

Factors Associated with Joint Decision on Contraceptive Use Among Currently Married Women In Nigeria: Evidence From Repeated Cross-Sectional, Nationally Representative Data

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Abstract

Background: While joint decisions among partners have been associated with a higher likelihood of using modern contraceptives, limited empirical evidence exists in factors explaining joint decision-making among partners. Hence, this study examines factors associated with joint decisions on contraceptive use among married women in Nigeria.

Methods: Secondary analysis of the three most recent repeated cross-sectional nationally representative surveys by pooling data from three successive Demographic and Health Surveys (individual recode) datasets for the years 2008, 2013, and 2018. Analysis of data was restricted to women currently married and living with their partner, having at least one surviving child in the age group 20-40 years. The weighted sample size for 2018, 2013, and 2008 was (18,016, 16,807, and 14,410) making a total sample of 49,233 women. Binary logistic regression was performed.

Result: Factors that consistently predicted joint decisions on the use of modern contraceptives across all three data points are region of residence, education, religion, household wealth, and autonomy. **Conclusion:** The implication of our findings is that any intervention seeking to promote joint contraceptive use among couples must take into consideration the socioeconomic, cultural, and religious barriers that adversely affect women ability to make informed decisions on their reproductive health.

Keywords: Joint decision, Modern contraceptives, women

Introduction

The decline in fertility in sub-Saharan Africa has been slow over time as the region is still characterized by high fertility. Empirical evidence suggests the region has witnessed a decline in fertility level from 6.3 to 4.6 between 1990 and 2019 relative to a global fertility decline of 3.2 in 1990 to 2.5 in 2019 (UNDESA, 2020). Similarly, within the same period, the use of modern contraceptives among women of reproductive age has increased from 13% to 29% (UNDESA, 2020). Notwithstanding the improvement witnessed between 1990 and 2019 in sub-Saharan Africa, Total Fertility Rate (TFR) in the continent remains high, thereby contributing significantly to the high population in the region. In Nigeria, the fertility level remains high (TFR=5.0), with a corresponding low modern contraceptive prevalence (mCPR) among currently married women 15-49 years, estimated at 18% (NBS and UNICEF, 2022). This is far from the Federal Government of Nigeria's target of 27% by the year 2020 (NPC and ICF International, 2019). Three years down the line, the goal of achieving a modern contraceptive prevalence of 27% seems far from reality.

Vast number of studies (Adebawale et al., 2013; Ahinkorah et al., 2021; Ahmed & Seid, 2020; Asimwe et al., 2014; Geremew & Gelagay, 2018; Jacobs et al., 2017; Lasong et al., 2020) have identified individual and contextual level factors as predictors of modern contraceptive use among women. Individual level factors such as maternal age, parity, level of education and contextual factors such as place of residence, exposure to media and household wealth index

predominate the majority of these studies. However, there seems to be paucity of studies that have systematically explore the influence of joint decision making on modern contraceptive use overtime despite studies (Eshete & Adissu, 2017; Mutombo & Bakibinga, 2014; Nketiah-Amponsah et al., 2012, 2022) confirming positive association between joint decision and use of modern contraceptive. According to these studies, in settings where both partners jointly decide on contraceptive use resulted in a higher contraceptive prevalence rate relative to areas where contraceptive use is not jointly decided. These studies also found knowledge of contraceptives, younger age group, wealth index, level of education, level of woman's autonomy and number of living children were significantly associated with joint decision on contraceptive use.

Moreso, even though women have the right to take decisions regarding their reproductive health independently, in most societies, especially low-income countries, the decision of the woman is often set aside by their partner (Abu Aragaw, 2015; Delbiso, 2013; Hameed et al., 2014) This will obviously affect the fertility behaviour of the woman including fertility preference and the decision to control the number of children. Other African studies (Asresie et al., 2020; Bogale et al., 2011; Eshete & Adissu, 2017) have found a link between joint contraception decision-making and place of residence. Some authors (Eshete & Adissu, 2017) in Southern Ethiopia for instance, found more than half of the women jointly decide contraceptive use with their partner, although with differentials according to place of residence. More women residing in urban areas were more likely to jointly decide the use of contraceptive with the partners relative to their rural counterpart. The urban-rural differentials revealed better contraceptive knowledge (which might be attributed to better exposure to media and other information sources) and age difference among women residing in the rural area predicted joint decision on contraceptive use, while among women from rural area, high fertility level and support from the parent of the women significantly predicted joint decision on contraceptive among partners (Eshete & Adissu, 2017).

Notwithstanding, studies (Blackstone et al., 2017; Bogale et al., 2011; Prata et al., 2017; Upadhyay & Karasek, 2012) that have examined factors associated with joint decision on contraceptive use, emphasizing the role of partners, this study, examines the predictors of joint decision on modern contraceptive use over a ten year period 2008-2018, taking into account the low modern contraceptive prevalence that has persist over time and paucity of studies examining trends using data from different data point. Examining the effect joint decision on modern contraceptive use in the absence of panel data and limited longitudinal studies in literature, this present study is able to bridge research gap in this aspect.

Materials and Methods

Study Area

Nigeria has one of the highest fertility rates in the world with a TFR of 5.0 and low modern contraceptive prevalence of 18% among married women 15-49 years (NBS and UNICEF, 2022). The study performed a secondary analysis of the three most recent repeated cross sectional nationally representative survey data (2008, 2013 and 2018).

Data Source, Population, Sampling, and Sample Size

Data were pooled from three successive Demographic and Health Surveys (individual recode) datasets for the year 2008, 2013 and 2018. The DHS is a nationally representative survey which collects data from women of reproductive age 15-49 years who had given birth to at least one live birth for the five-year period preceding the survey and have at least three surviving children. The sampling design consisted of stratified three-stage cluster approach. By grouping each state into urban and rural areas, stratification was achieved. Within each cluster, a complete list of households was generated, resulting in a sampling frame for selecting households. Analysis of data was restricted to women currently married and living with their partner, having at least one surviving children in the age group 20-40 years. Weighted sample size 2018, 2013 and 2008 was (18,016, 16,807 and 14,410) making a total sample of 49,233 women.

Measurement of Variables

The outcome variable is decision to jointly use contraceptive between the woman and her partner. A question was asked from the woman – who makes decision when using contraception? The response to the question was categorised into – mainly respondent; mainly husband/partner; joint decision; others. However, in this study, the responses were categorised into two namely: joint decision coded as “1”, otherwise “0”. Explanatory variables used in this study were based on their significant association with the outcome variable at the bivariate analysis and

literature (Blackstone et al., 2017; Nketiah-Amponsah et al., 2012) which include: age, age at birth, place of residence (rural or urban), region of residence, educational attainment, occupation (working; not working), household wealth index (based on NDHS classification), antenatal attendance, place of delivery, decision on large household purchases and exposure to mass media. Media exposure was measured from a composite of three variables namely: frequency of listening to radio, television and reading newspaper. It was then dichotomised as either exposed to at least one media source, coded as 1, and not exposed to any media source, coded as 0. Knowledge of contraceptives was defined as knows at least one method of contraception, coded as 1, while knows no method was coded as 0. The variable Children Ever Born (CEB) was recoded into high fertility (TFR>4) and low fertility (TFR ≤4). Autonomy was measured using four variables namely decision on earnings, large household purchase, healthcare and visit to family/relatives. Those who jointly decide on at least one of these indicators were coded as “1”, implying autonomy, otherwise “0”, lack of autonomy. The variable work status was missing for the 2018 dataset.

Data Analysis

In performing the analysis, due to the complex nature of the DHS data, Stata “svy” command was applied to handle the complex DHS design. Both univariate and multivariate analyses were performed. At the univariate level, descriptive analysis namely (frequency and percentage) was performed. At the bivariate level, association were tested using chi square and unadjusted binary logistic regression (tables not shown). At the multivariate level, binary logistic regression was performed. The binary logistics regression provides logit and odds effect of each of the explanatory variables on joint decision on contraceptive use among women and their partners. The results were presented as Adjusted Odds Ratio (AOR) and confidence intervals at 95% level of significance.

Ethical Approval

Approval to use the dataset was gotten from Measure DHS website upon registration and making request for the use of the data. The protocol used for the survey was reviewed and approved by the National Health Research Ethics Committee of Nigeria (NHREC) and the ICF Institutional Review Board. All the questionnaires were finalized in English and translated into the three major languages of Hausa, Yoruba and Igbo.

Results

Socio-demographics

Table 1 presents the socio-demographic characteristics of the women. Women in the age group 20-30 years and those with no formal education account for the majority across all the three data points. Nearly two thirds across all the three data points are in the high fertility regime and more than half had their first childbirth during adolescent period. Around half of the women across all the three data points had autonomy in deciding use of contraceptives.

Table 1: Socio-demographics Characteristics

Socio-demographic characteristics	Study Period			
	2008 (n=14,410)	2013 (n=16,807)	2018 (n=18,016)	Total (n=49,233)
Age groups	(%)	(%)	(%)	(%)
20 – 30	(63.8)	(63.8)	(61.2)	(62.8)
30 – 40	(36.2)	(36.2)	(38.8)	(37.2)
Fertility regime				
Low (1-4 children)	(63.4)	(63.3)	(64.1)	(63.6)
High (5+)	(36.6)	(36.7)	(35.9)	(36.4)
Age at first birth				
< 20 years	(55.7)	(57.7)	(55.7)	(56.4)
20-29 years	(41.9)	(39.8)	(40.9)	(40.8)
30+ years	(2.4)	(2.5)	(4.4)	(2.8)
Religion				
Christianity	(43.8)	(36.8)	(37.7)	(39.2)
Islam	(54.6)	(61.6)	(61.8)	(59.6)
Traditional and others	(1.6)	(1.6)	(0.5)	(1.2)
Education				

No formal education	(44.6)	(47.8)	(44.0)	(45.5)
Primary	(22.9)	(18.6)	(14.4)	(18.3)
Secondary	(26.1)	(26.7)	(32.1)	(28.5)
Tertiary	(6.4)	(6.9)	(9.5)	(7.7)
Wealth quintile				
Poorest	(22.2)	(22.8)	(21.1)	(22.0)
Poorer	(21.8)	(21.8)	(21.6)	(21.7)
Middle	(18.7)	(18.1)	(20.1)	(19.0)
Rich	(18.1)	(18.2)	(19.0)	(18.5)
Richest	(19.2)	(19.1)	(18.2)	(18.8)
Residence				
Urban	(31.3)	(36.4)	(40.2)	(36.3)
Rural	(68.7)	(63.6)	(59.8)	(63.7)
Region				
North-central	(14.3)	(14.5)	(14.3)	(14.4)
North-east	(15.3)	(16.7)	(17.2)	(16.5)
North-west	(30.2)	(36.6)	(34.9)	(34.1)
South-east	(9.0)	(7.9)	19.6)	(8.9)
South-south	(12.8)	(9.1)	(8.9)	(10.0)
South-west	(18.4)	(15.2)	(15.1)	(16.1)
Work status				
Not working	(29.1)	(28.8)	Na	(18.3)
Working	(70.9)	(71.2)	Na	(81.7)
Number of living children				
1-4	(75.0)	(73.0)	(72.3)	(73.3)
5-8	(24.0)	(25.8)	(26.5)	(25.5)
At least 8	(1.0)	(1.2)	(1.2)	(1.2)
Media exposure				
No	(48.5)	(31.9)	(37.0)	(38.6)
Yes	(51.5)	(68.1)	(63.0)	(61.4)
Autonomy				
No autonomy	(49.4)	(53.6)	(49.2)	(50.7)
Has autonomy	(50.6)	(46.4)	(50.8)	(49.3)
Decision on contraceptives				
Joint decision	(9.4)	(10.1)	(12.1)	(10.6)
Individual decision	(90.6)	(89.9)	(87.9)	(10.6)

na=variable missing for the data point

3.2 Bivariate Result

The pattern of association between socio-demographic characteristics and joint decision on contraceptive use was similar for the ten-year period (Table 2). For the year 2008, women in the older age group constitute a higher proportion of respondents who jointly decided on contraceptive use relative to the younger ones. Also, women in the low fertility regime were more likely to jointly decide the use of contraceptives with their partners.

Concerning age at first birth, more women who gave birth to their first child between the age group 20-29 years were more likely to jointly decide on the use of contraceptives. The influence of religion and educational attainment was also significant. More women who were affiliated with the Christian religion and had secondary education were more likely to jointly decide the use of contraceptives with their partner relative to those affiliated with the Islam religion and had primary or no formal education.

Furthermore, women in the richest household wealth index and residing in urban areas relative to their counterparts from the poor household and residing in rural areas were more likely to jointly decide the use of contraceptives with their partner. According to region, women from the southwest and south-south region relative to their northern

counterparts were less likely to jointly decide on the use of contraceptives with their partner. Overall, exposure to mass media and autonomy was positively associated with joint decisions on the use of contraceptives with a partner.

Table 2: Socio-demographics Characteristics and joint decision on contraceptive use

Socio-demographic characteristics	Joint decision on contraceptives			
	2008 (n=14,410)	2013 (n=16,807)	2018 (n=18,016)	Total (n=49,233)
Age groups	(%)	(%)	(%)	(%)
20 – 30 years	(51.9)	(50.2)	(51.4)	(51.2)
31 – 40 years	(48.1)	(49.8)	(48.6)	(48.8)
χ^2 (p-value)	77.33**	108.06**	56.78**	228.11**
Fertility regime				
Low (1-4 children)	(71.9)	(73.4)	(71.9)	(72.4)
High (5+)	(28.1)	(26.6)	(28.1)	(27.6)
χ^2 (p-value)	30.18**	52.85**	40.26**	126.10**
Age at first birth				
< 20 years	(34.0)	(35.4)	(36.1)	(35.3)
20-29 years	(61.6)	(59.6)	(58.1)	(59.5)
30+ years	(4.4)	(5.0)	(5.8)	(5.2)
χ^2 (p-value)	84.29**	108.12**	96.79**	291.90**
Religion				
Christianity	(75.5)	(75.6)	(69.6)	(73.1)
Islam	(23.2)	(23.6)	(30.2)	(26.2)
Traditional and others	(1.3)	(0.8)	5(0.2)	(0.7)
χ^2 (p-value)	142.82**	257.07**	235.92**	633.18**
Education				
No formal education	(8.1)	(5.2)	(9.1)	(7.6)
Primary	(23.9)	(19.3)	(14.7)	(18.6)
Secondary	(47.9)	(55.0)	(53.3)	(52.5)
Tertiary	(20.1)	(20.5)	(22.9)	(21.3)
χ^2 (p-value)	220.36**	342.39**	320.00**	875.86**
Wealth quintile				
Poorest	(4.0)	(1.7)	(4.2)	(3.3)
Poorer	(7.1)	(5.8)	(9.0)	(7.5)
Middle	(12.0)	(14.7)	(17.3)	(15.1)
Rich	(27.0)	(25.4)	(27.5)	(26.7)
Richest	(49.9)	(52.4)	(42.0)	(47.4)
χ^2 (p-value)	157.58**	181.51**	177.72**	510.86**
Residence				
Urban	(59.4)	(65.2)	(65.7)	(63.9)
Rural	(40.6)	(34.8)	(34.3)	(36.1)
χ^2 (p-value)	149.77**	132.13**	183.31**	493.86**

Table 3: Socio-demographics Characteristics and joint decision on contraceptive use

Socio-demographic characteristics	Joint decision on contraceptives			
	2008 (n=14,410)	2013 (n=16,807)	2018 (n=18,016)	Total (n=49,233)
Region	(%)	(%)	(%)	(%)
North-central	(13.3)	(13.4)	(13.9)	(13.6)
North-east	(2.8)	(3.6)	(7.5)	(5.0)
North-west	(3.1)	(10.1)	(14.1)	(10.0)
South-east	(15.3)	(16.6)	(18.9)	(17.2)
South-south	(22.2)	(18.2)	(13.8)	(17.4)
South-west	(43.3)	(38.1)	(31.8)	(36.8)
χ^2 (p-value)	104.15**	71.25**	77.32**	215.75**
Work status				
Not working	(17.5)	(17.0)	Na	(10.1)
Working	(82.5)	(83.0)	Na	(89.9)
χ^2 (p-value)	44.37**	45.77***	Na	90.71**
Number of living children				
1-4	(79.1)	(78.1)	(76.1)	(77.5)
5-8	(20.4)	(21.6)	(23.4)	(22.1)
At least 8	(0.5)	(0.3)	(0.5)	(0.4)
χ^2 (p-value)	5.55*	12.86**	8.95**	26.06**
Exposure to mass media				
No	(31.8)	(7.9)	(12.6)	(16.0)
Yes	(68.2)	(92.1)	(87.4)	(84.0)
χ^2 (p-value)	102.51**	191.77**	318.93**	574.45**
Autonomy				
No autonomy	(27.5)	(19.6)	(24.6)	(23.7)
Has autonomy	(72.5)	(80.4)	(75.4)	(76.3)
χ^2 (p-value)	132.03**	479.75**	273.57**	804.09**

3.3 Multivariate Analysis

Table 4 presents the result of the binary logistic regression showing the odds of a joint decision on the use of contraceptives with a partner. Factors that consistently predicted joint decisions on the use of modern contraceptives across all three data points are region of residence, education, religion, household wealth, and autonomy. For all three data points, joint decision-making with a partner on the use of contraceptives was consistently lower among women from the northern region of the country relative to their partner in the south.

In contrast, a higher level of educational attainment was significantly associated with higher odds of jointly deciding the use of contraceptives with a partner. Regarding the influence of religion, lower odds of a joint decision on modern contraceptive use among partners was lower for women affiliated to Islam relative to their Christian counterpart.

Concerning the influence of household wealth, women from the rich and richest households were more likely to jointly decide on the use of contraceptives with their partner relative to women from the poor and poorest households. Except for the year 2008, exposure to media was positively associated with joint decisions on the use of contraceptives with partners. Overall, having autonomy was significantly associated with a higher likelihood of jointly deciding the use of a contraceptive with a partner.

Regardless of the data point, women in the older age group 31-40 years, with a higher level of education, from the rich and richest household, working and having autonomy were all significantly associated with a higher odds of joint decision on contraceptive use among the women and their partner. On the other hand, lower odds of a joint decision on the use of contraceptives were found among women whose age at first birth is 30+ years, who reside in the northern region of the country, and affiliated with the Islam religion.

Table 4: Binary logistic regression showing predictors of joint decision on contraceptive use.

Outcome: Joint decision on contraceptive use	2008 (n=14,410)		2013 (n=16,807)		2018 (n=18,016)		Total (n=49,233)	
Variables	OR	95% C.I	OR	95% C.I	OR	95% C.I	OR	95% C.I
Age groups								
20 – 30 years	1.000		1.00		1.000		1.000	
31 – 40 years	1.26*	1.0-1.5	1.35**	1.1-1.6	1.12	1.0-1.3	1.23**	1.1-1.4
Age at first birth								
< 20 years	1.000		1.000		1.000		1.000	
20-29 years	0.94	0.8-1.1	0.93	0.8-1.1	0.89	0.8-1.0	0.92	0.8-1.0
30+ years	0.70	0.4-1.3	0.67	0.4-1.2	0.81	0.5-1.3	0.72*	0.5-1.0
Residence								
Urban	1.000		1.000		1.000		1.000	
Rural	0.72**	0.6-0.9	0.92	0.8-1.1	0.79**	0.7-0.9	0.80**	0.7-0.9
Region								
North-central	1.000		1.000		1.000		1.000	
North-east	0.23**	0.2-0.3	0.41**	0.3-0.6	1.00	0.8-1.2	0.58**	0.5-0.7
North-west	0.17**	0.1-0.3	0.42**	0.3-0.6	0.76*	0.6-1.0	0.48**	0.4-0.6
South-east	0.95	0.7-1.3	1.15	0.9-1.5	0.67**	0.5-0.8	0.89	0.8-1.0
South-South	0.92	0.7-1.2	0.79	0.6-1.0	0.56**	0.4-0.7	0.73**	0.6-0.8
South-west	1.22	1.0-1.5	1.21	1.0-1.5	1.13	0.9-1.4	1.18*	1.0-1.3
Education								
No formal education	1.000		1.000		1.00		1.000	
Primary	1.73**	1.2-2.3	2.30**	1.7-3.0	2.36**	1.9-2.9	2.14**	1.9-2.5
Secondary	2.17**	1.6-2.9	3.48**	2.6-4.7	2.65**	2.1-3.1	2.86**	2.4-3.3
Tertiary	3.46**	2.4-5.1	4.90**	3.4-7.0	3.54**	2.7-4.7	4.03**	3.3-4.9
Religion								
Christianity	1.000		1.000		1.000		1.000	
Islam	0.71**	0.6-0.9	0.67**	0.5-0.8	0.41**	0.3-0.5	0.58**	0.5-0.6
Traditional and others	1.20	0.7-2.2	0.65	0.3-1.3	0.23*	0.1-0.7	0.63*	0.4-0.9
Wealth quintile								
Poorest	1.000		1.000		1.000		1.000	
Poorer	1.18	0.8-1.7	1.59*	1.0-2.5	1.22	0.9-1.6	1.28*	1.0-1.6
Middle	1.41	1.0-2.1	2.44**	1.5-3.8	1.63**	1.2-2.1	1.74**	1.4-2.1
Rich	2.41**	1.7-3.5	2.93**	1.8-4.7	2.02**	1.5-2.7	2.25**	1.8-2.7
Richest	3.33**	2.2-5.0	5.22**	3.2-8.5	2.78**	2.0-3.8	3.40**	2.7-4.2
Media exposure								
No	1.000		1.000		1.000		1.000	
Yes	1.08	0.9-1.3	1.27*	1.0-1.6	1.50**	1.2-1.8	1.28**	1.1-1.4
Work status								
Not working	1.000		1.000		na		1.000	
Working	1.50**	1.2-1.9	1.20	1.0-1.5	na	na	1.53**	1.3-1.8
Autonomy								
No autonomy	1.000		1.000		1.000		1.000	
Has autonomy	1.50***	1.3-1.8	2.08**	1.8-2.5	1.82**	1.6-2.1	1.80**	1.6-2.0
Fertility regime								
Low (1-4 children)	1.000		1.000		1.000		1.000	
High (5+)	0.93	0.8-1.1	1.03	0.9-1.2	1.08**	1.6-2.1	1.01	0.9-1.1

*=statistically significant at 0.05, **=statistically significant at 0.001,

Discussion

This study has examined factors associated with decision to jointly decide contraceptive use among women and their partners using evidence from a repeated cross-sectional nationally representative data for the period 2008-2018. Our study found factors that consistently predicted joint decision on contraceptive use for the ten-year period include region of residence, education, religion, household wealth, and autonomy. These factors have been well reported in previous literature. With respect to region, while joint decision on the use of contraceptives was relatively lower for the northern region of the country, several explanations exist for this. In the northern region of the country, the use of modern contraceptives is shaped by several cultural and religious factors (Adebawale et al., 2013; Viswan et al., 2017). Also, this region has consistently reported low modern contraceptive prevalence overtime (NPC and ICF International, 2019). Women residing in rural area were less likely to jointly decide contraceptive use with their partner. This is likely because women in rural areas are more likely to attain low economic status such as level of education, thereby impacting on their level of autonomy and their decision-making power. In another study (Eshete & Adissu, 2017), the authors were of the opinion that higher contraceptive use among urban women might be attributed to the fact that they are better exposed to information about family planning.

Also, in our present study, increasing level of education and being affiliated to Christian religion was associated with higher likelihood of joint decision on contraceptive use. This corroborated the findings of previous studies (Eshete & Adissu, 2017; Mutombo & Bakibinga, 2014; Nketiah-Amponsah et al., 2012). The positive effect of education can be explained in several ways. First, women who are well educated will no doubt be better informed and have accurate knowledge about contraceptives in addition to the benefits associated with its use relative to the uneducated women. Also, women who are still schooling are more likely to use contraceptive for the purpose of avoiding getting pregnant which can cause interference in their education. These findings, also aligns with an Ethiopian study (Eshete & Adissu, 2017). In the study, women with no formal education and affiliated with the Islam religion had lower odds of making joint decision on contraceptive use with their partners. The influence on religion on contraceptive use might be due to religious factors that tend to influence the acceptability of contraceptives among couples from different religious settings (Tiruneh et al., 2016).

In this our current study, higher household wealth was associated with greater odds of joint decision-making process on contraceptive use. This finding can be attributed to greater capacity to obtain modern contraceptives without the need to rely on their partner. Also, it is important to note that wealth index according to the DHS measures is an aggregate of family assets including television, radio, phone, cars among others all of which can positively contribute to the ability of the woman to access information among others (Currie, 2009). In this present study, where mass media and work status were significant, women exposed to mass media and working had higher odds of making joint decision on contraceptive use relative to their counterpart not exposed to mass media and not working. Similarly, women with autonomy also demonstrated higher likelihood of joint decision on contraceptive use. Previous studies (Eshete & Adissu, 2017; Mutombo & Bakibinga, 2014) have also reported positive association between joint decision and use of modern contraceptives. This suggests an increasing need for better spousal communication among couples on reproductive health and use of contraceptives.

Conclusion

The study concluded by recognizing the importance of socio-economic characteristic of women and autonomy as factors to be considered when designing policies and programmes targeting the promotion of joint decision on contraceptives among women and their partner, with the overall goal of promoting increased contraceptive prevalence rate. The implication of our findings is that any intervention seeking to promote joint contraceptive use among couples must take into consideration the socioeconomic, cultural, and religious barriers that adversely affect the ability of women to make informed decision on their reproductive health. Also, future family planning program should make concerted effort at ensuring that male partners are well considered when developing their programs and the need to promote spousal communication on issues related to use of contraceptives.

Strength and Imitations

Notwithstanding the importance of this study on policy, some limitations are worth noting. First, because this study made use of secondary data, the reliability of the findings will to a large extent be dependent on the quality of reporting during the survey. Also, the outcome variable talks about joint decision making. However, response for the

male partner was obtained from the woman's perspective and might be subject to bias. Nevertheless, our study represents one of the few studies that have examined predictors of joint decision making using repeated cross sectional nationally representative data across three data points, thus making important contribution to literature.

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