SOCIO-DEMOGRAPHIC CHARACTERISTICS OF FAMILY PLANNING ACCEPTORS AND DELINQUENT ACCEPTORS IN A PUBLIC CLINIC IN BENIN CITY 1981 - 1985

BY

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DEDICATION

Dedicated to my Unborn Child

DECLARATION

I hereby declare that this thesis is my own work and that it has not been submitted in any form for another degree or diploma in any other institution. Information and excerpts from published and unpublished work of others have been acknowledge in the text.

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CERTIFICATION

This thesis entitled "Socio-Demographic Characteristics of Family Planning Acceptors and Delinquent Acceptors In A Public Clinic in Benin City, 1981 - 1985," by Osaretin Ehigiator Adonri, meets the regulation governing the Award of M.Sc. Sociology of Ahmadu Bello University, Zaria and is approved for its contribution to knowledge and literary presentation.

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ABSTRACT

This study examines the socio-demographic characteristics of family planning clients who patronised a public clinic in Benin City between 1981 and 1985. Out of 1000 clients, there were 257(.25.7%) acceptors and 74 + 3 (74.3%) delinquent acceptors.

Acceptors were found to be mainly clients aged 30 years and above, with four or more children and not necessarily of high educational status. Most of them were Protestants and employed in the civil service.

Delinquent acceptors were mainly clients aged 15-29 years, with three or less children and not necessarily of low educational status. Many delinquent acceptors belonged to the religious group classified as "Others" and they were mostly housewives and petty traders.

However, parity was found to be the most important variable determining the regularity of a woman's patronage of the clinic. Low parity women were more delinquent in most cases, irrespective of age and educational status.

The trend in social and demographic characteristics of clients revealed general increases in the proportion of young, low parity, high educational status, housewife and civil servant clients as well as clients of Catholic faith.

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ABBREVIATIONS

F.G.N.	-	Federal Government of Nigeria
HES	-	High Educational Status
LES	-	Low Educational Status
IUCD	-	Intra-Uterine Contraceptive Device
K.A.P.	-	Knowledge Attitude and Practice
M.F.E.P.	-	Ministry of Finance and Economic Planning
N.P.B.	-	National Population Bureau
PPFN	-	Planned Parenthood Federation of Nigeria

Chapter 1

INTRODUCTION

This study was motivated by the much talked about population problem and the need to solve the problem through family planning programmes, especially in Nigeria. This introductory chapter gives a bird's eye view of the population problem as a prelude to the statement of the research problem which is examined in the second section of the chapter. The third section outlines the major objectives of the study, while the fourth section deals with the significance of the study. A brief background information of the study area (Benin City) is given in section five. The last section gives a summary of the chapter.

1.1 The Population Problem

Concern about population has occupied the minds of astute thinkers throughout history. Theories of population are found in early Chinese writings as far back as the time of Confucius (4th century B.C.). Philosophers at that time were aware that if population was too small, land would be idle and taxes would not be paid. But if it was too large, there would be hardship (Keyfitz, 1972).

One of the most influential theories of population was that of Reverend R.T. Malthus. In Malthus' work which was published in 1798, he posited that population had the

tendency to out-grow its means of subsistence and that if "preventive" measures were not taken, vice and misery would act as "positive" checks to keep population at a level manageable by the means of subsistence (Glass, 1959).

Ever since the time of Malthus, the relationship between population and the standard of living in a society has been a subject of much controversy. A cursory review of four basic schools of thought seems appropriate at this point.

The first school of thought is based on Malthus' theory. However, the adherents of this school of thought known as "Neo-Malthusians" differ from Malthus in that they actively propagate artifical methods of birth control as a means of eliminating misery and absolute poverty that would result if human beings are allowed to procreate to their natural level (Pradervand, 1980).

The second school of thought which belongs to Marxist camp holds that it is the mode of production that needs adjustment and not population. The population problem according to this view is the product of the capitalist mode of production and the eradication of capitalism will solve all population problems. This group is often referred to as the "Anti-Malthusians".

The third school of thought are the "Non-Malthusians" who made their mark at the 1974 World Population Conference held at Bucharest. Although this group was formed before the conference, the conference's Plan of Action gave recognition to its major proposition that it is impossible "to solve problems of society through birth control measures" (Hofsten, 1980). At that conference, birth control as top priority and solution to population problem was rejected and emphasis was placed on the promotion of rapid social and economic development in less developed countries.

Students of developmental studies in International politics - "underdevelopment theorists" belong the fourth school of thought. They hold that poverty and underdevelopment in Third World countries are not due to over-population. The major problem according to them is the integration of Third World countries into the international capitalist system. The mechanism which maintains the dependence of Third World countries on developed ones for expensive finished goods and subjects them to the role of exporting only cheap raw materials is the cause of poverty and underdevelopment. In the view of these scholars, "relative over-population" is only a reflection of this phenomenon (Egero, 1980, Amin, 1971). To solve the problem, "underdevelopment theorists" advocate disengagement from the international capitalist system and/or unity among Third World countries to change the pattern of unequal exchange between rich and poor nations.

From the various schools of thought, three fundamental approaches to solving the population problem have been proposed since the 1950s. The first involves the introduction of full-scale family planning as top priority and national policy. The second approach emphasizes rapid economic growth and industrialization, while the third centers on appropriate reforms in economic and social institutions (Wright, 1974).

In many developing countries of the world, high population growth rates, in the neighbourhood of 2.5% and 3.5% per annum and the fear of the consequences of such growth rates, now and in future, seem to have revived the ghost of Malthus. Thus, in the first African Population Conference held in Accra in 1971, Kofi Busia, the then Prime Minister of Ghana in an address observed that:

> The Malthusian theory that population tends to increase at a faster rate than its means of subsistence and that unless it is checked by moral restraints (and we may add family planning)... is now being treated with more respect than was accorded it some years back. In certain parts of the world, the squalor and poverty predicted by Malthus is already in evidence (Quoted by Bondestam, 1980, p.1).

In certain parts of Africa, including Ghana, Kenya and Egypt, population policies based on family planning have been adopted in a bid to check rapid population growth rates and probably to avoid the Malthusian

"positive" checks or the "death rate solution" in the words of Paul Ehrlich (1971). However, it is doubtful if such measures will lead to any significant reduction in fertility rates within the present level of socio-economic development in most developing countries. It is our contention that family planning will have more significant effect on fertility rates within the context of an all-round plan for socio-economic and political development in the country.

1.2 Statement of the Problem

The demographic situation in Nigeria is not known with certainty because of the lack of adequate demographic information in the country. However, various estimates put the total population of Nigeria between 80 and 100 million. A crude birth rate of about 50 per 1,000 and a growth rate which lies between 2.5% and 3% per annum has been estimated (National Population Bureau (NPB), 1984). Thus, Nigeria is one of the most populous countries in Africa with one of the highest population growth rates in the world. This situation can be attributed to the excess of births over deaths which resulted from recent socio-economic developments and improved health care services.

A careful study of the attitude of the Federal Government on the population issue shows a shift towards birth control over time. For example, in the Second and Third National Development Plans, of 1970-74 and 1975-80 respectively, the large and rapid growth of the population was recognized, This, however, was not considered "a significant or serious obstacle to domestic economic progress" (Federal Government of Nigeria (FGN), 1975:293). All the same, the need to encourage the provision of family planning information and services to couples wishing to limit the size of their families, by the National Population Council and other non-governmental agencies was stressed.

The Fourth National Development Plan regarded the previous plans as "a passive reaction to the population problem" (FGN, 1981:361), and stressed the need for "a closely monitored" trend. As with the previous plans, however, the strengthening of socio-economic forces and the provision of facilities for family planning in health institutions were considered enough to solve the population problem.

Recently, (circa, 1984) the Federal Ministry of Health and the National Population Bureau sponsored the Futures Group, under contract to the United States Agency for International Development, to analyse the relationship between population factor and the efforts of the country to achieve overall social and economic goals. In a report,

the Futures Group found that rapid population growth is hindering economic development in Nigeria. The report stressed the need for immediate population/family planning programme, pointing out that "a delay in only 10 years would make a difference of 130 million in the size of Nigeria's population" (Futures Group, 1985:48).

Presently, (1987) the draft of a population policy based on family planning is said to have been discussed and adopted in principle by the Council of Ministers (Akpaka, 1987).

Concern about rapid population growth has also been expressed in public fora. This is reflected in headlines such as "Population Control: What the people say" (Emodi and Ibironke (eds), 1984). "The Role of Family Planning in Development" (Fajobi, 1984). "Two Experts suggest ways of controlling Population Growth" (Ehi-Asuelimen, 1986), "How to forestall Population Explosion" (Udo, 1986) and Birth Control Next Battle-line for Soldiers" (Ogbeide, 1986), which have appreared among others in leading Nigerian newspapers.

In various studies, articles and commentaries by members of the public, many problems in socio-economic development in the country are attributed to rapid population growth. In the field of education for instance, the lack of places in schools for those qualified and willing to go to schools have been attributed to rapid population growth.

According to Fadayomi's (1983) calculations, the number of (primary) school places must double every 30 years or so just to maintain the same proportion of children in schools at the present growth rate. The supply of class-rooms and teachers must also be expanded at the same rate. It is argued that the resources needed for such expansion is not readily available in a developing country like Nigeria.

In the field of employment, the number of young school leavers seeking employment in the modern sector of the economy is said to outstrip the number of places available. Thus, there is the problem of unemployed young school leavers, which coupled with the relatively recent graduate unemployment phenomenon is said to be one of the most important problems facing the government of Nigeria today. This problem has also been traced, in part, to rapid population growth.

Rapid population growth has been said to affect the attainment of set goals in the health sector because the level of fertility helps to determine the number of women in their reproductive years and the number of children under the age of five. These segments of the population are at the greatest risk of death and disease and thus likely to require health services. Secondly, rapid population growth contributes substantially to the increase

in the cost of developing health infrastructure in the form of buildings, personnel, drugs, etc. to meet the health needs of the country (Futures Group, 1985:34). The inability of the Nigerian government to cope with the health needs is portrayed by reference to the low percentage of the population covered by modern health care services, high infant and maternal mortality rates and relatively low life expectancy compared to that of developed countries.

Rapid population growth has also been associated with low levels of economic development. A rapidly growing population, it is argued, usually has a very large proportion of persons under fifteen years of age. These people are essentially consumers. The necessity of supporting a large economically inactive members of the community is associated with a high dependency ratio which puts a lot of pressure on the working population. The necessary savings which is a major stimulus to economic development is thereby affected.

Inadequate power supply,transportation, housing and water supply have also been traced, in part, to rapid population growth rates. Thus many commentators on population in Nigeria have advocated a reduction in the present growth rate.

On the other hand, it has been argued that rapid population growth is not a problem. Rather it could be a positive force to development by the creation of the necessary economies of scale and sufficient labour force in the future. Examples of countries like Thailand, Malaysia, Ecuador, Jordan, Brazil, etc. are given to show that high population growth rates can be combined with high economic growth rates (Simon, 1986).

The problem of education in Nigeria, according to the opposite view, is one of lack of commitment on the part of government than non-availability of resources, while the problem of inadequate health services is attributed to rigid adherence to the western style health care delivery system, to the detriment of indigenous, more universal and perhaps less expensive health care system. Adherents of these views attribute population problems to various other factors which include the distribution of population in space, "unnecessary" concentration of efforts on population programmes by international aid agencies, unequal trade terms between developed and developing countries, as well as the political system which determines the distribution of power, wealth and priorities of economic development plans in the country.

Thus, there has been an extensive debate about the desirability or otherwise of rapid population growth rates in the country. However, there is hardly any spokesman who would argue that population growth can logically continue forever in a finite world. Even Fredrick Engels (a foremost Anti-Malthusian), in a letter to Kautsky in 1881 saw the possibility of the number of people becoming so great that limits will have to be set to their increase (Engel, 1881). This coupled with Futures' Group report is perhaps instrumental to the recent efforts by the Federal Government to promulgate a population policy based on family planning.

However, since family planning involves voluntary adoption of methods of birth control, its practice is subject to the whims and caprices of those who are aware and willing to use the facility. While some women may be using contraceptives regularly, others may be intermittent in their usage.

Any family planning programme aimed at reducing fertility should not only be based on a thorough knowledge of the socio-demographic characteristics of family planning clients generally, but also require an in-depth knowledge of the characteristics of regular family planning clients (acceptors) and irregular family planning clients (delinquent acceptors). Relatively few studies have been done on this aspect of family planning in Nigeria. This study is an attempt in this aspect of

of family planning studies. It is also an attempt to study the trend in socio-demographic characteristics of both categories of clients over a five year period in order to portray changes and variations (if any) in these characteristics over time.

Survey researchers in family planning have had to contend with the problem of validity of information as both researchers and respondents are sometimes biased due to the nature of questions (of rather private nature) necessary to obtain valid information (Caldwell, 1975:60). The use of available data in family planning clinics and other contraceptive outlets have sometimes proved to be a valid source of information for family planning studies. (The Population Council, 1970:3). This study uses records kept on family planning clients in a public clinic organized by the Planned Parenthood Federation of Nigeria (PPFN) in Benin City, as a major source of data.

1.3 Objectives of Present Study

The main objectives of this study are:

a) To determine the socio-demographic characteristics of family planning clients in a public clinic in Benin City.

b) To examine the socio-demographic characteristics of regular and irregular patrons of the clinic with a view to determining differences, if any, between them.

c) To study the trends in socio-demographic characteristics of the categories of clients over the five year period.

d) To make recommendations that may be useful for the formulation of a population policy in Nigeria.

1.4 Significance of Study

This study like other knowledge, attitude and practice (KAP) of family planning studies, is an attempt to determine the socio-demographic characteristics of family planning clients. Studies of this kind have been widely used for population policy formulation and programme design in many countries (Hauser, 1967:402). This study will add to the body of knowledge needed for programmes design and implementation in Nigeria.

Specifically, this study seeks to distinguish between regular patrons (who may be using contraceptives for birth limitation) and irregular patrons (who may be using contraceptives for other purposes) of the family planning clinic. Any policy measure aimed at promoting family planning for fertility reductions will benefit from a knowledge of the characteristics of these categories of contraceptors. The knowledge gained will not only help to identify those who may have to be persuaded to use contraceptives more regularly, but it can also serve as

a basis for evaluating the desirability or otherwise of a population policy based on voluntary birth control in an effort to reduce fertility rates.

Lastly, this study covers a period prior to the official promulgation of a population policy for Nigeria. The findings will, therefore, serve as a basis for evaluating future performances of any population programme in the study area.

1.5 The Study Area: Background Information

Benin City is the capital of Bendel state of Nigeria. It is a fairly large urban area. The population of the area according to the 1963 census was 110,251. By 1986, it was estimated at 340,000 (Ministry of Finance and Economic Planning (MFEP) Statistics Office, 1986).

The Binis are polytheists; they recognise the chief God called Osanobua or Osa. Other gods are Olokun, Obiemwen, Ogiuwu and Esu. (Thamas, 1910). The chief God has many identical attributes as the christain God.

Marriage holds a central place among the Binis. It is regarded as abnormal for a young man or woman of marriageable age to be unmarried. Polygyny is widely practised and men are at liberty to take as many wives as they like. Children are regarded as wealth. The indigenous occupations of the people include farming, brass and bronze casting, wood carving and blacksmithing. The Binis

are also keen traders, from ancient times, markets have been established in certain towns and villages (Egharevba, 1971). With modernization, more opportunities have opened up in manufacturing, construction, banking and insurance. Perhaps, the state and federal ministries are the largest employers of labour in the non-traditional sector of the economy.

Benin City and its environs are served by about 18 (registered) hospitals, 76 clinics, 6 health centres, 5 dispensaries, 64 chemists and 375 patent medicine stores. Most of these institutions are privately owned (MFEP, 1985). There is also a University teaching hospital. The Planned Parenthood Federation of Nigeria's (PPFN) clinic in the city, where data for this study were obtained, is the only institution in the city whose sole business is the provision of family planning services.

1.6 Summary

Man has for a long time been concerned with the population problem. But since Malthus' work on population, the essence of the problem has become more controversial. The debate has essentially been between those who think population is the problem to be tackled and those who think the problem lies elsewhere. This has given rise to varied approaches to solving the problem.

The problem of population growth seems more marked in developing countries due to falling death rates which are unaccompanied by falling fertility rates in recent times. Some African countries such as Kenya, Egypt and Ghana have promulgated population policies based on family planning, to reduce the population growth rates; but it is doubtful if such policies will be successful in the absence of an all-round plan for socio-economic development.

In Nigeria, the attitude of the government seems to favour birth control as evident in various development plans and the recent effort to promulgate a population policy based on family planning. This seems to be in recognition of various socio-economic problems attributed to rapid population growth rates and the Futures' Group report of 1985. The success of such a policy will be enhanced, not only by an understanding of the socio-demographic characteristics of family planners generally, but also the identification of the characteristics of regular and irregular family planners. This is the major objective of this study which covers a five year period.

This study was carried out in Benin City, a fairly large urban area in Nigeria. The indigenous people are polytheists and polygynous. They place a high value on children. The people engage in occupations like farming, trading, blacksmithing, etc. In the modern sector, the

civil service is perhaps the largest employer of labour. The city is served by a number of health institutions and a family planning (PPFN) clinic, whose sole responsibility is the provision of family planning services.

Chapter 2

LITERATURE REVIEW AND METHODOLOGY

The first section of this chapter reviews the relevant literature, while the second section outlines the six hypotheses to be tested in this study. Section three focuses on methodological issues such as sources and nature of data, sampling procedure and method of data analysis. In section four, some of the key concepts of the study are operationally defined, while a summary of the chapter is given in the last section.

2.1 Literature Review

Various studies have been carried out to determine the extent of family planning knowledge, attitude and practice (KAP) in Nigeria. Such studies also attempt to determine the socio-demographic characteristics of family planners in the community. Notable among such works are those of Okediji (1968), Onifade (1973), Caldwell and Ware (1977), Ukaegbu (1977) and Nichol, et al (1986).

Okediji's (1968) survey which was carried out in Ibadan examined the relationship between socio-economic factors and ideal family size/actual number of children. He also examined attitude towards the use of contraceptives as well as knowledge and practice of family planning. His study demonstrated the importance of socio-economic factors in determining knowledge, attitude and practice

of family planning. The level of a woman's education, her income and occupation were found to affect the extent of her knowledge, attitude and practice of family planning. For instance, those of high socio-economic status were found to be more favourably disposed to family planning.

Onifade's (1973) study which was carried out at Ibadan, was designed to find out women's attitude towards all forms of prevention of unwanted pregnancies as well as to establish the social background of respondents. High education was found to be positively correlated with knowledge, attitude and practice of family planning. The general use of modern family planning methods was however, found to be low. An interesting finding of Onifade's study was that even among white collar workers, where the majority of the respondents had not less than secondary eduction, a few used some form of contraceptives. Among them, Aspirin and Codeine were used as contraceptives (Onifade, 1973:41). This situation probably suggests lack of access to contraceptives and birth control information rather than a negative attitude towards the use of contraceptives. It is interesting to note that majority of them thought contraceptives should be part of the routine service of government hospitals.

Caldwell and Ware's (1977) study was mainly concerned with the evolution of family planning practice in Ibadan. They found that the spread of family planning devices over the decade prior to the study was largely among the educated, especially those with some secondary education or more. They also noted that a sizeable proportion of women practising family planning were adopting contraception largely to retain existing birth intervals. Many contraceptors also use contraceptives before the birth of their first child.

Some studies have been carried out in rural areas. Ukaegbu's (1977) study was among "currently married women" of all ages in 16 Ngwa Igbo villages in former East Central state (now in Anambra state). He found that although fertility rate was quite high among the women, a majority of them claimed to have used traditional methods of birth control, while very few have used modern methods. However, a high proportion of wives (78 %) expressed willingness to attend family planning clinics. Ukaegbu's study suggests a strong potential for family planning among rural people. The strong desire for many children among the women, however, may indicate desire to use family planning to maintain existing traditional birth interval rather than to limit fertility.

KAP studies in Nigeria have not been restricted to married women only. The main objective of the study by Nichols et al (1986), was to ascertain the attitude of

adolescents towards sexual activities and contraceptives. A sample of never married males and females between the ages of 14-25 years was used. They found that the reported use of contraceptives among sexually active adolescents was high. This finding was consistent with Cadwell and Ware's (1977) finding that a high proportion of women used birth control methods before the birth of their first child.

Majority of KAP studies were conducted in urban and rural areas. A few, however, have been conducted using national samples. An early attempt to conduct a survey using samples from both southern and northern Nigeria was carried out by Daramola and Wright (1966). Samples were drawn from Lagos and Katsina province (now in Kaduna state) for the study. They found a high proportion of non-use of contraceptives among the women. However, education of both wife and husband was found to play a major role in the knowledge, attitude and practice of family planning.

A recent nation-wide fertility (sample) survey which incorporated questions on knowledge, attitude and practice of family planning was conducted in 1981/1982, by the National Population Bureau as part of the World Fertility Survey Programme. The sample was drawn from all the 19 states of the Federation (NPB, 1984). The study found a generally low level of knowlege and practice of family planning in the country. For instance, only about

one-third of the women had heard of any method of birth control, while 84.9% of the women had never used any type of contraceptive.

However, knowledge, use and ever-use of contraceptives were found to vary with education, place of residence, region of residence and religion. Awareness and use of contraceptives were found to be lowest among illiterates, rural dwellers, in the north-eastern region as well as among Muslims. "Current" use of contraceptives also varied in the same direction except by place of residence.

The results of KAP studies in Nigeria tend to suggest a general approval for family planning methods, but knowledge and use of modern contraceptives is very low. A basic optimism implicit in these findings and expressed in some studies (Oyemade and Ogunmuyiwa,1981) is that if large scale effort is focused on the provision of family planning information and services, it is possible to accelerate fertility decline in the community. Studies in some other developing countries tend to support this contention.

In a review of studies of the association among contraceptive availability, contraceptive use and fertility, Boulier (1985) found evidence, from cross-national studies, to show that the expansion of family planning programmes in developing countries over the 1965-1975 decade resulted in increased use of contraceptive and a remarkable decline in fertility over the period. Evidence on the precise magnitude of the effect of family planning programme and the way in which

differentials in socio-economic characteristics of couples affected the decline in fertility was however found to be weak.

In assessing the role of family planning in fertility decline, Brackett et al (1978), examined data from the World Fertility Survey (WFS) report for ten developing countries. Despite broad differences in geography, culture, religion and level of economic development in the countries studied, Brackett and others noted that a large proportion of women in each country said they did not want any more children. The desire not to have additional children was found to be strong among rural, poor and uneducated women. From these findings, Brackett et al (1978) concluded that the level of socio-economic development is not a dominant factor in determining fertility control. Thus, family planning programmes will have significant and independent effect on fertility.

However, some scholars disagreed with the dominant role attributed to family planning programmes in a bid to reduce fertility in a community. Davis (1967) argued that family planning advocates tend to ignore the power and complexity of social factors in reproduction. He noted that the creation and care of human beings is socially motivated and any deliberate attempt to reduce birth rates must involve a change in socio-economic structure of society. Davis (1967) maintained that optimism based on positive responses in KAP surveys tend to overlook the fact that

the practice of contraception is compactible with high fertility. Davis'(1967) assertion tends to be supported by emperical evidance from some developing countries. In a Contraceptive Prevalence Survey (CPS) conducted in Botswana, Kenya and Zimbabwe, for example, Way et al (1987) noted that these countries have achieved a relatively high contraceptive prevalence rate in sub-saharan Africa. The study found that 28% of currently married women in Botswana, 17% in Kenya and 38% in Zimbabwe reported using family planning methods at the time of the survey. In Botswana and Zimbabwe, approximately 70% of women reported knowledge of at least one source they could obtain contraceptives within a thirty minute travel time, while 48% of Kenyan women knew of similar sources. Despite relatively high contraceptive prevalence rate, total fertility was found to be as high as 6.5 in Botswana and Zimbabwe and 7.7 in Kenya.

On the other hand, notable fertility decline was recorded in Taiwan before the introduction of the National Family Planning Programme in 1963 (Li, 1973). In a temporal and spacial analysis of fertility decline in Taiwan, Li (1973) found evidence to show that Taiwan's fertility was neither induced or accelerated by the family planning programme. Rather, there was evidence to support the hypothesis, that institutional variables, such as mortality decline and educational level influenced fertility.

In developing countries taken as a whole, Davis (1967) observed that birth rates are rising and in these countries with population policies, there is no indication that government is controlling the rate of reproduction. This trend has been attributed to the level of socio-economic development in developing countries.

Thus, there has been a debate as to the role of institutional changes and family planning programmes in fertility decline and the process by which population growth will decline in a society. Some scholars emphasize the role of family planning, while other emphasise socio-economic development in the society. However, a consensus position, supported by emperical evidence, seems to have emerged (Teitelbaum, 1974). This position holds that social setting and family planning efforts go together most effectively to bring about a decline in fertility. In a study done by the Population Council in 26 developing countries (Berelson, 1974), it was found that those countries with strong family planning programmes showed more contraceptive use and more decline in fertility rates than those with moderate and weak programmes. Also, within those countries with moderate and weak family planning programme strength, those with high development status showed much higher contraceptive use and more decline in fertility rates than those with

middle and low development status. This finding tends to support the proposition that programmes direct at economic development and population growth are mutually supportive.

In many developing countries, including Nigeria, Botswana, Kenya and Zimbabwe, where contraceptives are available and fertility rates are high, it appears that contraceptives are being used for purposes other than family limitation. Oni and McCarthy's (1986) study of the use of contraceptives for birth spacing in Nigeria found that women have used or/and are using contraceptives as substitutes for periods of post-partum abstinence. Such women are likely to be irregular contraceptors.

Not much has been done in a single study to determine the socio-demographic characteristics of regular contraceptors (acceptors) and irregular contraceptors (delinquent acceptors) with a view of highlighting similarities and/or differences between them. Such a study will add to the body of knowledge in family planning studies and provide useful information for family planning programme design and implementation especially if changes and variations in these characteristics are studied over time.

2.2 Hypotheses

The six hypotheses tested in this study attempt to examine the relationship betweem some socio-demographic

characteristics of the surveyed women and acceptance as well as delinquency in the use of contraceptives. The social and demographic variables (independent variables) analysed are age, parity and education. They are hypothesized in relation to acceptors and delinquent acceptors (dependent variables) as follows:-

1) Acceptors are more likely to be old than younger women.
2) Acceptors are more likely to be high parity women than low parity women.
3) Acceptors are more likely to be high educational status women than low educational status women.
4) Delinquent acceptors are more likely to be young women than older women.
5) Delinquent acceptors are more likely to be low parity women than high parity women.
6) Delinquent acceptors are more likely to be low educational status women than high educational status women.

2.3 Sources and Nature of Data

The data for this study were derived from records kept at the Benin City branch of the Planned Parenthood Federation of Nigeria (PPFN). The PPFN is the largest single non-governmental family planning organization in the country (Fajobi, 1986:4). The Benin branch which was established in 1970 opens on Mondays through Fridays from 8.00 a.m. to 3.30 p.m. for normal business. Consultation for expert advice and other treatments is thrice weekly (Monday, Wednesday and Friday) after the normal day's transactions.

The main objectives of the PPFN include the provision of family planning information and services as well as giving expert advice to sub-fertile and infertile women. In Benin, family planning information and services can also be obtained from some of the government and private health institutions in the city. In government hospitals, family planning clinics are usually attached to the maternal and child health units of the hospital; where services are rendered to married women only. However, the PPFN clinic is the only institution in the city whose sole business is the provision of family planning information and services and marital status is not an important factor in getting the services of the clinic.

Contraceptives sold at the PPFN clinic are heavily subsidized. Thus, the clinic is one of the cheapest sources of contraceptives in Benin city. Apart from the purchase of drugs and contraceptives, registered patrons of the clinic get all other services free of charge. This, coupled with the fact that the clinic is the only institution in the city whose sole responsibility is the provision of family planning services, makes it attract clients from all parts of the city.

Patronage of the clinic is enhanced by the activities of field workers who visit potential clients in all parts of the city. They keep records on contact made and the number of contacts who respond. The field workers include male motivation workers whose main targets are husbands of potential clients. Each client has a record card in which all transactions in the clinic are recorded. Certain social and demographic information such as clients' age, education, occupation, parity, religion, types of contraceptives dispensed and coital habit are included in the client's record card. These information were collected from 1981 to 1985 except in the case of information on the occupation of 1985 clients. New record cards introduced in that year (1985) did not elicit information on occupation.

To distinguish between regular (acceptors) and irregular (delinquent acceptors) patrons , we carried out preliminary investigation on the coital habit of the sample of clients. This revealed a coital frequency of 2.2 times a week. Any client who discontinued patronage of the clinic for three of more consecutive months was considered to be under high risk of pregnancy during the period. Such clients were regarded as delinquent acceptors in this study. In the case of intra-uterine contraceptive devices (IUCD) users, any client who removed the device without replacing it or adopting other types of contraceptives within a three month period was also regarded as a delinquent acceptor. On the other hand, any client who patronized the clinic regularly without a break or with a break of less than three months at a time was considered as being under less risk of pregnancy and was regarded as an acceptor. Further investigation into the coital habit of clients revealed a frequency of 2.4 times a week for delinquent acceptors and 2.0 times a week for acceptors.

2.4 Sampling Procedure

A total of 10,093 clients attended the clinic between 1981 and 1985. This was made up of 1583 clients for 1981, 1931 clients for 1982, 2165 clients for 1983, 2073 clients for 1984 and 2341 clients for 1985.

A random sample of 1000 clients which constituted about 10% of the total number of clients for the five year period was used in this study. The sample size for each year was proportional to the number of clients for the year. Thus, a sample of 157 clients was drawn for 1981, 191 clients for 1982, 215 clients for 1983, 205 clients for 1984 and 232 clients for 1985.

The samples of acceptors and delinquent acceptors were drawn from the initial sample of 1,000 clients using regularity of patronage which was the criterion for distinguishing acceptors from delinquent acceptors. A total of 257 clients were found to be regular patrons of the clinic, while 743 clients were irregular patrons of the clinic.

2.5 Method of Data Analysis

Basic statistics such as mean and proportions will be used to offer a general description of the sample. Cross tabulation analysis will be used to study the effect of the independent variables on the dependent variables, while chi-square analysis will be employed to test for significance.

2.6 Operational Definitions

Some of the concepts used in this study have various meanings both to laymen and other social scientists. The purpose of this section is to operationally define some of the key concepts used in this study.

Acceptor:

An acceptor is defined as a client who patronized the clinic on regular basis from the registration date without a break or with a break of less than three months at a time.

Delinquent acceptor:

A delinquent acceptor is defined as a client who discontinued patronage of the clinic for three or more consecutive months at a time.

High Educational Status (H.E.S.) Women:

These are women with some secondary or more education.

Low Educational Status (L.E.S.) Women:

These are women without secondary school education. They are mainly those with primary education.

Young Clients:

Young clients - acceptors or delinquent acceptors - are women within the 15-29 age group.

Old Clients:

Old clients - acceptors or delinquent acceptors - are women 30 years and above.

High Parity Clients:

These are women with four or more children.

Low Parity Clients:

These are women with one to three children.

2.7 Summary

Various studies have been carried out in Nigeria to determine the extent of knowledge, attitude and practice of family planning as well as the socio-demographic characteristics of adult and adolescent contraceptors.

In many of such studies, a woman's socio-economic status was found to affect the level at which she practices family planning, high socio-economic status women being more favourably disposed to the use of contraceptives.

The results also show a some-what general approval for family planning but knowledge and use of modern contraceptives is generally low in Nigeria. This often leads to the contention that large scale efforts on family planning information and the provision of basic infrastructure will lead to a reduction in fertility rates. Some studies from other developing countries tend to support this contention, while others emphasize the role of socio-economic development in a bid to reduce fertility in the community. However, a concensus position recognises that

social setting and population programmes are mutually supportive in bringing about low fertility in the society.

In some developing countries where contraceptives are available, studies have shown that women use contraceptives as substitutes for post-partum abstinence and other purposes. Contraception for such purposes may lead to irregular usage of contraceptives. Not much has been done to determine the characteristics of regular contraceptors (acceptors) and irregular contraceptors (delinquent acceptors) in a single study.

The six hypotheses tested in this study postulated certain relationships between some socio-demographic variables and acceptors as well as delinquent acceptors.

The data for the study were derived from records kept by the PPFN clinic in Benin City. Client's record cards used in the clinic elicit certain socio-demographic information such as age, parity, education, occupation and religion, used in this study.

Out of a total of 10,093 clients who attended the clinic between 1981 and 1985, a random sample of 1000 clients was selected. 257(25.7%) acceptors and 743(74.3%) delinquent acceptors were drawn from the main sample of 1000 clients, using regularity of patronage as criterion.

Chapter 3

SOCIO-DEMOGRAPHIC CHARACTERISTICS OF CLIENTS

This chapter describes the socio-demographic characteristics of family planning clients. The purpose is not only to identify the prominent characteristics of clients but also to demonstrate the similarities and/or differences between the characteristics of acceptors and delinquent acceptors.

In section one, we describe the characteristics of acceptors and delinquent acceptors as well as those of all clients. In section two, the six hypotheses outlined in the previous chapter are tested, while the last section gives a summary of the chapter.

3.1 Characteristics of Clients

3.1.1 Age

The age distribution of clients is shown in Table 3.1. It is seen that acceptors aged 40 years and above had the highest percentage of 19.5. This was closely followed by 18.3% for those in the 35-39 age group. 17.1% of the acceptors were in the 25-29 age group, while 16.3% were in the 30-34 age group. 16.0% of acceptors were aged 20-24 years. While the youngest age group (15-19) recorded the least percentage of 12.8.

Our data show that the highest proportion of acceptors were aged 30 years and above. This suggests that the pressure to practise family planning on a more or less permanent basis is more at old, than younger ages. Old women may be practising family planning for birth limitation since they are more likely to have had the required number of children they want.

Table 3.1 Age distribution of clients.

Age group	Clients: Acceptors No.	Acceptors %	Delinquent Acceptors No.	Delinquent Acceptors %	Total No.	Total %
15-19	33	12.8	75	10.1	108	10.8
20-24	41	16.0	134	18.0	175	17.5
25-29	44	17.1	204	27.6	248	24.8
30-34	42	16.3	202	27.2	244	24.4
35-39	47	18.3	99	13.2	146	14.6
40+	50	19.5	29	3.9	79	7.9
TOTAL	257	100.0	743	100.0	1000	100.0

In the case of delinquent acceptors. Table 3.1 shows that there were more delinquent acceptors in the 25-29 age group than in any other age group. Members of this age group constituted 27.6% of delinquent acceptors.

This was closely followed by those aged 30-34 with 27.2%. The 20-24 age group comprised 18.0%, while the 35-39 age group made up 13.2%. The youngest age group (15-19) constituted 10.1%, and the least proportion (3.9%) was in the oldest (40 +) age group.

Thus the majority (55.6%) of delinquent acceptors were in the younger age group (15-29). This differs from the distribution of acceptors where most acceptors were in the older (30+) age group. Young women may be using contraceptives irregularly for purposes other than birth limitation since they are less likely than older women to have had the required number of children.

Table 3.1 also shows that more than half (53.1%) of all clients were aged 15-29 years and a substantial proportion (24.4%) were aged 30-34 years, in the older age group. This finding is quite consistent with findings elsewhere (Ware, 1975; Oyediran, et al. 1976) which have reported that most women who practice family planning are within the 25-34 age group. It is pertinent to note that this age group includes the peak of fertility in many developing countries (see NPB, 1984:76).

3.1.2 Parity

The distribution of clients by parity is shown in Table 3.2. It shows that the highest proportion (16.5%)

of acceptors were those with seven children. 13.2% of acceptors had six children, while 10.9% had eight children. It is also seen that acceptors with three children made up 10.5%, while those that have had no children and those with one child constituted 9.7% and 9.3% respectively. There were equal proportions (6.6%) of acceptors with four and five children, while those with nine children constituted 3.5%. The least proportion (3.1%) of acceptors was among those with ten or more children. The mean parity was 4.6 children.

Table 3.2 Distribution of Clients by Parity

	Clients					
	Acceptors		Delinquent Acceptors		Total	
Parity	No.	%	No.	%	No.	%
0	25	9.7	112	15.1	137	13.7
1	24	9.3	117	15.7	141	14.1
2	26	10.1	78	10.5	104	10.4
3	27	10.5	136	18.4	163	16.3
4	17	6.6	80	10.8	97	9.7
5	17	6.6	75	10.1	92	9.2
6	34	13.2	59	7.9	93	9.3
7	42	16.5	41	5.5	83	8.3
8	28	10.9	38	5.1	66	6.6
9	9	3.5	3	0.4	12	1.2
10+	8	3.1	4	0.5	12	1.2
TOTAL	257	100.0	743	100.0	1000	100.0

It is curious to note that about 10% of acceptors were of zero parity. This is an unusually high percentage in a society which is not only known for its high fertility but traditionally abhors childlessness. The relatively high proportion of women of zero parity could be due to regular patronage of the clinic by women who engage in regular sexual activities for various reasons, which may include staving off pregnancy during periods of training or "trying to weather financial difficulties" (Okediji et al., 1976:131). This group of women may be substantial in an urban area.

However, our data show that majority of acceptors were of high parity. It appears that most acceptors attend the clinic on more regular basis after the birth of the fourth child.

It is observed from Table 3.2 that women with three children were the most delinquent acceptors (18.4%). Those with one child constituted 15.7%, while those who have had no children comparised 15.1%. Delinquent acceptors with four children were next (10.8%), closely followed by those with two children (10.5%) and those with five children (10.1%). 7.9%of delinquent acceptors had six children, while those with seven and

eight children made up 5.5% and 5.1% respectively. Less than one percent (0.94%) of delinquent acceptors had nine or more children. The mean parity of delinquent acceptors was 3.2 children compared to 4.6 children for acceptors. It is also observed that the majority of delinquent acceptors were those of zero to three parity, while most acceptors had four or more children.

Our data also show that majority (54.5%) of all clients who attended the clinic were of low parity. This is a little bit puzzling because the need for family planning usually arises after women have had the required number of children they want. Evidence from some studies (Ukaegbu, 1978; Farooq, et al., 1976; Mott, 1976) show that ideal family size of between 5.7 and 7.5 and total fertility of about the same size is prevalent in Nigeria. It is therefore appropriate to suppose that the practice of family planning by majority of low parity women as evident in our data is mainly for purposes other than family limitation. It is likely that some of the clients in this study may be using family planning methods for birth spacing (see also Oni and McCarthy, 1986)

3.1.3 Education

From the distribution of clients by educational attainment in Table 3.3., it is observed that the highest percentage (31.9) of acceptors was registered among those with primary education, that is, one out of every three acceptors had primary education. The proportion (22.6%) of acceptors with secondary education was substantially lower than that of acceptors with primary education. Acceptors with post-secondary education constituted 20.6%, while those with no formal education made up 16.3%. The least proportion (8.6%) was among those with some secondary education.

Table 3.3 shows that the proportion (51.8%) of acceptors with more than some secondary education was higher than that of those with less than some secondary education. This is not unexpected since the demographic transition theory attaches great significance to the role of education in the formation of attitudes towards small family size norms. It is expected that the higher the educational status of women, the more they will practise family planning on a more regular basis for birth limitation.

Table 3.3 Distribution of clients by educational attainment

Level of education	Clients: Acceptors No.	%	Delinquent Acceptors No.	%	Total No.	%
No formal education	42	16.3	107	14.4	149	14.9
Primary	82	31.9	278	37.4	360	36.0
Some secondary	22	8.6	137	18.4	159	15.9
Secondary	58	22.6	130	17.5	188	18.8
Post-secondary	53	20.6	91	12.3	144	14.4
TOTAL	257	100.0	743	100.0	1000	100.00

It is also seen from Table 3.3 that women with primary education constituted the largest proportion (37.4%) of delinquent acceptors and those with some secondary education made up 18.4%. The third largest group was found among women with secondary education (17.5%), followed by those with no formal education (14.4%) and women with post-secondary education (12.3%). The distribution of delinquent acceptors by education attainment shows that 51.8% of them had less than some secondary education. In the case of acceptors, the same proportion (51.8%) had some secondary or more education.

Table 3.3 also shows that the majority (50.9%) of all clients had less than some secondary education. This may be due to the fact that our data pertain to a public clinic. Most highly educated women, who may belong to the upper class, are not likely to patronize public clinics, because many may prefer private clinics which they think befit their status. Moreover, they are more likely to buy contraceptives from local chemists and medicine stores. The more education women are not only more likely to be able to pay high prices demanded from such private sources, but they are also more likely to depend on medical literature which comes with contraceptives than their less educated counterparts.

3.1.4 Occupation

Table 3.4 shows the distribution of clients by occupation. It shows that civil servants had the highest percentage (36.4%) among acceptors. A percentage of 27.3 of acceptors were housewives, while 25.0% of them were petty traders. Company employees ranked fourth with 6.1%, while the self employed made up 5.3% of acceptors. There were no farmer or unemployed acceptors.

From the distribution of acceptors, it is seen that one out of every three acceptors was a civil servant. This shows that civil servants were more consistent in the practice of family planning than clients in less bureaucratised

occupations. The bureaucratic nature of civil service job may make civil servants feel the burden of child-bearing more than women in other occupations. Many civil servants may be practising family planning on regular basis for family limitation. It has to be noted that 16 (10.8%) of acceptors were categorized as students. This tends to support our assertion that some women may be practising family planning regularly to stave off pregnancy during periods of training.

Table 3.4 Distribution of clients by occupation

Occupation	Clients					
	Acceptors		Delinquent Acceptors		Total	
	No.	%	No.	%	No.	%
Petty traders	33	25.0	176	35.0	209	32.9
Housewives	36	27.3	171	34.0	207	32.6
Civil servants	48	36.4	86	17.0	134	21.1
Self-employed	7	5.3	31	6.2	38	6.0
Company employees	8	6.1	21	4.2	29	4.6
Farmers	-	-	10	2.0	10	1.6
Unemployed	-	-	8	1.6	8	1.3
TOTAL*	132	100.0	503	100.0	635	100.0

*Total reflects non-availability of information on the occupation of 1985 clients and the exclusion of clients categorized as students.

It is also observed from Table 3.4 that petty traders comprised the largest percentage (35.0) of delinquent acceptors, followed by housewives with 34.0%. The third largest group of delinquent acceptors were civil servants with 17%. The self-employed comprised 6.2%, while company employees made up 4.2%, of delinquent acceptors. 2% of delinquent acceptors were farmers and the unemployed constituted 1.6%.

The pattern of distribution of delinquent acceptors shows that petty traders and housewives were in the majority (61.0%). This pattern is different from that already noted for acceptors where civil servants constituted the largest proportion.

The distribution of all clients by occupation is similar to that of delinquent acceptors with petty traders and housewives in the majority (65.5%). It is observed from Table 3.4 that about three out of every five client was a petty trader or housewife, while about one out of every four client was employed in occupations (civil service and company employement) not related to the home. This observation coupled with other earlier observation that majority of clients have less than some secondary education tends to support our assertion that a high proportion of clients may be of low socio-economic status.

3.1.5 Religion

The distribution of clients by religious affiliation in Table 3.5 shows that Protestants were more than any other religious group among acceptors. They constituted 39.3% of the sample. Members of "Other" faiths were the second largest group of acceptors with 34.2%. Catholics comprised 23.0%, while the corresponding percentage for Islam was 3.5.

Table 3.5 Distribution of clients by religious affiliation

	Clients					
	Acceptors		Delinquent Acceptors		Total	
Religion	No.	%	No.	%	No.	%
Catholic	59	23.0	210	28.3	269	26.9
Protestant	101	39.3	215	28.9	316	31.6
Islam	9	3.5	11	1.5	20	2.0
Others*	88	34.2	307	41.3	395	39.5
TOTAL	257	100.0	743	100.0	1000	100.0

*Others were categorized as members of faiths which exclude those mentioned above. It includes African traditional religions and other religious sects.

In the case of delinquent acceptors, it is seen from Table 3.5 that women of "Other" faiths had the highest percentage (41.3). Protestants were next with 28.9%, while Catholics constituted 28.3%. The least proportion (1.5%) was among Muslims.

Members of "Other faiths" also had the highest proportion (39.6%)among all clients, while Protestants constituted 31.6%. The third largest group were Catholics with 26.9% and the least proportion was among Muslims with 2.0%.

The relatively high proportion of clients of "Other" faiths may be due to the method of data collection in the clinic. Various religious groups like "Aladura", "Brotherhood of the Cross and Star", Jehovah Witnesses", etc. were grouped together with practitioners of African traditional religions as "Others". The pattern of distribution may be different if these sects were differentiated.

However, it should be noted that many of the other religious sects have incorporated many traditional African values into their doctrines and practices (Bond et al., 1979). Considering the high value placed on children in the traditional set-up, the high patronage of the clinic by members of "Other" faiths is a little bit puzzling. It would appear that many women are using family planning methods for other purposes, which may include the retention of traditional birth interval which has been considerably reduced by changes in socio-economic conditions in urban areas. (Oni, 1985).

It is pertinent to note that despite the high value for children associated with members of "Other" faiths, about one-third of acceptors were of "Other" faiths. This seems to support the findings of Ware (1975) and Ukaegbu (1978) that high value for children nothwithstanding, there is a

limit beyond which the number of children may be considered too many. After such a level, women are expected to practise family planning on a more or less regular basis for birth limitation.

The relatively high proportion of Protestants among acceptors and all clients may be due to the liberal attitude of Protestants towards the use of some contraceptives. Protestant doctrine approves the use of all methods of contraceptives that are "mutually acceptable, non-injurious to health and appropriate to the degree of effectiveness required in specific situations" (Whelpton, et al., 1966:19). On the other hand, the only methods morally acceptable to Catholics are the rhythm method and prolonged abstinence. In all the sample, however, about one out of four clients was a Catholic and there seems to be no marked difference between the proportion of Catholic and Protestant delinquent acceptors. This pattern is curious given the opposition of Catholics to the use of contraceptives. A possible explanation may be the inconveniences of prolonged abstinence and the rhythm methods especially in urban areas where the duration of breast feeding, which reduces post-partum fertility, is become shorter (see Oni, 1985).

Although, some studies (see NPB, 1984) have shown that Muslims are less disposed to the use of contraceptives, Islamic doctrines generally approves of contraceptive methods (Gadalla, 1978:17). The main reason for the very low

percentage of Muslims in our study may be the relatively few Muslims in the area of study. Benin city is not a predominantly Muslim area.

3.1.6 Contraceptive use

The distribution of clients by type of contraceptives dispensed is shown in Table 3.6. It is seen that the oral contraceptive was the most dispensed contraceptive to acceptors. 58.2% of acceptors were given the pill. 22.6% of acceptors were given IUCD and 15.8% were given injectables. Cream, foam, jelly and vaginal tablets were dispensed to 2.3% of acceptors, while only 1.1% were given the condom. No acceptor was given the diaphragm.

Ninety seven (97) acceptors got more than one type of contraceptive. Of this number, 35 (36.1%) changed from one type of contraceptive to another, while 62 (63.9%) were given more than one type of contraceptive at a time.

From Table 3.6, it is also observed that oral contraceptives was the most dispensed contraceptive to delinquent acceptors. 62.6% of them were given the pill, while IUCD were dispensed to 15.0% of them. Injectables were dispensed to 8.9% of delinquent acceptors and 8.6% were given cream, foam, jelly, and vaginal tablets. Only 4.1% of them were given the condom. The least dispensed contraceptive to delinquent acceptors was the diaphragm. 0.8% of them got the diaphragm.

Sixty-three (63) delinquent acceptors used more than one type of contraceptives. Forty (63.5%) of them changed contraceptives compared to 36.1% for acceptors, while 23 or 36.5% were given more than one type of contraceptives on request. The corresponding percentage for acceptors was 63.9%. It is seen that a higher proportion of acceptors requested for more than one type of contraceptives at a time and a relatively higher proportion of acceptors used more of the effective contraceptives like IUCD and Injectables.

Table 3.6 Distribution of clients by type of contraceptives dispensed.

	Clients					
	Acceptors		Delinquent Acceptors		Total	
Contraceptives	No.	%	No.	%	No.	%
Oral contraceptives	206	58.2	504	62.6	710	61.3
IUCD	80	22.6	121	15.0	201	17.3
Injectables	56	15.8	72	8.9	128	11.0
Cream, Foam, Jelly, Vaginal tables	8	2.3	69	8.6	77	6.6
Condom	4	1.1	33	4.1	37	3.2
Diaphragm	-	-	7	0.8	7	0.6
TOTAL*	354	100.0	806	100.0	1160	100.0

* Total reflects those who used more than one type of contraceptive.

The distribution in Table 3.6 also shows that oral contraceptives was the most dispensed contraceptive to all clients. 61.3% of all clients were given the pill. A percentage of 17.3 clients were given IUCD, while the third most dispensed contraceptive were injectables, with a percentage of 11.0. Cream, foam, jelly and vaginal tablets were dispensed to 6.6% of clients, while 3.2% were given the condom. The least dispensed contraceptive was the diaphragm with only 0.6% of clients.

Various factors determine the use of different types of contraceptives. These include medical consideration, efficiency, convenience, cost, as well as availability. There was no medical examination carried out before contraceptives were dispensed, except in cases where clients have peculiar ailments like hypertension. The high percentage dispensation of oral contraceptives may be due to its relatively low cost[1], high effectiveness,[2] and availability in the clinic, since most clients depend on the officials of the clinic for a choice of contraceptives. Also oral contraceptives do not involve medical expertise before they can be used.

Clients who requested for more than one type of contraceptives might have used them together probably because no contraceptive has been found to be 100% efficient. Those who changed from one type of contraceptive to another may have done so due to various side effects, like internal

heat in the stomach, pepperish sensation, heavy menses, etc. associated with the use of some contraceptives.

3.2 Test of Hypotheses

The six hypotheses tested in this section postulate that clients of certain age, parity and educational attainment are more likely to be acceptors than delinquent acceptors, while others are more likely to be delinquent acceptors than acceptors. Since each of the socio-demographic variable is likely to affect the practice of family planning independently, the effect of each of them on the number of acceptors and delinquent acceptors is tested when the other variables are held constant. Thus, each sub-sample is divided into four sub-groups according to the relationship being tested.

The first hypothesis states that acceptors are more likely to be old women than younger ones.

To test the hypothesis, the parity and educational status of acceptors are controlled. Table 3.7 shows the four groups of acceptors, while controlling for parity and educational status. The first group is made up of low parity (1-3), high educational status (HES) acceptors, while the second group is made up of those of low parity and low educational status (LES). The third and the fourth groups are made up of acceptors of high parity (4+) but of HES and LES respectively.

Table 3.7 Distribution of acceptors by age groups with parity and educational status held constant.

Age group	Acceptors									
	1-3 & HES*		1-3 & LES**		4+ & HES		4+ & LES		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%
15-29	11	27.5	15	62.5	27	38.6	21	37.5	74	38.9
30+	29	72.5	9	37.5	43	61.4	35	62.5	116	61.1
TOTAL***	40	100.0	24	100.0	70	100.0	56	100.0	190	100.0

Chi-square = 8.1 (df=3) Sig. level = 0.05

* High educational status

** Low educational status

*** Total reflects the exlusion of zero parity women and illiterates.

From the pattern of distribution in Table 3.7, it is seen that the proportion of old acceptors in groups one, three and four were substantially higher than those of acceptors in the younger age group. Considering women with LES and low parity, the proportion of old acceptors was less than that of young acceptors. This may be due to the tendency of LES women to have many children. At low parity, a few of them will practise family planning on regular basis, especially at old age, since this is likely to lead to birth limitation.

In all the sample, however, 61.1% of acceptors were old, while 38.9% were young. A chi-square test shows that the difference is significant at 0.05 level. Thus we fail to reject our hypothesis. Old women may have had the required number of children they wanted and thus were more likely to practise family planning on more regular basis.

The second hypothesis states that acceptors are likely to be of high parity than of low parity. Table 3.8 shows the four groups of acceptors, while controlling for age and educational status.

Table 3.8 Distribution of acceptors by low and high parity with age and education status held constant.

PARITY	Acceptors								TOTAL	
	15-19& HES*		15-29 % LES**		30+ & HES		20+ & LES			
	No.	%	No.	%	No.	%	No.	%	No.	%
1-3	9	23.7	17	47.2	31	43.1	7	15.9	64	33.7
4+	29	76.3	19	52.8	41	56.9	37	84.1	126	66.3
TOTAL***	38	100.0	36	100.0	72	100.0	44	100.0	190	100.0

Chi-square = 14.4 (df=3) Sig. level = 0.05

* High educational status

** Low educational status

*** Total reflects the exlusion of zero parity women and illiterates.

From the distribution in Table 3.8 it is seen that the proportions of high parity acceptors were more than those of low parity acceptors in all the groups. A total percentage of 66.3 acceptors were of high parity, while 33.7% were of low parity. A chi-square test shows that this difference is statistically significant at 0.05 level. We therefore fail to reject our second hypothesis. In other words, there is a significant relationship between the number of children a women has and her acceptance of family planning. It seems that at high parity many women would have had the required number of children and therefore were likely to practise family planning on a more regular basis.

The third hypothesis states that acceptors are more likely to be of high educational status than of low educational status. To test this hypothesis, parity and age were held constant as shown in Table 3.9

As expected, the proportion of HES acceptors in the first group of young low parity women was higher than that of LES women. The same was true in the second group of old women of low parity as well as in the fourth group of old, high parity women. Unexpectedly, however, the proportion of LES women was higher than HES women in the third group of young high parity women. It appears that at high parity many LES women would practise family planning on regular basis especially at young ages, when most women are highly fecund.

Table 3.9 Distribution of acceptors by high and low educational status with parity and age held constant

Educational Status	Acceptors: 1-3 & 15-29		1-3 & 30+		4+ & 15-29		4+ & 30+		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%
HES*	15	57.7	25	65.8	23	47.9	47	60.3	110	57.9
LES**	11	42.3	13	34.2	25	52.1	31	39.7	80	42.1
TOTAL***	26	100.0	38	100.0	48	100.0	78	100.0	190	100.0

Chi-square = 3.4 (df=3) Not sig. level = 0.05

* High educational status

** Low education status

*** Total reflects exclusion of zero parity women and illiterates.

However, a percentage of 57.9% women were of HES, while 42.1% were LES. This difference is not significant at 0.05 level to make us reject our null hypothesis. Thus, when parity and age are controlled, acceptance of family does not seem to vary according to educational status. This is unexpected. It is observed from our data that when parity is held constant the difference between HES and LES acceptors is not much at young ages. This is as compared to the substantial difference between HES and LES acceptors at

older ages, under the same conditions. Our data also show, contrary to expectation, that the proportion of LES acceptors was higher than that of HES acceptors in group three of young, high parity women but not in group one of young low parity women. It would appear that age and parity played a major role in the lack of significant difference between HES and LES acceptors in our study.

The fourth hypothesis states that delinquent acceptors are more likely to be young than older women. In testing this hypothesis, parity and education status are held constant.

Table 3.10 shows that the proportion of young delinquent acceptors was more than that of older ones in the second, third and fourth groups. In the first group of low parity HES women, the proportion of older women was higher, than that of young women. It is likely that many HES women do not consider one to three children as ideal; under such conditions they are likely to practise family planning on irregular basis at old age since the physiological capacity to have children is limited by age.

However, a total of 58.4% of delinquent acceptors were young, while 41.6% were older. A chi-square test shows this difference to be significant at 0.05 level. This seems to suggest that at young ages many women are not likely to have had the required number of children they want and are therefore likely to practise family planning on irregular basis.

Table 3.10 Distribution of delinquent acceptors by age groups with parity and educational status held constant.

Age group	Delinquent Acceptors								TOTAL	
	1-3 & HES*		1-3 & LES**		4+ & HES		4+ & LES			
	No.	%	No.	%	No.	%	No.	%	No.	%
15-29	75	44.9	86	62.3	74	71.8	71	61.2	306	58.4
30+	92	55.1	52	37.7	29	28.2	45	38.8	218	41.6
TOTAL***	167	100.0	138	100.0	103	100.0	116	100.0	524	100.0

Chi-square = 22.0 (df=3) Sig. level = 0.05

* High educational status

** Low educational status

*** Total reflects exclusion of zero parity women and illiterates

The fifth hypothesis states that delinquent acceptors are more likely to be of low parity than of high parity.

In Table 3.11, age and educational status were held constant in each of the four sub-groups of delinquent acceptors. It is observed that the proportion of low parity women was higher than that of high parity women among young, HES women. The same was true of old women of high and low educational status. In the case of young, LES women (group 2), the proportion of high parity women was more than that of low parity women.

Table 3.11 Distribution of delinquent acceptors by low and high parity with age and educational status held constant.

	Delinquent Acceptors								TOTAL	
	15-29 & HES*		15-29 & LES **		30+ & HES		30+ & LES			
Parity	No.	%	No.	%	No.	%	No.	%	No.	%
1-3	90	60.4	71	45.2	77	63.6	67	69.1	305	58.2
4+	59	39.6	86	54.8	44	36.4	30	30.9	219	41.8
TOTAL***	149	100.0	157	100.0	121	100.0	97	100.0	524	100.0

Chi-square = 17.1 (df=3) Sig. level = 0.05

* High educational status

** Low educational status

*** Total reflects exclusion of zero parity women and illiterates

LES women are generally expected to be of high parity. But the proportion of high parity delinquent acceptors is relatively low among old, LES women. A possible explanation for the difference in group two is that at young ages women are likely to be more sexually active, and thus many of them may require the services of the clinic.

A total of 58.2% of delinquent acceptors were of low parity, while 41.8% were of high parity. This difference is statistically significant at 0.05 level. The numerical strength of women of low parity over those of high parity in the irregular patronage of the clinic could be attributed to the wish of low parity women to have more children.

The sixth hypothesis states that delinquent acceptors are more likely to be of low educational status than of high educational status. Table 3.12 shows the distribution of delinquent acceptors by educational status with parity and age held constant.

Table 3.12 Distribution of delinquent acceptors by high and low educational status with parity and age held constant.

	Delinquent Acceptors									
Educational Status	1-3 & 15-29 No.	%	1-3 & 30+ No.	%	4+ & 15-29 No.	%	4+ & 30+ No.	%	TOTAL No.	%
HES*	82	50.9	85	59.0	67	46.2	36	48.6	270	51.5
LES**	79	49.1	59	41.0	78	53.8	38	51.4	254	48.5
TOTAL***	161	100.0	144	100.0	145	100.0	74	100.0	524	100.0

Chi-square = 5.3 (df = 3) not Sig. level = 0.05

* High educational status

** Low educational status

*** Total reflects exclusion of zero parity women and illiterates.

As expected, the proportions of LES women were higher among young and old high parity women (groups 3 and 4). However, the proportions of HES women were unexpectedly higher than LES women among young and old low parity women (groups 1 and 2). It is observed that at low parity HES women are more delinquent than LES women, and at high parity, there is not much difference between HES and LES. It would

appear that parity and age play a major role in determining the proportions of HES and LES delinquent acceptors. Considering all the samples, 51.5% of delinquent acceptors were of HES, while 48.5% were of LES. This difference is not significant at 0.05 level. The numerical strength of HES delinquent acceptors over LES delinquent acceptors is however contrary to our hypothesis, that LES women are more delinquent than HES women.

The tendency of HES women to be more delinquent than LES women could be attributed to the tendency of HES women of low parity to practise family planning on a more or less irregular basis. This suggests that at low parity many HES women may still like to have more children.

3.3 Summary

This chapter described the social and demographic characteristics of clients. It also attempted to establish certain relationships between acceptors as well as delinquent acceptors and some social and demographic variables.

Our analysis shows that many clients who attended the clinic were in the 15-29 age group. Delinquent acceptors were also found to be more in the same age group, while more acceptors were found in the highest age group (30+).

Low parity women attended the clinic more than high parity women. They were also more delinquent, while most acceptors were of high parity. The mean parity of delinquent acceptors was 3.2 children, compared to 4.6 children for acceptors.

Majority of women who attended the Benin clinic between 1981 and 1985 were either of low educational status or had no formal education. Many LES women were also delinquent acceptors. However, there was neither a significant difference between the proportion of acceptors of HES and LES nor between HES and LES delinquent acceptors. It appears that at low parity, most women are delinquent irrespective of educational status.

As far as occupation is concerned, it was shown that petty traders attended the clinic more than women of other occupations. However, they were also more delinquent. On the other hand, more acceptors were found among civil servants than any other occupation. The occupation of most women coupled with their educational status, suggest that majority of women who attended the clinic were of low socio-economic status.

Women of "Other" faiths which include various religious sects and practitioners of African traditional religion visited the clinic more than women of other religious groups. The highest proportion of delinquents

were also of "Other" faiths, but Protestants were more among acceptors. Our data also show that most Catholics were delinquent acceptors.

The oral contraceptive was the most frequently dispensed contraceptive to all clients. However, a higher proportion of acceptors were given more effective contraceptives like IUCD and injectables, while a relatively higher proportion of delinquent acceptors were given the less effective contraceptives like cream, foam, jelly and vaginal tables. Lastly, more acceptors requested for more than one type of contraceptive at a time probably to ensure efficacy.

3.4 Footnotes

1 One cycle of oral contraceptives sells for ₦1 in the clinic. "Copper T" an IUCD costs ₦5, while injectables like "Depo-provera" and "Noristerat" sells for ₦3 each. The Diaphragm costs ₦5, while "Sampoon" foaming tablets cost ₦2.

In 10 other contraceptive outlets including the University Teaching Hospital, one cycle of oral contraceptive is sold for ₦2 - ₦3.50, IUCD from ₦12 - ₦15 and injectables ₦15-₦25, while the Diaphragm sold for ₦10-₦20.

2 World Health Organization sources put the annual failure rate (including patients error and omission) of combined oral contraceptives at about 2.6 unwanted pregnancies per 100 couples. This may be compared to 25 for cream, foam, jelly and vaginal tablets, 17.5 for diaphragm, 11.5 for condom and 0.25 for injectables (Depo-provera).

This information was obtained from a chart made available to the PPFN clinic by Up John Nigeria Limited, makers of "Depo-provera."

Chapter 4

TRENDS IN SOCIAL AND DEMOGRAPHIC CHARACTERISTICS OF CLIENTS

In this chapter, we describe the trend in social and demographic characteristics of all clients in section one. Sections two and three deal with trends in social and demographic characteristics of acceptors and delinquent acceptors respectively, while a summary of the chapter is given in the last section. The main objective is to determine variations (if any) in the social and demographic characteristics of clients over the period (1981-1985) under consideration. From this speculations are made about future trends.

4.1 Trends in Social and Demographic Characteristics of all Clients

4.1.1 Age

Table 4.1 shows the yearly distribution of all clients by age groups. It is seen from the Table that the proportion of clients aged 15-19 increased throughout the period from 3.8% in 1981 to 14.7% in 1985.

In the 20-24 age group, the proportion of clients also increased from 8.9% in 1981 to 23.7% in 1985. However, the increase in proportion seems more significant in the 15-19 age group than in the 20-24 age group.

Table 4.1 Yearly distribution of clients by age

Age Group	YEAR 1981 No.	%	1982 No.	%	1983 No.	%	1984 No.	%	1985 No.	%
15-19	6	3.8	15	7.9	24	11.2	29	14.1	34	14.7
20-24	14	8.9	27	14.1	32	14.9	47	22.9	55	23.7
25-29	42	26.8	51	26.7	59	27.4	50	24.4	46	19.8
30-34	56	35.6	60	31.4	56	26.0	36	17.6	36	15.5
35-39	29	18.5	32	16.8	27	12.6	24	11.7	34	14.7
40+	10	6.4	6	3.1	17	7.9	19	9.3	27	11.6
TOTAL	157	100.0	191	100.0	215	100.0	205	100.0	232	100.0

In 1981, only about one out of 25 clients was in the 15-19 age group, by 1985, this has increased to about three out of 20. On the other hand, one out of 10 clients was in the 20-24 age group in 1981, this has increased to only about one out of four clients in 1985.

The proportion of clients in the 25-29 age group was almost the same in 1981 (26.8%) and 1982 (26.7%). However there was a slight increase in 1983 (27.4%), after which decreases were recorded in 1984 (24.4%) and 1985 (19.8%).

Clients aged 30-34 show a general declining trend from 35.6% in 1981 to 15.5% in 1985. The same decline in trend, from 18.5% in 1981 to 11.7% in 1984, was recorded in the 35-39 age group. In 1985 however, the proportion of clients, aged 35-39, increased to 14.7%. In the highest age group (40+) there was an initial decline in proportion from 6.4% in 1981 to 3.1% in 1982, the proportion, however, increased from 1983 (7.9%) to 1985 (11.6%).

Generally, the proportion of young clients, especially those age 15-24 years, increased yearly. The increase in trend noticed in the 15-24 age group was more consistent than that of the oldest age group (40+) where the proportion of clients also showed some yearly increase. The consistent increase in trend of young clients could be due to their innovative characteristics. The youth tend to be more innovative than older people. Secondly, Caldwell and

Caldwell (1976) have noted that recent social change has increased the likelihood of pre-marital and extra-marital sexual relations and the desire to shorten periods of post-natal sexual abstinence while not decreasing intervals between births. The increasing proportion of young contraceptors could be due to this change. This trend may continue in future as more young women are exposed to family planning information and services.

4.1.2 Parity

The yearly distribution of clients by parity is shown in Table 4.2. It is observed that the proportion of clients of zero parity increased generally from 5.1% in 1981 to 23.3% in 1985.

The proportion of clients with one to three children also increased from 29.9% in 1981 to 46.9% in 1984, after which there was a decline (40.5%) in 1985.

In the case of clients with four to six children, the proportion declined from 38.2% in 1981 to 22.4% in 1984, but there was a slight increase to 23.3% in 1985. Those clients who have seven or more children also exhibited a decline from 26.8% in 1981 to 10.7% in 1984 with an increase to 12.9% in 1985.

Our data show that the proportion of zero and low parity women tended to increase, while that of high parity

Table 4.2 Yearly distribution of clients by parity

	YEAR									
	1981		1982		1983		1984		1985	
Parity	No.	%	No.	%	No.	%	No.	%	No.	%
0	8	5.1	12	6.3	22	10.2	41	20.0	54	23.3
1-3	47	29.9	72	37.7	99	46.1	96	46.9	94	40.5
4-6	60	38.2	59	30.9	63	29.3	46	22.4	54	23.3
7+	42	26.8	48	25.1	31	14.4	22	10.7	30	12.9
TOTAL	157	100.0	191	100.0	215	100.0	205	100.0	232	100.0

clients tended to decline. For instance, in 1981, about one out of every 20 clients was of zero parity. By 1985, this has increased to nearly one out of every four clients. In contrast, about one out of every four clients had seven or more children in 1981, by 1985, this has declined to about one out of every 10 clients. This trend may be due to the increasing patronage of the clinic by unmarried women (since martial status is not a condition for getting services from the clinic) and married women (of low parity) who are likely to be concerned with birth spacing. This trend is likely to continue as more women become aware of the alternative uses of contraceptives.

4.1.3 Education

The yearly distribution of clients by educational attainment (Table 4.3) shows that in 1981 about one out of every four clients had no formal education, however in 1985 this has declined to about one out of every 10 clients.

In the case of those with primary education, increases were recorded from 31.8% in 1981 to 39.7% in 1982 and 48.8% in 1983. However, the proportions declined in 1984 (30.2%) and 1985 (28.8%) respectively.

There was a fluctuating trend for clients with some secondary education - a decline from 17.2% in 1981 to 11.0% in 1982, an increase to 14.4% and 20.5% in 1983 and 1984 respectively and another decline to 16.4% in 1985.

Table 4.3 Year distribution of clients by educational attainment

Level of Education	YEAR 1981 No.	%	1982 No.	%	1983 No.	%	1984 No.	%	1985 No.	%
No formal education	38	24.2	45	23.6	26	12.1	24	11.7	16	7.0
Primary	50	31.8	76	39.7	105	48.8	62	30.2	67	28.8
Some secondary	27	17.2	21	11.0	31	14.4	42	20.5	38	16.4
Secondary	27	17.2	32	16.8	35	16.3	42	20.5	52	22.4
Post secondary	15	9.6	17	8.9	18	8.4	35	17.1	59	25.4
TOTAL	157	100.0	191	100.0	215	100.0	205	100.0	232	100.0

The proportion of clients with secondary education declined slightly from 17.2% in 1981 to 16.8% in 1982, with almost the same proportion (16.3%) in 1983. However, there were increases in proportion in 1984 (20.5%) and 1985 (22.4%) respectively.

Clients with post secondary education exhibited a decline from 9.6% in 1981 to 8.9% and 8.4% in 1982 and 1983 respectively. After 1983, there were significant increases in 1984 and 1985, For instance in 1985, one out of every four clients had post secondary education, compared to one out of every 10 clients recorded in 1981.

Our findings seem to show that more clients with secondary and post secondary education attended the clinic in 1984 and 1985 than in earlier years. One possible explanation may be the increasing cost of drugs in recent times. This may have affected the cost of contraceptives. The high educational status women who are likely to be more informed and willing to use contraceptives, but unlikely to patronise public clinics under normal circumstances, may be taking advantage of the subsidized rates at the clinic. The influx of HES women may be responsible for the low representation of low educational status women in our sample in 1984 and 1985.

The future trend is likely to depend on the cost of contraceptives in the open market in the future.

4.1.4 Occupation

Table 4.4 shows the yearly distribution of clients by occupation. It is observed that except for the decline from 33.6% in 1981 to 31.6% in 1982, the proportion of clients who are petty traders showed little variation from year to year. However, the proportion of clients who are housewives increased steadily from 28.5% in 1981 to 35.2% in 1984.

The proportion of clients who are civil servants showed little variations between 1981 and 1983. The corresponding percentage for 1981 was 19.7 while those for 1982 and 1983 were 19.3 and 20.0 respectively. In 1984, however, there was a substantial increase (25.3%).

The proportion of clients who are self-employed increased from 5.8% in 1981 to 9.3% in 1982, then declined in 1983 (6.3%) and 1984 (2.5%), respectively. In the case of clients who are company employees, there was a decline from 8% in 1981 to 6.2% and 2.3% in 1982 and 1983 respectively. The 1984 proportion (2.5%) was almost equal to the 1983 proportion.

The proportion of farmers who are clients showed a slight increase from 1.5% in 1981 to 1.9% and 2.3% in 1982 and 1983 respectively, and then declined sharply to 0.6% in 1984. As for clients who are unemployed, the proportion fluctuated from 2.9% in 1981 to 0.6% in 1982 and 1.1% in 1983. The 1984 proportion was 0.6.

Table 4.4 Yearly distribution of clients by occupation*

	YEAR							
	1981		1982		1983		1984	
Occupation	No.	%	No.	%	No.	%9	No	%
Petty traders	46	33.6	51	31.6	58	33.1	54	33.3
Housewives	39	28.5	50	31.1	61	34.9	57	35.2
Civil servants	27	19.7	31	19.3	35	20.0	41	25.3
Self employed	8	5.8	15	9.3	11	6.3	4	2.5
Company employees	11	8.0	10	6.2	4	2.3	4	2.5
Farmers	2	1.5	3	1.9	4	2.3	1	0.6
Unemployed	4	2.9	1	0.6	2	1.1	1	0.6
TOTAL**	137	100.0	161	100.0	175	100.0	162	100.0

* Information on the occupation of 1985 clients was not available

** Total reflects the exclusion of clients categorized as "students".

From our data, it is seen that while the proportion of petty traders stabilized, the proportion of civil servants increased from about one out of every five clients in 1981 to about one out of every four clients in 1985. This increase in the proportion of civil servants (who are likely to be women of HES) could also be due to recent price increase of drugs (contraceptives) in the open market.

Our data also revealed a steady increase in the proportion of housewives who are clinets. This increase could be the result of field workers' access to housewives who are likely to be more available for counselling than women in other home related occupations like petty trading. It is speculated that future trend may depend on the activities of field workers and their access to potential clients.

4.1.5 Religion

The yearly distribution of clients by religious affiliation (Table 4.5) shows that the proportion of Catholic clients increased steadily from 22.9% in 1981 to 28.8% in 1983. There was a decrease in 1984 (20.9%) followed by a substantial increase in 1985 (35.8%).

The proportion of clients who are Protestants declined from 37.6% in 1981 to 30.6% in 1985, however, there was little difference in proportion in 1982 (30.9%), 1983 (31.2%) and 1984 (29.3%)

Table 4.5 Yearly distribution of clients by religious affiliation

	YEAR									
	1981		1982		1983		1984		1985	
Religion	No.	%	No.	%	No.	%	No.	%	No.	%
Catholic	36	22.9	45	23.6	62	28.8	43	20.9	83	35.8
Protestant	59	37.6	59	30.9	67	31.2	60	29.3	71	30.6
Islam	5	3.2	6	3.1	3	1.4	3	1.5	3	1.3
Others*	57	36.3	81	42.4	83	38.6	99	48.3	75	32.3
TOTAL	157	100.0	191	100.0	215	100.0	205	100.0	232	100.0

* "Others" were categorized as members of faiths which exclude those mentioned above. It includes African Traditional Religion and Other religious sects.

There was almost equal proportion of clients who are Muslims in 1981 (3.2%) and 1982 (3.1%). The proportion declined to 1.4% in 1983 after which no significant difference in proportion was notice in 1984 (1.5%) and 1985 (1.3%) respectively.

The trend for "Others" can be described as fluctuating. For instance, there was an increase in proportion from 36.3% in 1981 to 42.4% in 1982. This declined to 38.6% in 1983 but 1984 registered a sharp increase (48.3%), while there was a significant decline in 1985 (32.3%).

In general, the proportion of clients of the religious groups tended to vary yearly. However, the proportion of clients who are Catholics showed some increase in trend as compared to proportion of clients who are Protestants and Muslims which tended to decline.

The possibility of more Catholics and fewer other religious groups patronising the clinic in future is likely to depend on a number of factors which may include increase in educational attainment of potential clients, the price of contraceptives and the perception of the efficacy of the rhythm method especially by Catholics. It may be mentioned in passing that rhythm and abstinence are the only birth control methods recommended for Catholics by the Holy See.

4.2 Trends in Social and Demographic Characteristic of Acceptors

4.2.1 Age

The yearly distribution of acceptors by age in Table 4.6 shows that there were no acceptors in the youngest age group in 1981 and 1982. The proportion of acceptors in the age group (15-19) was 5.9% in 1982, this increased to 20% in 1984 but declined to 17.4% in 1985.

There were no acceptors in the 20-24 age group in 1981. The recorded proportion of 3.5% in 1982 declined to 2.9% after which there was a marked increase (25.0%) in 1984. The proportion, however, declined to 22.0% in 1985.

The distribution in the 25-29 age group exhibited a general decline from 28.0% in 1981 to 11.0% in 1985. Acceptors aged 30-34 also showed a decline in proportion from 32.0% in 1981 to 9.2% in 1985.

Those acceptors who are aged 35-39 years showed little variation in 1981 (20.0%), 1982 (20.7), 1983 (20.6%) and 1985 (20.2%). The only significant variation was the decline to 11.6% in 1984. A similar trend was recorded for acceptors in the highest(40 +) age agroup with 20.0% in 1981, 20.7% in 1982 and 20.6% in 1983. A decline to 16.7% was recorded in 1984, but in 1985, the proportion (20.2%) increased almost to the 1983 level.

Table 4.6 Yearly distribution of Acceptors by Age

Age Groups	YEAR 1981 No.	%	1982 No.	%	1983 No.	%	1984 No.	%	1985 No.	%
15-19	-	-	-	-	2	5.9	12	20.0	19	17.4
20-24	-	-	1	3.5	1	2.9	15	25.0	24	22.0
25-29	7	28.0	7	24.0	8	23.5	10	16.7	12	11.0
30-34	8	32.0	9	31.1	9	26.5	6	10.0	10	9.2
35-39	5	20.0	6	20.7	7	20.6	7	11.6	22	20.2
40+	5	20.0	6	20.7	7	20.6	10	16.7	22	20.2
TOTAL	25	100.0	29	100.0	34	100.0	60	100.0	109	100.0

Our data show that the proportion of young acceptors (15-29) tended to decline. This is not unexpected because as we noted earlier, many young women may either by using contraceptives to take care of pregnancies that may result from pre-marital affiars or to shorten periods of post-natal abstinence. Sexual activities for such purposes are likely to be sporadic and may not encourage constant use of contraceptives. The proportion of clients in these categories, therefore, is not expected to be increasing among regular patrons (acceptors) of the clinic.

4.2.2 Parity

Table 4.7 shows the yearly distribution of acceptors by parity. It is seen that there were no acceptors of zero parity in 1981 and 1982. In 1983, the percentage was only 5.9, which increased substantially to 13.3% in 1984 and 13.8% in 1985.

There was no acceptor with one to three children in 1981. The proportion was 6.9% in 1982, this increased uninterruptedly to 38.4% in 1985.

The proportion of acceptors with four to six children increased from 24.0% in 1981 to 30.0% in 1984, However, in 1985, the proportion declined to 23.9%

In 1981, acceptors with more than six children comprised three out of every four acceptors; by 1985, a little above one out of every five acceptors had more than six children. This shows a substantial decrease in proportion.

Table 4.7 Yearly distribution of acceptors by parity

Parity	YEAR									
	1981		1982		1983		1984		1985	
	No.	%	No.	%	No.	%	No.	%	No.	%
0	-	-	-	-	2	5.9	8	13.3	15	13.8
1-3	-	-	2	6.9	11	32.4	22	36.7	42	38.4
4-6	6	24.0	8	27.6	10	29.3	18	30.0	26	23.9
7+	19	76.0	19	65.5	11	32.4	12	20.0	26	23.9
TOTAL	25	100.0	29	100.0	34	100.0	60	100.0	109	100.0

Our findings seem to indicate that the proportions of zero and low parity women were increasing. This is unexpected because we assumed that zero and low parity women were unlikely to be concerned with birth limitation. Consequently, we do not expect their proportion to increase among regular patrons (acceptors) of the clinic. However, very sexually active women who may not be concerned with birth limitation, may be using contraceptives regularly to prevent pregnancies temporarily. Such women, however, are not expected to be regular contraceptors for a long period. This is reflected in our data which shows that no zero parity client has been an acceptor for more than three years. However, the few cases of acceptors of zero and low parity in our sample especially between 1981 and 1983 make interpretation of the trend rather difficult.

4.2.3 Education

From Table 4.8 which shows the yearly distribution of acceptors by educational attainment, it is observed that the proportion of acceptors with no formal education increased from 28% in 1981 to 31.0% in 1982 and then declined to 23.5% and 13.3% in 1983 and 1984 respectively. A substantial decline was noticed in 1985 (9.2%). In the case of acceptors with primary education, there was a general decline from 40.0% in 1981 to 28.4% in 1985.

Table 4.8 Yearly distribution of acceptors by educational attainment

Level of education	YEAR 1981 No.	%	1982 No.	%	1983 No.	%	1984 No.	%	1985 No.	%
No formal education	7	28.0	9	31.0	8	23.5	8	13.3	10	9.2
Primary	10	40.0	11	38.0	12	35.3	18	30.1	31	28.4
Some secondary	2	8.0	1	3.5	3	8.8	8	13.3	8	7.3
Secondary	4	16.0	5	17.2	7	20.6	14	23.3	28	25.7
Post secondary	2	8.0	3	10.3	4	11.8	12	20.0	32	29.4
TOTAL	25	100.0	29	100.0	34	100.0	60	100.0	109	100.0

The proportion of acceptors with some secondary education did not show any consistent increase or decrease. For instance, there was a decline from 8.0% in 1981 to 3.5% in 1982 and then an increase to 8.8% and 13.3% in 1983 and 1984 respectively. The corresponding percentage for 1985 was 7.3.

The yearly distribution of acceptors with secondary and post secondary education showed general increases during the period in question. However, the increase in the proportion of post-secondary acceptors seems more significant. In 1981, acceptors with secondary education comprised about four out of every 25 acceptors. In 1985, they comprised one out of every four acceptors. On the other hand, the ratio of acceptors with post-secondary education to all acceptors was 1:25 in 1981 but by 1985 it has increased to 3:10.

In generaly, the proportion of acceptors with some secondary or more education tended to increase while that of acceptors with less than some secondary education tended to decline. This trend may continue since highly educated women are more likely to be under social and economic pressure to practice family planning on a more regular basis for birth limitation than their less educated counterparts.

4.2.4 Occupation

The yearly distribution of acceptors by occupation is shown in Table 4.9. It is observed that the proportion of acceptors who are civil servants declined from 30.4% in 1981 to 29.6% in 1982, after which it increased to 34.5% in 1983 and 43.4% in 1984.

The proportion of housewives who are acceptors showed a general decline from 30.4% in 1981 to 24.5% in 1984. A similar trend was exhibited by acceptors who are petty traders whose proportion declined generally from 30.4% in 1981 to 22.6% in 1984.

The pattern for company employees showed an increase from 4.4% in 1981 to 7.4% in 1982, thereafter, there was a decline to 6.9% and 5.7% in 1983 and 1984 respectively. In the case of the self-employed, there was an increase from 4.4% in 1981 to 7.4% in 1982. This however, declined to 6.9% in 1983 and 3.8% in 1984. There were no farmer or unemployed acceptors.

Our data show that the proportion of acceptors employed in occupations related to the home, such as petty trading and full-time housewives declined, while that of civil servants tended to increase. This suggests that more civil servants are practising family planning regularly. This is not unexpected since civil servants are more likely to experience the incompatibility of child-bearing and child-rearing with their jobs than others in less bureaucratised occupations like petty trading and farming.

Table 4.9 Yearly distribution of acceptors by occupation*

Occupation	YEAR 1981 No.	%	1982 No.	%	1983 No.	%	1984 No.	%
Civil servants	7	30.4	8	29.6	10	34.5	23	43.4
House-wives	7	30.4	8	29.6	8	27.6	13	24.5
Petty traders	7	30.4	7	26.0	7	24.1	12	22.6
Company employees	1	4.4	2	7.4	2	6.9	3	5.7
Self-employed	1	4.4	2	7.4	2	6.9	2	3.8
TOTAL**	23	100.0	27	100.0	29	100.0	53	100.0

* Information on the occupation of 1985 acceptors was not available.

**Total reflects the exclusion of acceptors categorized as "students".

4.2.5 Religion

From the yearly distribution of acceptors by religious affiliation in Table 4.10, it is seen that the proportion of Catholic acceptors was almost the same in 1981 (20.0%) and 1982 (20.7%). It increased to 23.5% in 1983 and tended to stabilize, with a small difference in proportion in 1984 (23.3%) and 1985 (23.9%).

For Protestant acceptors, there was an increased from 32.0% in 1981 to 41.7% in 1984; in 1985, the proportion declined to 40.3%

Muslims who are acceptors showed a general decline from 16.0% in 1981 to 0.9% in 1985. The decline was more significant in 1983 (3.0%), 1984 (0%) and 1985 (0.9%).

The proportion of acceptors of "Other" faiths declined from 32.0% in 1981 to 31.0% in 1982. There was an increase in proportion to 35.3% in 1983, while the 1984 (35.0%) and 1985 (34.9%) proportions showed little variation.

Table 4.10 seems to suggest that there was little variation in the yearly proportion of acceptors who are Catholics and of "Other" faiths, especially in the last three years. However, the proportion of Protestants who are acceptors tended to increase while that of Muslim acceptors tended to decline. This trend is likely to continue since birth limitation which may be a consequence of regular

4.10 Yearly distribution of acceptors by religious affiliation

Religion	YEAR									
	1981		1982		1983		1984		1985	
	No.	%	No.	%	No.	%	No.	%	No.	%
Catholic	5	20.0	6	20.7	8	23.5	14	23.3	26	23.9
Protestant	8	32.0	11	37.9	13	38.2	25	41.7	44	40.3
Islam	4	16.0	3	10.4	1	3.0	-	-	1	0.9
Others*	8	32.0	9	31.0	12	35.3	21	35.0	38	34.9
TOTAL	25	100.0	29	100.0	34	100.0	60	100.0	109	100.0

* "Others" were categorized as members of faiths which exclude those mentioned above. It includes African traditional religion and other religious sects.

patronage of the clinic seems to be affected by religious doctrines and practices which die hard. Future trend may also depend on other developments, especially the extent to which various religious groups encourage the acquisition of formal education.

4.3 Trends in Social and Demographic Characteristics of Delinquent Acceptors

4.3.1 Age

Table 4.11 shows the yearly distribution of delinquent acceptors by age. It shows (yearly) increases in the proportion of delinquent acceptors in the youngest age group (15-19) from 4.5% in 1981 to 12.2% in 1983. However, there was a decline in 1984 (11.7%) after which there was an increase in 1985 (12.2%). The increase in proportion in the 20-24 age group however was uninterrupted from 10.6% in 1981 to 25.2% in 1985.

In the 25-29 age group, the proportion increased from 26.5% in 1981 to 27.2% in 1982 and 28.2% in 1983, then declined to 27.6% in 1984 with the same proportion (27.6%) in 1985.

Delinquent acceptors aged 30-34 years showed a decline in proportion from 36.4% in 1981 to 20.7% in 1984. The 1985 proportion (21.1%) was a slight increase on the 1984 proportion.

Table 4.11 Yearly distribution of delinquent acceptors by age

Age Groups	YEAR 1981 No.	%	1982 No.	%	1983 No.	%	1984 No.	%	1985 No.	%
15-19	6	4.5	15	9.3	22	12.2	17	11.7	15	12.2
20-24	14	10.6	26	16.0	31	17.1	32	22.1	31	25.2
25-29	35	26.5	44	27.2	51	28.2	40	27.6	34	27.6
30-34	48	36.4	51	31.5	47	26.0	30	20.7	26	21.1
35-39	24	18.2	26	16.0	20	11.0	17	11.7	12	9.8
40+	5	3.8	-	-	10	5.5	9	6.2	5	4.1
TOTAL	132	100.0	162	100.0	181	100.0	145	100.0	123	100.0

In the case of delinquent acceptors aged 35-39 years, there was a percentage decline from 18.2 in 1981 to 11.0 in 1983 and a slight increase (11.7%) in 1984. However, the least percentage (9.8) was recorded in 1985.

In the highest age group (40+), the trend fluctuated somewhat. The proportion declined from 3.8% in 1981 to zero percent in 1982 then increased to 5.5% in 1983 and 6.2% in 1984, while the 1985 proportion was 4.1%

Our data show that the proportion of delinquent acceptors in the younger age group, especially those aged 15-24 years increased, while those in the older age group tended to decline. For instance, in 1981, about one out of every ten delinquent acceptors was in the 20-24 age group. By 1985, this has increased to about one out of every four delinquent acceptors. On the contrary, about one out of every five delinqeunt acceptor was in the 35-39 age group in 1981, by 1985, this has declined to about one out of every ten delinquent acceptors. This trend is likely to continue because many young clients attracted to the clinic are either likely to be at the beginning or the peak of their child bearing years. They are therefore more likely to be irregular patrons of the clinic since the use of contraceptives may be for purposes other than for birth limitation.

4.3.2 Parity

The yearly distribution of delinquent acceptors by parity is shown in Table 4.12. It is observed that the proportion of delinquent acceptors of zero parity increased yearly from 6.1% in 1981 to 31.7% in 1985. The high increase in proportion of women of zero parity may be due to the increasing patronage of the clinic by unmarried adolescents whose sexual activities are usually sporadic in nature (Ezimokhai et al.1981), an attitude which does not encourage consistent use of contraceptives.

The proportion of delinquent acceptors of low parity (1-3) also exhibited yearly increases. In 1981, one out of every three delinquent acceptors was a woman of low parity, while in 1984, it was one out of every two delinquent acceptors. In 1985 however, it registered a decline (42.2%). On the other hand, the proportion of delinquent acceptors with four to six children tended to decline from 40.9% in 1981 to 19.3% in 1984. The 1985 proportion (22.8%) showed an increase on the 1984 proportion.

In the case of those with more than six children, there was a slight increase in percentage from 17.4% in 1981 to 17.9% in 1982. After 1982, there was a significant decline to 3.3% in 1985.

It is seen from our data that more delinquent acceptors of zero and low parity seem to be patronising the clinic. This trend may continue because a woman's

Table 4.12 Yearly distribution of delinquent acceptors by Parity

Parity	YEAR									
	1981		1982		1983		1984		1985	
	No.	%	No.	%	No.	%	No.	%	No.	%
0	8	6.1	12	7.4	20	11.0	33	22.8	39	31.7
1-3	47	35.6	70	43.2	88	48.7	74	51.0	52	42.2
4-6	54	40.9	51	31.5	53	29.3	28	19.3	28	22.8
7+	23	17.4	29	17.9	20	11.0	10	6.9	4	3.3
TOTAL	132	100.0	162	100.0	181	100.0	145	100.0	123	100.0

marital status is not an important consideration in getting services from the clinic. It may be mentioned that one of the cardinal objectives of the clinic is the strong emphasis on child spacing. Many more women of low parity are likely to visit the clinic in future for irregular supply of contraceptives for the purpose of spacing birth, as they become aware of the services of the clinic.

4.3.3 Education

The yearly distribution of delinquent acceptors by educational attainment in Table 4.13 shows that the proportion of delinquent acceptors without formal education declined from 23.5% in 1981 to 22.2% in 1982 and 9.9% in 1983. It, however, increased to 11.1% in 1984 before the least proportion (4.9%) was recorded in 1985.

There were increases in the proportion of delinquent acceptors with primary education from 30.3% in 1981 to 40.1% in 1982 and 51.4% in 1983. However, decreases were recorded in 1984 (30.3%) and 1985 (29.2%) respectively. In the case of those with some secondary education, there was a decline from 18.9% in 1981 to 12.4% in 1982, after which there was a gradual increase from 1983 (15.5%) to 1985 (24.4%).

The proportion of delinquent acceptors with secondary education declined from 17.4% in 1981 to 16.7% in 1982 and 15.5% in 1983. However, there was an increase in 1984 (19.3%) with almost the same proportion (19.5%) in 1985.

Table 4.13 Yearly distribution of delinquent acceptors by educational attainment

Level of education	YEAR									
	1981		1982		1983		1984		1985	
	No.	%	No.	%	No.	%	No.	%	No.	%
No formal education	31	23.5	36	22.2	18	9.9	16	11.1	6	4.9
Primary	40	30.3	65	40.1	93	51.4	44	30.3	36	29.2
Some secondary	25	18.9	20	12.4	28	15.5	34	23.4	30	24.4
Secondary	23	17.4	27	16.7	28	15.5	28	19.3	24	19.5
Post-secondary	13	9.9	14	8.6	14	7.7	23	15.9	27	22.0
TOTAL	132	100.0	162	100.0	181	100.0	145	100.0	123	100.0

The trend for those with post secondary education showed a decline from 9.9% in 1981 to 8.6% in 1982 and 7.7% in 1983. There were increases in proportion in 1984 (15.9%) and 1985 (22.0%) respectively.

Our data show that the proportion of delinquent acceptors with less than some secondary education was declining, while the proportion of those with more than some secondary education tended to increase. It appears that more women of HES patronized the clinic in 1984 and 1985 than in the previous years. We expected more low educational status women to patronise the clinic yearly since they are more likely than HES women to practice family planning irregularly. A possible explanation for this trend is that some HES contraceptors who may not have borken ties with their private sources of contraceptives may be taking occasional advantage of the clinic as a cheaper source of contraceptives.

It is also noted that the proportion of delinquent acceptors with no formal education declined substantially during the period under consideration. Their proportion also declined substantially among acceptors (See table 4.8). This seems to suggest that many clients with no formal education may have discontinued patronage of the clinic, while fewer new clients may be using the services of the clinic yearly. This may be due to the various side effects associated with contraceptive use. Women with no formal education are likely to react more negatively to such side effects. They are also more likely to be uninformed of

the services of the clinic, and may depend more on their husbands, than highly educated women, to take family planning initiative.

4.3.4 Occupation

Table 4.14 shows the yearly distribution of delinquent acceptors by occupation. It shows that the proportion of delinquent acceptors who are petty traders declined from 34.2% in 1981 to 32.8% in 1982. However, there was an increase in proportion to 34.9% and 38.5% in 1983 and 1984 respectively. In the case of delinquent acceptors who are housewives, about one out of every three delinquent acceptors was a housewife in 1981, but by 1984, this has increased to about two out of every five delinquent acceptors.

There was little variation in the proportion of delinquent acceptors who are civil servants in 1981 (17.5%), 1982 (17.2%) and 1983 (17.1%). In 1984, there was a slight decline in proportion (16.5%).

The self employed delinquent acceptors showed an increase in proportion from 6.1% in 1981 to 9.7% in 1982. This declined to 6.2% in 1983 and 1.9% in 1984. For those delinquent acceptors employed in companies, there was a general decline from 8.8% in 1981 to 0.9% in 1984.

Table 4.14 Yearly distribution of delinquent acceptors by occupation*

Occupation	YEAR 1981 No.	%	1982 No.	%	1983 No.	%	1984 No.	%
Petty traders	39	34.2	44	32.8	51	34.9	42	38.5
Housewives	32	28.1	42	31.3	53	36.3	44	40.4
Civil servants	20	17.5	23	17.2	25	17.1	18	16.5
Self employed	7	6.1	13	9.7	9	6.2	2	1.9
Company employees	10	8.8	8	6.0	2	1.4	1	0.9
Farmers	2	1.8	3	2.2	4	2.7	1	0.9
Unemployed	4	3.5	1	0.8	2	1.4	1	0.9
TOTAL**	114	100.0	134	100.0	146	100.0	109	100.0

* Information on theoccupation of 1985 delinquent acceptors was not available

**Total reflects the exclusion of delinquent acceptors categorized as "students"

The proportion of farmers who are delinquent acceptors increased slightly from 1.8% in 1981 to 2.2% in 1982 and 2.7% in 1983. However, there was a decline to 0.9 in 1984. Delinquent acceptors who are unemployed showed no regular pattern of increase or decrease. The proportion fluctuated from 3.5% in 1981 to 0.9% in 1984 with 0.8% in 1982 and 1.4% in 1983.

Our data seem to indicate that the proportion of women employed in occupations associated with the home like petty trading, was increasing, while the proportion of civil servants showed little variations from year to year. This trend is likely to continue if the clinic continues to attract clients of low socio-economic status.

4.3.5 Religion

From Table 4.15 which shows the yearly distribution of delinquent acceptors by religious affiliation, it is seen that Catholic delinquent acceptors increased from 23.5% in 1981 to 24.1% in 1982 and 29.8% in 1983. There was a decline in 1984 (20.0%) after which a sharp increase (46.3%) was recorded in 1985.

In the case of delinquent acceptors who are Protestant, a general decline in trend from 38.6% in 1981 to 22.0% in 1985 was recorded.

Table 4.15 Yearly distribution of delinquent acceptors by religious affiliation

	YEAR									
	1981		1982		1983		1984		1985	
Religion	No.	%	No.	%	No.	%	No.	%	No.	%
Catholic	31	23.5	39	24.1	54	29.8	29	20.0	57	46.3
Protestant	51	38.6	48	29.6	54	29.8	35	24.1	27	22.0
Islam	1	0.8	3	1.9	2	1.2	3	2.1	2	1.6
Others*	49	37.1	72	44.4	71	39.2	78	53.8	37	30.1
TOTAL	132	100.0	162	100.0	181	100.0	145	100.0	123	100.0

* "Others" were categorised as members of faiths which exclude those mentioned above. It includes African traditional religion and other religious sects.

No regular pattern of increase or decrease can be discerned in the case of delinquent acceptors who are Muslims. The proportion fluctuated from 0.8% in 1981 to 1.6% in 1985, with 1.9% in 1982, 1.2% in 1983 and 2.1% in 1984. The same fluctuating trend was noticed in the case of members of "Other" faiths, who are delinquent acceptors. The highest proportion was in 1984 (53.8%) and the least proportion (30.1%) was in 1985. The corresponding proportions for 1981, 1982 and 1983, were 37.1%, 44.4% and 39.2%, respectively.

In general, delinquent acceptors who are Catholics showed some yearly increase, while the proportion of delinquent acceptors who are Protestants declined generally. The increasing proportion of Catholics may be attributed to the increasing use of contraceptives as substitutes for the rhythm method. This trend is likely to have a substantial effect on the composition of delinquent acceptors in the long run especially if the clinic attracts more women of high socio-economic status in future.

4.4 Summary

The yearly distribution of all clients and delinquent acceptors by age, shows that the proportion of young women, especially those aged 15-24 years increased, while the proportion of older women declined. The proportion of young acceptors, however, tended to decline, while there was little variation in the proportion of old acceptors from year to year.

The trend for all clients and delinquent acceptors by parity showed increases in the proportion of zero and low parity women, while high parity women tended to decline. In the case of acceptors, the proportion of zero and low parity acceptors also tended to increase. This is unexpected since zero and low parity acceptors are not expected to be concerned with birth limitation and thus not likely to increase in proportion among regular contraceptors. However, some very sexually active women may be using contraceptives regularly over short periods of time.

The trend by educational attainment revealed that the proportion of HES women increased for both categories of clients, especially in 1984 and 1985. Many HES women, who may have depended on private sources of contraceptives may be taking advantage of the clinic's relatively cheaper contraceptives.

The trend by occupation of all clients showed increasing proportion of housewives and civil servants, while there was little yearly variation in the proportion of petty traders. In the case of delinquent acceptors, the proportion of housewives and petty traders increased generally. General increase in proportion was however found among acceptors who are civil servants.

The yearly distribution of all clients by religious affiliation revealed that the proportion of Catholic clients increased while that of Muslims tended to decline. The same trend was noticed among delinquent acceptors except in the case of Islam, where the proportion of delinquent acceptors who are Muslims tended to fluctuate. In the case of acceptors, there was little yearly variation in the proportion of Catholics and "Other" faiths acceptors but the proportion of Protestant acceptors tended to increase.

In general, the possibility of more clients patronising the clinic in future is likely to depend on a number of factors including the socio-economic status of potential clients, perception of the efficacy of other traditional methods of birth control, like rhythm (which is recommended by Catholics) and the price of contraceptives.

Chapter 5

SUMMARY, DISCUSSION AND RECOMMENDATIONS

In this chapter, a summary of the study is given in the first section, while the second section discusses the major findings. Lastly, we put forward some recommendations which may enhance the formulation of a population policy in Nigeria.

5.1 Summary

This study examines the socio-demographic characteristics of a sample of 1,000 family planning clients, randomly selected from 10,093 clients who attended a public (PPFN) clinic in Benin City between 1981 and 1985. We distinguished between acceptors and delinquent acceptors and examined the characteristics of each category of clients.

Acceptors were defined as those clients who patronized the clinic regularly or had a break of less than three months at a time. On the other hand, delinquent acceptors were defined as those clients who discontinued patronage of the clinic for three or more consecutive months at a time.

The major objectives of the study were as follows:

1) To determine the socio-demographic characteristics of clients in the clinic.
2) To examine the socio-demographic characteristics of regular and irregular patrons of the clinic with a view of determining differences, if any, between them.

3) To study trends in socio-demographic characteristics of the categories of clients between 1981 and 1985.

4) To make recommendations, on the basis of our findings, that may be useful in the formulation of a population policy in Nigeria.

The data for the study were obtained from records kept in the (PPFN) clinic. The clinic collected information on age, parity, educational attainment, occupation, religion and coital habit of clients as well as the type of contraceptives dispensed to clients.

The six hypotheses tested in this study postulated certain relationships between age, parity and educational status of client and acceptance as well as delinquent acceptance of family planning.

Our data revealed that 257 (25.7%) of the clients who attended the clinic during the period under consideration were acceptors, while 743 (74.3%) were delinquent acceptors.

In our analysis, we found that 53.1% of the clients who attended the clinic were between 15 and 29 years of age, while the corresponding percentage for delinquent acceptors was 55.8. On the other hand, most acceptors (54.1%) were found in the older age group, that is, 30 years and above.

The yearly distribution of all clients showed that the proportion of young clients especially those aged 15-24 increased, while the proportion of older clients tended to decline. A similar trend was noticed in the case of delinquent acceptors. However, the proportion of young acceptors tended to decline from year to year, while there was little yearly variation in the proportion of old acceptors.

The distribution of clients by parity revealed that 54.5% of women who attended the clinic were of zero to three parity. 59.6% of delinquent acceptors were also of zero to three parity. Majority (60.4%) of acceptors however, had four or more children. The mean parity of all clients was 3.6, while the corresponding mean parities for acceptors and delinquent acceptors were 4.6 and 3.2 respectively.

The trend by parity showed that the proportion of low parity clients increased yearly, while the proportion of high parity clients tended to decline. A similar trend was exhibited by delinquent acceptors and acceptors. Increasing proportion of low parity clients suggests that more clients are using the services of the clinic for purposes other than birth limitation. However, the small number of low parity acceptors represented in our sample did not allow for any meaningful interpretation.

A high proportion (50.9%) of clients who attended the clinic during the period under consideration had either

primary or no formal education. 51.8% of delinquent acceptors also had primary or no formal education. On the other hand, only 48.2% of acceptors had primary or no formal education. The trend by educational attainment revealed that the proportion of HES acceptors and delinquent acceptors increased, especially in 1984 and 1985.

As far as occupation is concerned, petty traders and housewives made up 65.5% of all clients. Petty traders were found to be more (35%) than any other occupation among delinquent acceptors, although the proportion (34%) of housewives was substantial. On the other hand, about one out of every three acceptors was a civil servant. This was the highest ratio by occupation among acceptors.

The trend for all clients by occupation showed some yearly increases in the proportion of housewives and civil servants. The proportion of petty traders tended to increase yearly among delinquent acceptors, while yearly increases were noticed among civil servant acceptors.

Women of "Other" faiths, which included practitioners of African traditional religion and other religious sects, attended the clinic more than any other religious group. They constituted 39.5% of the sample. Members of "Other" faiths were also more (41.3%) among delinquent acceptors. Protestants were, however, more (39.3%) among acceptors.

The trend by religious affiliation showed some yearly increases in the proportion of Catholics among all clients and delinquent acceptors. The proportion of Protestants increased somewhat among acceptors, while there was little or no variation in the proportion of acceptors of Catholic and "Other" faiths.

The oral contraceptive was the most dispensed contraceptive to both acceptors and delinquent acceptors. However, acceptors got relatively more effective contraceptives and requested for more than one type of contraceptive at a time, than delinquent acceptors.

In the test of hypotheses, one and four, we found a significant difference between the proportion of young (15-29 years) and old (30+) acceptors, and the difference between the proportion of young and old delinquent acceptors was also found to be significant. Thus we failed to reject our hypotheses that acceptors are more likely to be old than young women and also that delinquent acceptors are more likely to be young than old women.

In the case of the hypotheses which related acceptors and delinquent acceptors to parity, we also found significant differences between proportions of low parity (1-3) and high parity (4+) acceptors as well as between low parity and high parity delinquent acceptors. This finding gave support to our hypotheses that acceptors are more likely to be high parity than low parity women, and that delinquent acceptors are more likely to be low parity women than high parity women.

In the hypotheses which related acceptors and delinquent acceptors to educational attainment however, there was no significant difference between the proportion of HES and LES acceptors. We also did not find any significant difference between the proportion of HES and LES delinquent acceptors. This finding did not support our hypotheses that acceptors are more likely to be HES women than LES women and that delinquent acceptors are more likely to be LES women than HES women. Educational attainment seems to be of little significance for acceptance and delinquency, at low parity.

5.2 Discussion

A survey of the characteristics of all clients in this study suggests that women use contraceptives very early in their reproductive lives. It is interesting to note that 53.1% of all clients who attended the clinic during the period under consideration were aged 15-29 years and 54.5% of all clients had three or less children. This finding may be compared to the 1981-1982 Nigeria Fertility Survey (NFS) which found that only 6.5% of women below the age of 25 were "currently" using any form of contraceptives and this did not vary by type of place of residence (NPB, 1984:114). However, the NFS report noted that "the sensitivity of questions on sexual matters and contraception, the presence of others, particularly husbands (during the interview) might have

negatively affected responses" (NPB, 1984:115). Although our data may not have been biased by the factors above, it should be pointed out that the difference between the proportion of contraceptors under 25 years of age in our study and that of the National sample is very striking.

Contrary to some studies (Okediji, 1968, Onifade, 1973, Caldwell and Ware 1977) which have reported that women of high socio-economic status are more favourably disposed to the use of contraceptives, our data showed that majority (50.9%) of all clients who attended the public clinic had primary or no formal education. 73.4% of all clients in our study were either unemployed or employed as petty traders, full time housewives, farmers or in self-employment like sewing, hair plaiting, weaving, etc. This suggests that many of the patrons of the clinic are of low socio-economic status. This might be an indication of a change in attitude of low socio-economic group towards the use of modern contraceptives.

The religious affiliation of clients showed that women who belong to "Other" faiths patronised the clinic more than any other religious group. The attitude of Christians and Muslims towards the use of contraceptives and birth control, generally, has been variously studied (See Spitzer and Saylor (eds) 1969, Moore, 1973, Mahmood, 1977). On the other hand, not much work has been done about "Other"

faiths especially in Nigeria. Our data seem to suggest that women of "Other"faiths are not inhibited by their beliefs in the use of contraceptives. This seems an area for further investigation, though it may be necessary to identify and study each religious group, separately.

In general, our results seem to suggest that where family planning services are available at "affordable" prices, many young, low parity women, even of low socio-economic status will use contraceptives. This tends to support the stance of family planning advocates in an endeavour to reduce fertility rates. This is more so when our data suggest that the proportion of young, low parity contraceptors may be increasing yearly. The effect of this trend on fertility however, will depend to a large extent on whether contraceptives are used for birth limitation or for other purposes. We tried to infer this from the regularity of a woman's visit to the clinic in this study.

We found that 25.7% of clients attended the clinic regularly, while 74.3% attended irregularly. With a coital frequency of 2.0 times a week for acceptors and 2.4 times a week for delinquent acceptors, this suggests that the use of contraceptives by the majority of clients may be for purposes other than birth limitation. This is, however, based on the assumption that irregular patronage of the clinic means irregular use of contraceptives. It has to be noted that irregular visit could be due to other

causes especially the availability of alternative contraceptive outlets. However, since contraceptives sold in the clinic are heavily subsidized, the bias caused by the patronage of other contraceptive outlets (most of which are privately owned and operated for profit) may be reduced since clients are not likely to patronize costlier sources of contraceptives for a long time when exposed to a cheaper source.

Irregular patronage could also be due to either illness or migration which may make it no longer convenient for clients to patronize the clinic. In either case, women who are likely to be concerned with birth limitation may have been classified as delinquent acceptors. Bias caused by these occurrences is, however, reduced by the policy of the clinic to transfer client record cards to other PPFN clinics (where possible) in cases where clients, who wish to continue to use contraceptive move out of the city. Secondly, suspension of contraception due to illness is often recorded in client record cards, especially if it is recommended by the visiting doctor of the clinic.

On the other hand, our analysis of the trend in socio-demographic characteristics of acceptors suggests that many young, low parity acceptors may not be concerned with birth limitation. We observed that the duration (three or less years) within which they were represented in our sample could be periods of traditional birth interval or periods of

training. During such periods, very sexually active birth spacers or trainees may be using contraceptives regularly and pass as acceptors by our definition. It may be noted in passing that about 10.6% of acceptors were students. Thus the proportion of clients who may actually be practising family planning regularly for birth limitation could be lower than the proportion of acceptors found in our study.

It is interesting to note, however, that acceptors not only used more of the highly efficient contraceptives like IUCD and injectables but requested for more than one type of contraceptives at a time. This may be an indication of their willingness to prevent further pregnancies by ensuring the efficacy of contraceptives. However, women may be concerned with the efficacy of contraceptives for other reasons like ensuring desired birth intervals.

Nevertheless, if those who use contraceptives regularly are more likely to be concerned with birth limitation than those who use contraceptives irregularly, then majority (74.3%) of clients who patronized the clinic were more likely to use contraceptives for purposes other than birth limitation.

In general, we found that those who practised family planning regularly were mainly above 30 years of age, have four or more children and were not necessarily of high educational status. They were also more likely to be Protestants and employed in the civil service. On the other

hand, those who practised family planning irregularly were mainly between 15-29 years of age, have three or less children and were not necessarily of low educational status. They were also likely to be of "Other" faiths and employed as petty traders or housewives.

Further evidence from our data seems to suggest that a woman's parity is the most important variable affecting regularity of her visit to the clinic. For instance, in the test of hypothesis one, we found a low proportion of acceptors among old, low parity and low educational status (LES) women, but the proportion of old, high parity, LES acceptors was relatively high (See table 3.7). Since only parity varied among the two groups of clients, it could be held responsible for the substantial difference between the two groups. Also, in the test of hypothesis four (Table 3.10), we found an unexpectedly high proportion of old women among low parity, HES delinquent acceptors, but not among old, high parity, HES women. Again only parity varied.

Furthermore, the role educational status of women could play in acceptance or delinquency seems to be determine to a large extent by their parity. In the test of hypotheses three and six (Tables 3.9 and 3.12 respectively), we unexpectedly, did not find any significant differences between the proportions of HES and LES acceptors and delinquent acceptors. A critical analysis of our data shows that parity played a major role in this discrepancy. We found in Table 3.9 that the proportion of LES acceptors was higher than

that of HES acceptors in group three of young, high parity women but not in group one of young, low parity women. Also contrary to expectation, in Table 3.12, when age was held constant the proportion of HES delinquent acceptors was actually higher than the proportion of LES delinquent acceptors at low parity but this phenomenon was not exhibited under the same conditions at high parity. These observations strongly suggest that at low parity, most women would rather practise family planning irregularly and at high parity many of them would practise family planning more or less regularly no matter their age and educational status.

Apart from parity, age and educational status, our data also indicated that acceptors were more likely to be Protestants, while delinquent acceptors were more likely to belong to "Other" faiths. The tendency for Protestants to use contraceptives more regularly could be partly attributed to the fact that their doctrine allows the use of certain types of contraceptives. On the other hand, members of "Other" faiths could be said to be using contraceptives more irregularly, as a substitute for traditional post-natal abstinence, because of the high value for children in the traditional set-up. We noted earlier that many of the religious sects which make up "Others" have incorporated many traditional values, into their doctrines and practices.

However, the role of religion in the use of contraceptives cannot be easily determined. This is because it is often difficult to dissociate the influence of religion from other socio-economic conditions of members of various religious groups (Gadalla 1978:14). For example, the perception of the religious injuction concerning the use of contraceptives is likely to differ between rich and highly educated faithful and a poor illiterate of the same faith. Thus, there is usually a disparity between religious doctrines and peoples' actual beliefs and practices, especially if they belong to different socio-economic groups. The relatively high and increasing proportion of Catholics who are delinquent acceptors in our study is a reflection of the disparity between religious doctrines and peoples' practices. The influence of religion on the acceptance or other of family planning therefore is not likely to be significant without due consideration of other socio-economic variables.

There was also a difference between the occupational status of majority of acceptors and delinquent acceptors. Acceptors were more likely to be civil servants, while delinquent acceptors were more likely to be petty traders or housewives. This observation is likely to be a reflection of the education status of clients. Highly educated women are more likely to be employed as civil servants than as petty traders or full-time housewives.

We noted earlier the importance of educational status of women in the acceptance or otherwise of family planning, especially at low parity. This is likely to apply in the case of occupation.

From the foregoing, there seems to be no basis for optimism that significant decline in fertility will result from the voluntary practice of family planning as envisaged in some studies (see Oyemade and Ogunmuyiwa, 1981). Our data seem to indicate that majority of clients use contraceptives irregularly until the later years of their reproductive lives when they must have had four or more children. This situation is likely to be the same in many other public clinics in Nigeria.

The number of children (four or more) women seem to want before they practise family planning regularly, is about the average family size of most women in Nigeria today (see NPB, 1984). The recent efforts by the Federal Government of Nigeria to promulgate a population policy based on family planning is aimed at reducing the number of children per woman, possibly to three children per woman, which the Futures' Group seems to recommend.

It is apparent from the foregoing that any realistic effort towards the reduction of fertility rates through the voluntary and regular use of contraceptives, should first identify the causes of the high demand for children and the processes which being about changes in attitude towards large family size. This is briefly discussed here. High demand for children is usually necessitated by the need to insure against high infant and child mortality rates. In Nigeria, the infant mortality rate is as high as 70 per 1000 live births in urban areas and 150 per 1000 live births in rural areas (F.G.N. 1981:272). This situation is attributable to inadequate health care services in a country where only an estimated 35% of the population is presently covered by any form of modern health care services (FGN 1981:272).

Many children are also functional in a system where child labour is important in the economy and where children are a major source of social security for the aged. In many parts of Nigeria especially in the rural areas, children learn to help in house and farm work very early in their lives. Children are major contributors to the household economy and a major, if not the only, source of social security for the aged (see Caldwell, 1976). The importance of children as a source of social security for the aged can be attributed to the lack of specialized agencies which effectively take care of the aged in the society.

The processes which bring about changes in these conditions are embedded in profound socio-economic development. This was evident in the demographic transition which occured in many European countries in the 19th century.

With economic development, health services are improved and high infant and child survival rates reduces the need for high fertility as an insurance against high infant and child mortality rates. Urbanization which is a concominant of economic development, takes children off the farms and places them in situations where their labour is of less value. Also the dependence of parents on their children at old age is reduced if not eliminated. The care for the aged is usually taken over by specialized agencies as society progresses in the modernization process (Bulatao, 1984).

Under conditions of rapid economic development, highly educated labour force is usually required in the production processes. This tends to keep children and more women longer in school. The need for highly educated labour force does not only increase the cost of child upbringing, but it also improves the status of women and promotes late marriages. There is hardly any need for specialized labour, which requires long period of training, in the production process of a major part (traditional farming) of the Nigerian economy, at the present level of economic development. The result is that the cost of

child upbring is relatively low and women are usually relegated to the traditional role of child rearing.

5.3 Recommendations

From the discussion above, it is apparent that socio-economic development is a fundamental requirement of a developing country like Nigeria, as an essential ingredient for the improvement of the quality of life of its citizens. It is also a major pre-requisite for reducing the high demand for children in the country.

However, economic development involves a cluster of social, cultural, political and economic changes which may take a long time to materialize. Moreover, high fertility may have adverse effects on development and this may postpone the date at which modernization attains the level when small family size becomes the norm. In the short-run therefore, there is the need to encourage the regular use of contraceptives by the provision of free or highly subsidized contraceptives in government hospitals and other contraceptive outlets.

Results from our study show increasing patronage of the family planning clinic by youths. The practice of restricting contraceptive services, in government hospitals, to married women, may not be in the interest of the community. Youths may result to unrefined and ineffective methods of birth control. It is therefore necessary to make contraceptive services available to all women of

reproductive age in our community. The possible abuse of contraceptives can be minimized by proper education, (especially of our youths) on the use of contraceptives. Various media like the radio, television, newspapers, community associations, schools, etc. can be exploited for effective education of the populace.

We observed in this study that contraceptives may be used for purposes other than family limitation, especially in communities like ours where the demand for children is high. To achieve a reduction in the country's fertility rate, in the short-run, some measures, beyond the provision of family planning information and services, are needed to promote social change which is sufficient to reduce the demand for children and make women accept family planning. Based on this conviction, we recommend the following modifications in the social, economic and political set up (in addition to a family planning programme) as part of a population programme for Nigeria.

Firstly, a deliberate policy aimed at improving the status of women, to emancipate them from their traditional, subordinate and dependent status should be formulated. This can be achieved by the expansion of the existing educational opportunities, making education free and compulsory, up to secondary school level. Also, laws which prohibit undue subordination of women, which is expressed in such practices as forced marriages and confinement of housewives in purdah, should be promulgated and enforced. These measures will promote late marriages and

the tendency to have fewer children among women.

Secondly, the health care delivery system should be reorganized with emphasis on local initiative. Laymen should be made to deliver health care services in their communities, under the supervision of trained professionals. These groups of people will be particularly useful in providing first-aid, public health services, implementing the expanded programme on immunization and the oral rehydration therapy and providing family planning services especially in rural communities.

Thirdly, there should be a realistic social security scheme which includes, a generous retirement benefit for workers. The scheme should also guarantee food, clothing, shelter and medicare for the aged, especially those without children and those who cannot benefit from the pension scheme. This will reduce the dependence of parents on their children at old age.

Fourthly, there should be a deliberate attempt towards reducing the gap between the rich and the poor in the country. Family planning has been found to be more effective in countries where the wealth of the nation is more equitably distributed than in countries where the gap between the rich and poor is very wide as in Nigeria (King, 1974:48). An attempt in this direction could be made by the formulation and implementation of an egalitarian wage policy and a reappraisal of the Land Use Act of 1978 to make it more practicable

Lastly, the need to limit fertility is likely to be more meaningful where the people are directly involved in production, income distribution, re-investment and social welfare in the communities. In the process, they are likely to learn at first hand the relationship between child rearing and cost to the community. It is only under such conditions that the people are likely to appreciate the need (if any exists) to reduce their demand for more children.

To control fertility among a people, in the absence of coercive strategies will be difficult, if not impossible, unless the people see the need for it themselves , and possibly take part in the implementation of birth control programmes. There is the need therefore, for a political, re-orientation towards a system which allows for more participation of the people in the formulation and implementation of government policies especially on issues (like the number of children one should have) which directly affect their lives.

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