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Original Research Article

Partner characteristics, fertility preferences and contraceptive use among married women in Nigeria

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ABSTRACT

Background: Contraceptive use remains low in Nigeria, and decisions regarding family planning are often influenced by partner dynamics and fertility preferences. Understanding how these factors shape contraceptive behavior is essential for designing effective interventions.
Methods: This study used data from the 2018 Nigeria Demographic and Health Survey (NDHS), including 27,841 currently married women aged 15-49 years. The outcome variable was current contraceptive use (any method vs non-use). Descriptive statistics summarized respondents' characteristics. Bivariate analysis assessed associations between partner characteristics, fertility preferences, and contraceptive use. Multivariable logistic regression was used to identify factors independently associated with contraceptive use, adjusting for socio-demographic and household variables.
Results: Contraceptive use among married women was low. Women whose partners had higher levels of education were more likely to use contraceptives. Partner fertility preference was a strong predictor; contraceptive use increased when partners desired fewer children. Women who had achieved their desired family size or had more children than desired had higher odds of contraceptive use. Similarly, the number and sex composition of living children were associated with contraceptive behaviour. Women not living with their partners had lower likelihood of contraceptive use. These associations remained significant after adjusting for confounders.
Conclusions: Partner characteristics and fertility preferences play a critical role in shaping contraceptive use in Nigeria. Interventions aimed at increasing contraceptive uptake should incorporate male involvement and address couple-level decision-making dynamics, alongside improving access to services.

Keywords: Contraceptive use, Fertility preferences, Nigeria, Partner influence

INTRODUCTION

Access to effective family planning is a fundamental component of reproductive health and a key strategy for reducing maternal and child mortality. Contraceptive use enables individuals and couples to achieve their desired family size, prevent unintended pregnancies, and improve overall health outcomes.[1,2] Despite global progress, contraceptive uptake remains low in many low- and middle-income countries, particularly in Sub-Saharan Africa, where unmet need for family planning continues to be a major public health concern.[3-5]

Nigeria, the most populous country in Africa, faces significant challenges in reproductive health. Evidence from NDHS indicates that contraceptive use among married women remains low, while unmet need for family planning persists at considerable levels.[6] This gap reflects a complex interplay of socio-demographic, cultural, and structural factors influencing reproductive health behaviors. While previous studies have extensively examined the role of education, wealth, and access to services, increasing attention has been given to the role of partner dynamics and fertility preferences in shaping contraceptive use.[7,9]

In many settings, particularly in Sub-Saharan Africa, reproductive decisions are not made solely by women but are often influenced by their partners. Studies have shown that partner characteristics, including education level and fertility preferences, play a significant role in determining contraceptive use.[10-12] Women whose partners support family planning or desire fewer children are more likely to adopt contraceptive methods, while disagreement between partners can reduce contraceptive uptake.[13,14] Additionally, fertility preferences, including the desire for more children and the achievement of ideal family size, are strong determinants of contraceptive behavior.[15,16]

However, despite growing evidence on the importance of partner influence, there remains a need for context-specific analyses that examine how partner characteristics and fertility preferences jointly shape contraceptive use in Nigeria. Understanding these dynamics is essential for designing interventions that go beyond individual-level factors and address couple-level decision-making processes. Therefore, this study aimed to examine the influence of partner characteristics and fertility preferences on contraceptive use among married women in Nigeria using data from the 2018 Nigeria Demographic and Health Survey.

METHODS

Study design and data source

This study is a cross-sectional analysis based on secondary data obtained from the 2018 Nigeria Demographic and Health Survey (NDHS). The NDHS is a nationally representative survey that collects information on population, health, and nutrition indicators using a standardized methodology. The survey was implemented by the National Population Commission (NPC) in collaboration with ICF and other partners. The NDHS employed a two-stage stratified cluster sampling technique based on the 2006 population census sampling frame. In the first stage, enumeration areas were selected, followed by the selection of households in the second stage. The survey covered all 36 states and the Federal Capital Territory, stratified by urban and rural residence. The study population consisted of 27,841 currently married women aged 15-49 years who were included in the individual women's dataset.

Study variables

Outcome variable

The outcome variable was current contraceptive use, categorized as: using any method (modern or traditional) and not using any method.

Independent variables

The key independent variables focused on partner characteristics and fertility preferences, including: partner's education level, partner's fertility preference, living with partner, woman's fertility preference, difference between actual and ideal number of children, number of living sons and daughters, age at first cohabitation. Additional control variables included: age, educational level, religion, ethnicity, household wealth status, place of residence (urban/rural), region.

Statistical analysis

Data analysis was conducted using SPSS version 24. Descriptive statistics were used to summarize the characteristics of the study population. Bivariate analysis (Chi-square test) was performed to assess the association between independent variables and contraceptive use. Variables that were statistically significant at the bivariate level were included in the multivariable logistic regression model. Two models were fitted: Model 1 included key partner characteristics and fertility preference variables, while Model 2 adjusted for socio-demographic and household factors. Results were presented as odds ratios (OR) and adjusted odds ratios (AOR) with 95% confidence intervals (CI). A p value of <0.05 was considered statistically significant.

RESULTS

Characteristics of respondents

A total of 27,841 currently married women aged 15-49 years were included in the analysis. The mean age of respondents was approximately 32 years. Most women had no formal education (45.2%), and the largest ethnic group was Hausa (30.8%). The majority of respondents were Muslims (58.3%) and resided in rural areas (64.2%). Over one-third of women (34.3%) reported entering their first union at age 15 years or younger. Most women (91.1%) were living with their partners, and a large proportion (79.9%) had fewer children than their desired number (Table 1).

Bivariate analysis of factors associated with contraceptive use

Bivariate analysis showed that several factors were significantly associated with contraceptive use. Women who were using contraceptives were slightly older than non-users (mean age: 33.65 vs 31.63 years, $p<0.001$). Contraceptive use increased significantly with higher levels of education, rising from 5.3% among women with no education to 26.4% among those with secondary or higher education ($p<0.001$). Significant differences were also observed across ethnic and religious groups. Contraceptive use was lowest among Hausa women (6.2%) and highest among Yoruba women (32.2%) ($p<0.001$). Similarly, Christian women had a higher prevalence of contraceptive use (25.3%) compared to Muslim women (8.7%) ($p<0.001$).

Fertility-related factors were strongly associated with contraceptive use. Women who did not desire more children had higher contraceptive use (25.4%) compared to those who wanted more children (11.6%) (p<0.001). In addition, women with a higher number of living children, sons, and daughters were more likely to use contraceptives (p<0.001). Women who had achieved or exceeded their desired number of children had significantly higher contraceptive use (30.2%) compared to those with fewer children than desired (12.0%) (p<0.001).

Table 1: Characteristics of respondents among currently married women aged 15-49 years in Nigeria, NDHS 2018 (n=27,841).

Variable	Category	Number	Percent
Age in years	15-19	1,746	6.3
	20-24	4,092	14.7
	25-29	5,728	20.6
	30-34	5,132	18.4
	35-39	4,652	16.7
	40-44	3,444	12.4
	45-49	3,047	10.9
Education level	No education	12,580	45.2
	Primary	4,606	16.5
	Secondary	8,120	29.2
	Higher	2,535	9.1
Ethnicity	Hausa	8,567	30.8
	Other	7,148	25.7
	Igbo	3,746	13.4
	Yoruba	3,117	11.2
	Fulani	2,532	9.1
	Kanuri/Beri	645	2.4
	Tiv	635	2.2
	Ijaw/Izon	623	2.2
	Ibibio	407	1.5
	Igala	276	1.0
	Ekoi	122	0.4
	Don't know	23	0.1
Religion	Islam	16,242	58.3
	Other Christian	8,832	31.7
	Catholic	2,550	9.2
	Other	113	0.4
	Traditional religion	104	0.4
Age at first cohabitation	≤15	9,540	34.3
	16-17	5,189	18.6
	18-19	3,824	13.7
	20-21	2,840	10.2
	≥22	6,448	23.2
Residing with partner	Living with partner	25,364	91.1
	Living separately	2,477	8.9
	Declared infecund	757	2.7
	Sterilized (self/partner)	68	0.3
Actual-ideal number of children gap	Fewer than desired	22,242	79.9
	Equal to desired	2,465	8.9
	More than desired	2,316	8.3
	Non-numeric response	818	2.9
Number of living children (n = 26,022)	None	297	1.1
	1-2	8,561	32.9
	3-4	8,428	32.4
	≥5	8,736	33.6
Number of sons alive (26,022)	None	5,960	21.4

Continued.

Variable	Category	Number	Percent
	1-2	14,141	50.8
	3-4	6,316	22.1
	≥5	1,424	5.1
Number of daughters alive (26,022)	None	6,353	22.8
	1–2	14,220	51.1
	3-4	5,860	21.0
	≥5	1,408	5.1
Fertility preference	Wants within 2 years	9,332	33.5
	Wants after 2+ years	7,987	28.7
	Wants no more	6,985	25.1
	Undecided	1,670	6.0
	Timing uncertain	1,042	3.7
	Declared infecund	757	2.7
	Sterilized (self/partner)	68	0.3
Partner's fertility preference (n = 27,773)	Partner wants more	12,383	44.6
	Both want same	10,994	39.6
	Don't know	2,967	10.7
	Partner wants fewer	1,429	5.1
Place of residence	Rural	17,872	64.2
	Urban	9,969	35.8
Region	North-West	8,098	29.1
	North-East	5,587	20.1
	North-Central	5,192	18.6
	South-West	3,250	11.7
	South-East	3,117	11.2
	South-South	2,597	9.3
Household wealth index	Poorest	6,314	22.7
	Poorer	6,100	21.9
	Middle	5,566	20.0
	Richer	5,196	18.7
	Richest	4,665	16.8

Partner characteristics also showed significant associations. Contraceptive use increased with partner education, from 4.7% among women whose partners had no education to 23.2% among those whose partners had secondary or higher education (p<0.001). Women whose partners desired fewer children had higher contraceptive use compared to those whose partners wanted more children (p<0.001). However, residing with a partner was not significantly associated with contraceptive use (p=0.367). Place of residence, region, and household wealth status were also significantly associated with contraceptive use (p<0.001), with higher use observed among urban residents and women from wealthier households (Table 2).

Table 2: Bivariate association between explanatory variables and contraceptive use among married women in Nigeria, NDHS 2018 (n=27,841).

Variable	Category	Contraceptive use		P value
		Not using, N (%)	Using, N (%)	
Age (years)	Mean±SD	31.63 ± 8.82	33.65±7.31	<0.001**
Education level	No education	11,917 (94.7)	663 (5.3)	<0.001*
	Primary	3,782 (82.1)	824 (17.9)	
	Secondary or higher	7,842 (73.6)	2,813 (26.4)	
Ethnicity	Hausa	8,036 (93.8)	531 (6.2)	
	Igbo	2,741 (73.2)	1,005 (26.8)	
	Yoruba	2,113 (67.8)	1,004 (32.2)	
	Other	10,651 (85.8)	1,760 (14.2)	
Religion	Islam	14,835 (91.3)	1,407 (8.7)	<0.001*

Continued.

Variable	Category	Contraceptive use		P value
		Not using, N (%)	Using, N (%)	
	Christian	8,501 (74.7)	2,881 (25.3)	
	Other	205 (94.5)	12 (5.5)	
Fertility preference	Wants more children	16,227 (88.4)	2,134 (11.6)	<0.001*
	Wants no more	5,209 (74.6)	1,776 (25.4)	
Number of living children	Mean±SD	3.71±2.23	3.90 ± 1.91	<0.001**
Number of living sons	Mean±SD	1.74±1.51	2.02 ± 1.37	<0.001**
Number of living daughters	Mean±SD	1.69±1.49	1.86 ± 1.36	<0.001**
Actual-ideal number of children gap	Has equal or more	3,335 (69.8)	1,446 (30.2)	<0.001*
	Has less	19,577 (88.0)	2,665 (12.0)	
Living with partner	Living with partner	21,462 (84.6)	3,902 (15.4)	0.367*
	Living separately	2,079 (83.9)	398 (16.1)	
Partner education	No education	9,250 (95.3)	457 (4.7)	<0.001*
	Primary	3,574 (84.1)	678 (15.9)	
	Secondary or higher	10,379 (76.8)	3,130 (23.2)	
Partner fertility preference	Wants more children	11,165 (90.2)	1,218 (9.8)	<0.001*
	Wants fewer children	12,376 (80.1)	3,082 (19.9)	
Place of residence	Rural	15,963 (89.3)	1,909 (10.7)	<0.001*
	Urban	7,578 (76.0)	2,391 (24.0)	
Region	North-West	7,591 (93.7)	507 (6.3)	<0.001*
	North-Central	4,314 (83.1)	878 (16.9)	
	North-East	5,001 (89.5)	586 (10.5)	
	South-East	2,326 (74.6)	791 (25.4)	
	South-South	2,112 (81.3)	485 (18.7)	
	South-West	2,197 (67.6)	1,053 (32.4)	
Household wealth index	Poor	11,564 (93.2)	850 (6.8)	<0.001*
	Middle	4,747 (85.3)	819 (14.7)	
	Rich	7,230 (73.3)	2,631 (26.7)	

*Chi-square **t-test

Multivariable logistic regression analysis

Multivariable logistic regression analysis identified several factors independently associated with contraceptive use. Age was inversely associated with contraceptive use (aOR=0.95; 95% CI: 0.94-0.96, p<0.001). Education was a strong predictor, with women having primary (aOR=1.92; 95% CI: 1.66-2.22) and secondary or higher education (aOR=2.48; 95% CI: 2.14-2.87) showing significantly higher odds of contraceptive use compared to those with no education (p<0.001). Ethnicity and religion were also significant predictors. Compared to Hausa women, Igbo (aOR=1.64), Yoruba (aOR=1.77), and other ethnic groups (aOR=1.37) had higher odds of contraceptive use (p<0.001). Christian and other women had significantly higher odds of contraceptive use compared to Muslims (aOR=1.77; p<0.001).

Fertility-related factors remained strongly associated with contraceptive use. Women who did not want more children had higher odds of contraceptive use (aOR=1.57; 95% CI: 1.40-1.77). Increases in the number of living sons (aOR=1.32) and daughters (aOR=1.23) were also associated with higher contraceptive use (p<0.001). Similarly, women who had achieved or exceeded their desired number of children were more likely to use contraceptives (aOR=1.49; p<0.001).

Partner characteristics were significant predictors. Women whose partners had primary (aOR=1.41) or secondary or higher education (aOR=1.67) had higher odds of contraceptive use. Additionally, women whose partners desired fewer children had higher odds of contraceptive use (aOR=1.34; p<0.001). In contrast, women living separately from their partners had lower odds of contraceptive use (aOR=0.71; p<0.001).

Urban residence was associated with lower odds of contraceptive use compared to rural residence (aOR=0.80; p<0.001). Regional differences were also observed, with women in the South-East (aOR=0.65) and South-South (aOR=0.60) having lower odds compared to those in North-Central (p<0.05). Household wealth status showed a strong positive association. Women from middle (aOR=1.35) and rich households (aOR=1.95) had significantly higher odds of contraceptive use compared to those from poorer households (p<0.001) (Table 3).

Table 3: Multivariable logistic regression analysis of factors associated with contraceptive use among married women in Nigeria, NDHS 2018 (n=27,841).

Variable	Category	aOR	95% CI	P value
Age (years)		0.95	0.94-0.96	<0.001
Education level	No education	Ref		
	Primary	1.922	1.66-2.22	<0.001
	Secondary or higher	2.48	2.14-2.87	<0.001
Ethnicity	Hausa	Ref		
	Igbo	1.64	1.29-2.09	<0.001
	Yoruba	1.77	1.43-2.19	<0.001
	Other	1.37	1.16-1.61	<0.001
Religion	Islam	Ref		
	Christian/other	1.77	1.58-1.99	<0.001
	Others	0.47	0.25-0.87	0.017
Fertility preference	Wants more children	Ref		
	Wants no more	1.57	1.40-1.77	<0.001
Number of living sons		1.32	1.27-1.36	<0.001
Number of living daughters		1.23	1.19-1.27	<0.001
Actual-ideal number of children gap	Has less	Ref		
	Has equal or more	1.49	1.33-1.67	<0.001
Living with partner	Living with partner	Ref		
	Living separately	0.71	0.62-0.81	<0.001
Partner education	No education	Ref		
	Primary	1.41	1.19-1.66	<0.001
	Secondary or higher	1.67	1.43-1.94	<0.001
Partner fertility preference	Wants more children	Ref		
	Wants fewer children	1.34	1.23-1.46	<0.001
Place of residence	Rural	Ref		
	Urban	0.80	0.73-0.87	<0.001
Region	North-Central	Ref		
	North-West	1.01	0.86-1.22	0.877
	North-East	0.70	0.94-1.33	0.197
	South-East	0.65	0.55-0.90	0.006
	South-South	0.60	0.54-0.80	<0.001
	South-West	1.22	0.98-1.52	0.070
Household wealth index	Poor	Ref		
	Middle	1.35	1.19-1.53	<0.001
	Rich	1.95	1.72-2.21	<0.001

aOR: Adjusted odds ratio; CI: Confidence interval

DISCUSSION

This study examined the influence of partner characteristics and fertility preferences on contraceptive use among married women in Nigeria. The findings demonstrate that contraceptive use remains low and is shaped by a combination of socio-demographic, fertility-related, and partner-level factors. Importantly, the results highlight that contraceptive behavior is not solely an individual decision but is strongly influenced by couple dynamics and reproductive intentions.

Consistent with previous studies, education was a strong predictor of contraceptive use, with higher levels of education significantly increasing the likelihood of use.[15,17,18] Educated women are more likely to have better knowledge of contraceptive methods, greater autonomy in decision-making, and improved access to health services, all of which contribute to higher uptake.[20,21] Similarly, partner's education was positively associated with contraceptive use, supporting evidence that male education enhances support for family planning and facilitates informed reproductive decision-making within couples.[11-12,22-23]

Fertility preferences emerged as one of the most important determinants of contraceptive use. Women who did not desire more children and those who had achieved or exceeded their desired family size were more likely to use contraceptives. This finding aligns with studies showing that the demand for contraception increases as women approach or reach their fertility goals.[7,13,24-26] In addition,

the number and sex composition of children were significantly associated with contraceptive use. The positive association between the number of living sons and daughters and contraceptive use suggests that women tend to adopt contraception after achieving their desired family size or preferred gender composition, particularly in settings where gender preference exists.[26,27]

Partner dynamics also played a critical role. Women whose partners desired fewer children were more likely to use contraceptives, consistent with literature indicating that agreement between partners on fertility preferences increases contraceptive uptake.[11,12] Conversely, women living separately from their partners had lower odds of contraceptive use. This may reflect reduced frequency of sexual exposure or limited communication regarding reproductive decisions, which can influence contraceptive behavior. These findings reinforce the importance of considering the relational context in family planning programs.[28,29]

Socio-cultural factors, including religion and ethnicity, were also significantly associated with contraceptive use. Consistent with previous research, Muslim women were less likely to use contraceptives compared to their Christian counterparts.[30,31] This may be related to prevailing cultural norms, fertility expectations, and perceptions surrounding family planning. Similarly, ethnic differences in contraceptive use may reflect variations in cultural practices, family structures, and regional disparities in access to services.[17,32]

Household and structural factors further influenced contraceptive use. Women residing in wealthier households were more likely to use contraceptives, which is consistent with global evidence linking higher socioeconomic status with improved access to healthcare services.[33,34] Regional differences were also observed, highlighting persistent geographic inequalities in access to and utilization of family planning services in Nigeria.[35] These disparities underscore the need for targeted interventions that address both supply- and demand-side barriers.

Overall, the findings of this study indicate that contraceptive use among married women in Nigeria is shaped by a complex interplay of individual, partner, and structural factors. The strong influence of partner characteristics and fertility preferences suggests that family planning programs should move beyond women-centered approaches and incorporate strategies that engage men and promote couple-based decision-making.[11-13]

From a policy perspective, increasing contraceptive use in Nigeria requires interventions that address both access and social norms. Efforts should focus on improving education, expanding access to family planning services, and addressing misconceptions about contraceptive methods. In addition, promoting male involvement and enhancing communication between partners may significantly improve contraceptive uptake. These strategies are essential for achieving reproductive health goals and align with the broader objectives of the sustainable development goals, particularly those related to health and gender equality.[36]

This study has several strengths. First, it utilized data from the 2018 Nigeria Demographic and Health Survey, which is nationally representative and allows for generalization of findings to married women of reproductive age in Nigeria. The large sample size enhances the statistical power and reliability of the estimates. Additionally, the study provides a focused analysis of partner characteristics and fertility preferences, offering important insights into couple-level dynamics that are often underexplored in family planning research. The use of multivariable logistic regression further strengthens the findings by adjusting for potential confounding factors.

However, some limitations should be acknowledged. The cross-sectional nature of the NDHS data limits the ability to establish causal relationships, and findings should therefore be interpreted as associations. The use of self-reported data may introduce recall and social desirability bias, particularly for sensitive topics such as contraceptive use and fertility preferences. Furthermore, some important variables, such as quality of family planning services, partner communication, and cultural norms, were not directly measured in the dataset. Residual confounding may also be present despite adjustment for multiple variables. Finally, the analysis was restricted to currently married women, which limits the generalizability of the findings to unmarried or sexually active women outside of marriage.

CONCLUSION

This study demonstrates that contraceptive use among married women in Nigeria is influenced by a complex interplay of partner characteristics, fertility preferences, and socio-demographic factors. Partner education and fertility preferences were significant predictors of contraceptive use, highlighting the importance of couple-level decision-making in reproductive health behavior. Women who had achieved their desired family size or whose partners preferred fewer children were more likely to use contraceptives, emphasizing the role of fertility intentions in shaping demand for family planning.

The findings suggest that interventions aimed at increasing contraceptive uptake should move beyond individual-focused approaches and incorporate strategies that actively engage men and address couple dynamics. Strengthening female education, improving access to family planning services, and addressing socio-cultural barriers remain essential. In addition, programs that promote communication between partners and align reproductive goals may enhance contraceptive use. Addressing these factors is critical for reducing unmet need for family planning, preventing unintended pregnancies, and

improving maternal and child health outcomes. These efforts are also essential for achieving global reproductive health targets, including the Sustainable Development Goals related to health and gender equality.

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