.13	0.12	0.12
Force	$Chi^2 (1) = 20.8*$	$Chi^2 (1) = 52.0*$	$Chi^2 (1) = 55.5*$	$Chi^2 (1) = 133.1*$
	-0.13	-0.07	-0.08	-0.08
Desired No of Children	$Chi^2 (2) = 37.6*$	$Chi^2 (2) = 371.7*$	$Chi^2 (2) = 420.1*$	$Chi^2 (2) = 832.9*$
	0.18	0.21	0.22	0.22
No of living children	$Chi^2 (3) = 23.5*$	$Chi^2 (3) = 124.3*$	$Chi^2 (3) = 185.9*$	$Chi^2 (3) = 320.8*$
	0.14	0.12	0.14	0.13

Source: NDHS, 2003, 2008 and 2013 *p-value<0.01 and **p-value<0.05. No symbol refers to no significant association

4.5 Logistic regression model showing the effect on the independent variables on Contraceptives use among couples, reported in Odds Ratio (Unadjusted and Adjusted)

Contraceptives use	Pooled		2003		2008		2013	
	OR	OR	OR	OR	OR	OR	OR	OR
Decisions (Wife)	1.0(RC)	1.0(RC)	1.0(RC)	1.0(RC)	1.0(RC)	1.0(RC)	1.0(RC)	1.0(RC)
Husband	0.28*	0.62*	1.12	1.55	0.56	1.15	0.16*	0.40*
Joint decisions	0.56*	0.72	1.31	1.38	0.85	1.11	0.43*	0.56*
Resources (Wife)	1.0(RC)	1.0(RC)	1.0(RC)	1.0(RC)	1.0(RC)	1.0(RC)	1.0(RC)	1.0(RC)
Husband	1.22*	1.05	1.72	1.83	1.14	0.97	1.28	1.05
Joint Decision	1.54*	1.30*	1.43	1.43	1.62*	1.19	1.49*	1.40*
Force (No)	1.0(RC)	1.0(RC)	1.0(RC)	1.0(RC)	1.0(RC)	1.0(RC)	1.0(RC)	1.0(RC)
Yes	0.52*	0.89	0.32*	0.66	0.51*	0.79	0.60*	0.95
Ideal no of children(1-2)	1.0(RC)	1.0(RC)	1.0(RC)	1.0(RC)	1.0(RC)	1.0(RC)	1.0(RC)	1.0(RC)
3-4 Children	0.82	0.69	0.38	0.35	1.18	0.92	0.64	0.58
5+	0.22 *	0.42*	0.10*	0.17	0.28	0.48*	0.20*	0.40*
No of living Children (0)	1.0(RC)	1.0(RC)	1.0(RC)	1.0(RC)	1.0(RC)	1.0(RC)	1.0(RC)	1.0(RC)
1-2 Children	5.14*	4.74*	9.88*	7.06*	3.41*	3.10*	7.52*	7.28*
3-4 Children	10.67*	9.96*	12.39*	9.82*	7.02*	6.88*	16.59*	15.27*
5+ Children	12.50*	14.59*	18.86*	16.82*	8.91*	1.41*	18.03*	21.86*

Source: NDHS, 2003, 2008 and 2013 *p-value<0.01 and p-value <0.05; No symbol refers to no significant association

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The datasets pooled together, households where the husband alone makes decision are 72% less likely to use contraceptives. In 2003, those households are 12% more likely to use a contraceptive, while in 2008, such households are 15% less likely to use a contraceptive and in 2013 such households are 84% less likely to use a contraceptive compared to households where the wife alone makes decisions. Moreover, households where joint decisions are made are 54% less likely to use contraceptives when pooled together, and in 2003 households where joint decisions are made are 31% more likely to use a contraceptive to use, while in 2008, such households are 15% less likely to use a contraceptive and in 2013, 57% less likely to use a contraceptive, compared to households where wife alone makes decisions.

Control of resources was more likely to determine contraceptives use among households where the husband alone makes decision by 22% when the datasets are pooled. In 2003, households where the husband makes the decisions are 72% more likely to use contraceptives, while in 2008, households where the husband alone makes the decision are 14% more likely to use contraceptives, and in 2013 households where the husband makes the decision alone 49 s more likely to use contraceptives, compared to households where the wife alone makes the decision. More so, households whose decision are jointly made are 54% more likely to use contraceptives with the datasets pooled together, while in the 2003 dataset, households where joint decisions are made are 43% more likely to use any contraceptive method. In 2008, such couples are 62% more likely to use contraceptives, and in 2013, they are 49% more likely to use contraceptives, compared to households where the wife alone makes such decisions.

In the pooled data, control of resources was more likely to determine contraceptives use among households where the husband alone makes decision by 5% and households where both couples make joint decisions are 30% more likely to use contraceptives.

Households where the use of force is pronounced are 11% less likely to use contraceptives when the dataset is pooled. Couples how desire 3 to 4 children are 37% less likely to use contraceptive, while couples who desire 5 children and above are 58% less likely to use a contraceptive, when the data are pooled. Couples who have living children are more likely to use contraceptives than couples who do not have any children.

4.4   HYPOTHESES TESTING

Hypothesis 1

Ho: There is no significant relationship between socioeconomic status (Education, wealth index, religion, place of residence, and Region) and the use of contraceptives among couples in Nigeria.

H1: There is a significant relationship between socioeconomic status (Education, wealth index, religion, place of residence, and Region) and the use of contraceptives among couples in Nigeria.

Decision

From the chi-square test, the relationship between education of respondents and contraceptives use is statistically significant in 2003(χ^2 (2) =82.0, p<0.05), same for 2008(χ^2 (2) =732.1, p<0.05), and for 2013 (χ^2 (2) =940.4, p<0.05), when the dataset is pooled, (χ^2 (2) =1800.0, p<0.05), from this, we can conclude that there is a significant relationship between education of respondents and their contraceptives use. Therefore we retain the alternative hypothesis.

The chi-square test also show that the relationship between wealth status of respondents is statistically significant with contraceptives use in 2003 (χ^2 (2) =47.6, p<0.05), this is the same for

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2008 (χ^2 (2)=777.2, p<0.05), and its also the same for 2013 (χ^2 (2)=894.2, p<0.05), when the three dataset is pooled, the result is also the same (χ^2 (2)=170.0, p<0.05). This signifies that the wealth status of the couples is a good predictor of contraceptives use. Therefore we retain the alternate hypothesis.

The religion of respondents is also statistically significant with contraceptives use in 2003 (χ^2 (3)=65.8, p<0.05), in 2008, (χ^2 (3)=484.3, p<0.05), and in 2013 (χ^2 (3)=789.2, p<0.05), when the dataset is pooled, (χ^2 (3)=130.0, p<0.05). From the test of hypothesis, it shows that there is a significant relationship between Religion of couples and contraceptives use. Therefore we retain the alternate hypothesis.

Place of residence of respondents, whether the couples live in urban or rural area is also statistically significant with contraceptives use in 2003 (χ^2 (1)=41.1, p<0.05), and in 2008 (χ^2 (1) =313.6, p<0.05), then in 2013 (χ^2 (3)=479.3, p<0.05), and when the dataset is pooled together (χ^2 (1)=841.0, p<0.05). This signifies that the place of residence of the respondents is good predictor to contraceptives use. Therefore we accept the alternate hypothesis.

Region of residence of couples is also statistically significant with contraceptives use in 2003 (χ^2 (5)=91.7 p<0.05), same in 2008 (χ^2 (5)=892.5, p<0.05), and then in 2013 (χ^2 (5)=110.0, p<0.05), this is the same when the dataset is pooled (χ^2 (5)=210.0, p<0.05). This is to say that the Region of residence of respondents is a good indicator for predicting contraceptives use. Therefore, we accept the alternate hypothesis.

Hypothesis 2:

H0: There is no significant relationship between couples' decision making and contraceptives use in Nigeria.

H1: There is a significant relationship between couples' decision making and contraceptives use in Nigeria.

Decision

From the Pearson chi-square test, the relationship between decision making of respondents and contraceptives use is statistically significant in 2003($\chi^2 (2) =7.66$, $p<0.05$), same for 2008($\chi^2 (2) =138.5$, $p<0.05$), and for 2013 ($\chi^2 (2) =489.7$, $p<0.05$), when the dataset is pooled, ($\chi^2 (2) =568.5$, $p<0.05$), from this, we can conclude that there is a significant relationship between couples decision making and the use of contraceptives. Therefore we fail to accept the null hypothesis. The Cramer's V test also supported with assertion (0.08, 0.12, 0.24 and 0.17) respectively, which signifies a positive association between decision making and use of contraceptives among couples.

Hypothesis 3

H0: There is no significant relationship between social obligations (Desired number of children and Number of living children) and the use of contraceptives among couples in Nigeria.

H1: There is a significant relationship between social obligations (Desired number of children and Number of living children) and the use of contraceptives among couples in Nigeria.

Decision

The Pearson chi-square test shows that there is a significant relationship between the desired number of children of couples and contraceptives use in 2003 (χ^2 (2) =37.6, p<0.05), same for 2008 (χ^2 (2) =371.7, p<0.05), and in 2013 (χ^2 (2) =420.1, p<0.05), and when the dataset is pooled (χ^2 (2) =832.9, p<0.05). This indicates that the desired number of children is significant with contraceptives use. Therefore, we fail to accept the null hypothesis. The Cramer's V test also supported this assertion (0.18, 0.21, 0.22 and 0.22), this implies that there is a positive association between desired number of children and contraceptives use among couples.

The Pearson chi-square test shows that there is also a significant relationship between number of living children of couples and contraceptives use in 2003 (χ^2 (3) =23.5, p<0.05), same for 2008 (χ^2 (3) =124.3, p<0.05), and in 2013 (χ^2 (3) =185.9, p<0.05), and when the data is pooled (χ^2 (3) =320.8, p<0.05). This indicates that the number of living children of couples is significant with contraceptives use. Therefore, we fail to accept the null hypothesis. The Cramer's V test supported this assertion (0.14, 0.12, 0.14 and 0.13) respectively. This implies that there is a positive association between number of living children and contraceptives use among couples. All these variables the bases for power dynamics as put forward by the Social Dominance Theory

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This study examined the power dynamics and the use of contraceptives among couples in Nigeria. The gendered power typology as expounded by Pratto and Walker (2004) was used as a theoretical framework in examining how different power bases predict the use of contraceptives among couples in the household. The Social Dominance theory and its four elements were useful in predicting contraceptives use among couples.

5.1   Summary

The study analyzed data from the couple's recode data of the NDHS datasets from 2003, 2008 and 2013. The three datasets were pooled together. The sample size for the three datasets pooled together is 17,934. 1,148 respondents were drawn from the 2003 NDHS dataset, 8,342 from the 2008 NDHS dataset, while 8,444 respondents were drawn from the 2013 NDHS dataset. Univariate analysis in this study was carried out using tables of frequency distribution to describe the background characteristics of the respondents and. Bivariate analysis was done using the chi-square (χ^2) and Cramer's V test to show the association between use of contraceptives and the various socio economic and demographic background characteristics that are categorical variables. Furthermore, Logit regression model was used in the multivariate analysis to determine the strength of association and identify predictors of contraceptives use of couples in the study area.

The study found support for some but not all of the power bases specified in the social dominance theory. Overall, this study found some support for two critical power bases such as 'control over resources' and 'consensual ideologies' in predicting contraceptives use among couples. However, that is when the datasets were pooled, it was hypothesized that household

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decision making have a significant relationship with contraceptives use. The chi-square test proved it. The Regression analyses also supported this hypothesis. The findings revealed that control over resources, particularly by both husband and wife, is consistently a significant predictor in all models. This particular finding suggests that control over resources can significantly shape the likelihood of contraceptives use among couples, when joint effort over controlling resources (e.g., household's cash earnings) was emphasized.

Other variables used to measure social obligations like number of living children and desired numbers of children were also statistically significant with contraceptives use of couples at bivariate level. The socioeconomic characteristics of respondents (age, education, religion, wealth status, place of residence, region, etc) of couples were also statistically significant with contraceptives use. Binary logistic regression analyses also provided support regarding the role of consensual ideologies. In traditional patriarchal society like Nigeria, consensual ideologies are reflected in women's degree of participation in domestic decision-makings. The analyses revealed that women's participation in domestic decision-making index encourages the use of contraceptives in all models, implying that women's greater participation in decision-making could increase the use of contraceptives.

Understanding that gender roles, structural factors, and cultural norms play a very crucial role in shaping power dynamics between couples, it will be fruitful to build a general model as well as the specific models for women and men based on an integrated couple dataset. More work is needed to be done to understand the associations of the Social Dominance Theory variables, couple's attitude and interest in use of contraception, using paired couple data by combining women's and men's modules of NDHS or other relevant surveys.

5.2 Conclusion

From the study, couples who are educated use more of contraceptives than the uneducated ones. We can infer therefore from this that education is a good predictor for the use of contraceptive. Other variables that also predict the use of contraceptives among couples include wealth status of couples, decision making, resource control, place of residence, exposure to mass media, desired number of children and number of living children. To reduce the rapid population growth of Nigeria, there should be an increase in the use of contraceptive among couples. Also there should be a form of reward for couples with fewer children, which could be in form of tax waiving.

5.3 Policy Recommendations

Decisions on resource control and decision-making plays a role similar to egalitarianism in some cases: these power bases have an important effect in increasing contraceptives use among couples.

- Research should provide a basis for the development of policies for male involvement in contraceptives use.

- Support should be provided for operations research at the country level to test relevant intervention programmes on the use of contraceptives.

- Society should mobilize support to put as much pressure on men as on women- research should identify the constraints on mobilizing men for contraceptives use.

- More research is needed on the socioeconomic impact of contraceptives use, in particular in young couples.

- Policy makers might consider educating the populace about the needs for family planning on different social media platforms in Nigeria, short radio drama or short movie could stimulate couples to make joint decisions on contraceptives use.

- Men's failure to support and promote contraceptives use in the household should be addressed, particularly where there might be constraints within the health system.

- Programme managers need to do more to promote couples' contraceptives use at rural and urban place of residence.

- Health providers need to educate couples about the benefits of contraceptives.

- Men and women can be addressed separately as part of the same campaign to increase support and acceptability of contraceptives.

- An optimal model of an integrated gender-sensitive programme and a long-term strategy for the implementation of contraceptives use is lacking and needs to be developed.

- Community based educational and communication campaigns on family planning and its usefulness should be promoted

In conclusion, while women have been the ultimate target for family planning programs in Nigeria, men, as potential clients, will increase contraceptives usage in the household.

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APPENDIX

MAP OF NIGERIA
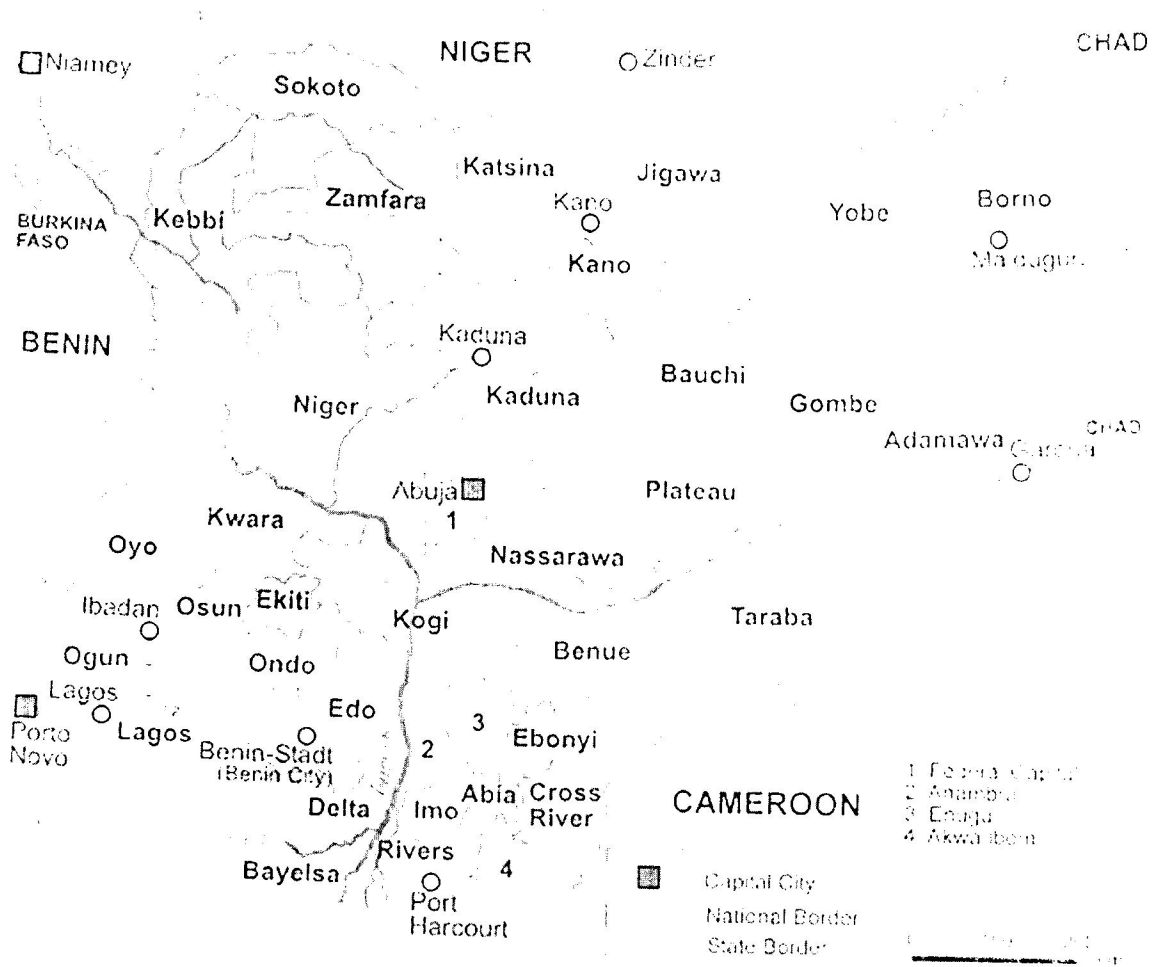
DO-FILE

```
set more off

set maxvar 15000

use "C:\Users\Mistu Rotex\Desktop\Files\Data Sets\ngir4bdt\NGCR4AFL.DTA", clear

gen str4 year="2003"

save dta03, replace

use "C:\Users\Mistu Rotex\Desktop\Files\Data Sets\2008 NDHS Data\NGCR52FL.DTA", clear

gen str4 year="2008"

append using dta03.dta

save dta0308, replace

use "C:\Users\Mistu Rotex\Desktop\Files\Data Sets\2013 NDHS DataSet\NGCR6AFL.DTA",
clear

gen str4 year="2013"

append using dta0308.dta

save dta030813, replace

encode year, gen(yr)



*********Generate weighting**************

gen wt=v005/100000
```

**********Decision making//Consensual ideology*************

recode v743a (1=1 wife) (4=2 husband) (2=3 "joint decision") (5/max=.). gen(newv743a)

recode v743b (1=1 wife) (4=2 husband) (2=3 "joint decision") (5/max=.). gen(newv743b)

recode v743d (1=1 wife) (4=2 husband) (2=3 "joint decision") (5/max=.). gen(newv743d)

gen decision=.

replace decision=1 if newv743a==1 | newv743b==1 | newv743d==1

replace decision=2 if newv743a==2 | newv743b==2 | newv743d==2

replace decision=3 if newv743a==3 | newv743b==3 | newv743d==3

la def decision 1 wife 2 husband 3 "joint decision"

la val decision decision

******Generate for resource control******************

recode v739 (1=1 wife) (4=2 husband) (2=3 "joint decision") (5/max=.). gen(newv739)

*********Generate for force******************

drop if v744a==8 | v744a==9

drop if v744b==8 | v744b==9

```
drop if v744c==8 | v744c==9

drop if v744d==8 | v744d==9

drop if v744e==8 | v744e==9

gen force=.

replace force=0 if v744a==0 | v744b==0 | v744c==0 | v744d==0 | v744e==0

replace force=1 if v744a!=0 & v744c!=0 & v744c!=0 & v744d!=0 & v744e!=0

la def force 0 No 1 Yes

la val force force
```

```
***************Generate for social obligation***************

recode v613 (0=.) (1/2=1 "1-2") (3/4=2 "3-4")(5/max=3 "5+"). gen(ideal)

recode v218 (0=0) (1/2=1 "1-2") (3/4=2 "3-4")(5/max=3 "5+"). gen(newv218)
```

```
******Socio-economic determinants******

***************Age of Women********************

recode v012 (min/19=1 "15-19")(20/24=2 "20-24")(25/29=3 "25-29")(30/34=4 "30-
34")(35/39=5 "35-39")(40/44=6 "40-44") (45/max=7 "45+"). gen(age1)
```

```
***************Age of Men****************************
```

recode mv012 (min/19=1 "15-19")(20/24=2 "20-24")(25/29=3 "25-29")(30/34=4 "30-34")(35 39=5 "35-39")(40/44=6 "40-44") (45/max=7 "45+"). gen(age2)

************Couples Educational Attainment********************

gen coupleedu=.

replace coupleedu=1 if v106==0&mv106==0

replace coupleedu=2 if v106!=0&mv106!=0

replace coupleedu=3 if v106==0&mv106!=0| v106!=0&mv106==0

la var coupleedu "Couples' educational attainment"

la def coupleedu 1 "both uneducated" 2 "both educated" 3 "only one educated"

la val coupleedu coupleedu

***************Couples Religion********************************

recode v130 (1 2=1 "christian") (3=2 "islam") (4 96=3 "traditional") (99=.). gen(newv130)

recode mv130 (1 2=1 "christian") (3=2 "islam") (4 96=3 "traditional") (99=.). gen(newmv130)

gen couplerel=.

replace couplerel=1 if newv130==1& newmv130==1

replace couplerel=2 if newv130==2& newmv130==2

replace couplerel=3 if newv130==3& newmv130==3

replace couplerel=4 if newv130!=newmv130

la var couplerel "Couples religion"

la def couplerel 1 "Christian" 2 "Islam" 3 "Traditional" 4 "Different religion"

la val couplerel couplerel

****************Generate Household Wealth
Index*********************************

recode v190 (1 2=1 "poor") (3=2 "average") (4 5=3 "rich"), gen(couple_wealth)

************Generate for exposure to mass media****************

replace v384a=. if v384a==9

replace v384b=. if v384b==9

replace v384c=. if v384c==9

gen exposure=.

replace exposure=0 if v384a==0 ' v384b==0 | v384c==0

replace exposure=1 if v384a!=0 & v384b!=0 & v384c!=0

la def exposure 0 "Not exposed" 1 " Exposed"

la val exposure exposure

************Generate for Contraceptives use*********************

recode v312 (0=0 No) (1/max=1 Yes). gen(contra)

*********************UNIVARIATE ANALYSIS****************************

*****************Table 1, Socioeconomic characteristics with weighted

pertcentage***********************

ta yr age1 [iw=wt]. row

ta yr age2 [iw=wt], row

ta yr coupleedu [iw=wt], row

ta yr couplerel [iw=wt], row

ta yr couple_wealth [iw=wt], row

ta yr v024 [iw=wt]. row

ta yr v025 [iw=wt]. row

ta yr contra [iw=wt]. row

ta yr exposure [iw=wt]. row

********************Table 2. Independent Variable with weighted

percentage***************

***********Decision making*********

ta yr decision [iw=wt]. row

***********Resource control and force********

ta yr newv739 [iw=wt], row

ta yr force [iw=wt], row

*********social obligation*********

ta yr ideal [iw=wt], row

ta yr newv218 [iw=wt], row

*****************BIVARIATE ANALYSIS*****************

ta age1 contra, row chi

bysort yr: ta age1 contra, row chi

ta age2 contra, row chi

bysort yr: ta age2 contra, row chi

ta coupleedu contra, row chi

bysort yr: ta coupleedu contra, row chi

ta couplerel contra, row chi

bysort yr: ta couplerel contra, row chi

ta couple_wealth contra, row chi

bysort yr: ta couple_wealth contra, row chi

ta v024 contra, row chi

bysort yr: ta v024 contra, row chi

ta v025 contra, row chi

bysort yr: ta v025 contra, row chi

*****************************Dependent variable*************

ta decision contra, row chi

bysort yr: ta decision contra, row chi

ta newv739 contra, row chi

bysort yr: ta newv739 contra, row chi

ta force contra, row chi

bysort yr: ta force contra, row chi

ta ideal contra, row chi

bysort yr: ta ideal contra, row chi

ta newv218 contra, row chi

bysort yr: ta newv218 contra, row chi

ta exposure contra, row chi

bysort yr: ta exposure contra, row chi

********************Multivariate**********************

xi: logit contra i.decision i.newv739 i.force i.ideal i.newv218, or

bysort yr: logit contra i.decision i.newv739 i.force i.ideal i.newv218, or

xi: logit contra i.decision i.newv739 i.force i.ideal i.newv218 i.couplerel i.coupleedu
i.couple_wealth i.v024 i.v025, or

bysort yr: logit contra i.decision i.newv739 i.force i.ideal i.newv218 i.couplerel i.coupleedu
i.couple_wealth i.v024 i.v025, or

*********************End of Do-File****************************

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