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# Contents

# Perception, Knowledge Level and Barriers to Reproductive Behaviour among Community Women in Selected Local Government Areas (LGAs) of Oyo State, Nigeria

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**Abstract**

Reproductive behaviour is important in the life of every household as it reflects on their reproductive anatomy. In Nigeria and other parts of the world, women were not given opportunities to speak on matters concerning their own lives, they were vulnerable; and this militated against them. The study adopted the descriptive research design of expo facto type. The target population consisted of community women who have been married for at least three years in marital life. A Multistage sampling procedure was adopted for the study. A snow ball sampling technique was used to select 1300 respondents. A self-designed questionnaire called Reproductive Health Behaviour Scale was the main instrument used for data collection which was complimented by key in-depth interview (KII). Data was analysed using frequency counts, percentages and bar charts. Findings showed that, majority of the respondents have adequate knowledge of and different methods of reproductive health. The study also identified barriers to effective women reproductive health knowledge and behaviour among women. Based on these findings, recommendations were made that information on reproductive health rights of women should be provided and that cultural and traditional religious injunctions should be discouraged.

**Keywords**: Reproduction, anatomy, health & behaviour

**Introduction**

Marriage is one of the institutions ordained by God, for a lifelong relationship between man and woman with reproduction as one of its major functions among many others. Notably, the focus on reproduction has shifted more to women, who were believed to be more interested in limiting their fertility than men, since they bore most of the physiological and child-care burdens of frequent childbearing (Watkins & Hodgson,1998).With modernization, childbearing has become increasingly detached from biological necessities and social pressures of earlier times (Van deKaa, 2001) and this has made reproductive behaviour decisions more dependent on individual preferences and dispositions (Jokela, Alvergne, Pollet & Lumaa,2011) .WHO (2003) sees reproductive health as a state of complete physical, mental and social well-being in all matters relating to the reproductive system and processes. By this, it can be seen that the most important components of reproductive health include family planning, safe motherhood, safe and satisfying sex, prevention and treatment of reproductive tract infections and sexually transmitted diseases, as well as the decision-making power associated with these.

One of the significant milestones of the twentieth century in the field of population and development is the recognition of women as equal partners in development efforts in all societies of the world (Odutolu, Adedimeji, Odutolu, Baruwa & Olatidoye, 2003). More so, two major events of the last decade, the 1994 International Conference on Population and Development in Cairo and the 1985 World Women Conference in Beijing were instrumental in this regard. It was recognised at these global conferences that issues affecting the reproductive health of women are linked to wider issues of economy, educational status and gender equality. Gender equity and women empowerment were particularly emphasised as a catalyst for promoting and sustaining economic growth and development ((UNFPA, 1995). At these conferences, issues relating to women were openly discussed most especially as it affects their status and reproductive health. A major response to this development is a review of programmes and strategies aimed at improving the reproductive health of women (Odutolu, Adedimeji, Odutolu, Baruwa & Olatidoye, 2003). Nigeria still has an extremely high maternal mortality ratio of 704 per 100000 live births implying that about 2.4 million live births annually, some 17 0000 Nigerian women die as a result of complications associated with pregnancy and childbirth.

The maternal mortality ratio (MMR) is about a hundred times worse than the industrialized countries (UNICEF, 2001). Each year as many as 60,000 Nigerian women die due to pregnancy related complications (WHO, 2005; Ladipo, 2006; USAID, 2008). With the above statistics, it becomes clear that there is need to tackle reproductive health problems in Nigeria. This is because of the gross inequalities in gender relations in Nigeria which create barriers to women's health.

Community women in most cases are not expected to speak out even in matters concerning their own lives, they are among the poorest of the poor and many lean on their husbands. All these militate against the life chances of women as individuals. Studies have shown that lack of adequate information and ignorance are key factors militating against women's reproductive behaviour particularly on family planning practices in Nigeria (Adinma & Nwosu, 1995; World Bank, 1998 Moronkola, Ojediran & Amosun, 2006). Besides, Nigeria's community women have experienced high fertility levels over the last two decades, despite the introduction of a National Policy on population in 1988 which stipulates four children per woman, and eighteen years for the commencement of child bearing (Ihejiamaizu, 2001). Most Nigerian women have an average of six children by the end of their reproductive years. It is against this background that this study is how to assess perception, knowledge level and barriers among community women in Akinyele local government area of Oyo state, Nigeria.

This study assesses the perception of reproductive behaviour and level of knowledge of reproductive health information among community women in Akinyele Local Government area of Oyo State. Identify the barriers to effective women's reproductive health knowledge and behaviour. It provides answer to the research question on the perception and knowledge level of reproductive health information among community women in Akinyele Local Government area of Oyo state, Nigeria to reproductive health behaviour.



**Methodology**

The researchers made descriptive research design of expo facto type. The target population for this study consisted of community married women who have spent at least three years in marital life in Akinyele Local government area (LGA) of Oyo state, Nigeria. The multistage sampling

procedure was used in drawing out the sample size. The stratified sampling technique was used to pick 13 wards based on the existing demographic structure that make up the LGA. The snow ball sampling technique was used to select 1300 respondents from various wards that were used for the study. According to 2006 Population census the total population of Akinyele local government is 211,359.

A self-designed questionnaire was the main instrument used for data collection. This instrument was developed by the researchers to collect information on reproductive health behaviour of women; on family size, timing and spacing of children, number of children and use of contraception and safe sex issues. It was made up of a section of 18 items drawn on closed ended questions respectively. Section A of the instrument focused on the respondents bio data such as age, age at marriage, religion, educational attainment, income per month, current residence etc. To strengthen research findings the instruments were complemented with the use of the qualitative method of the In-depth Interview (IDI).

The study adopted the scale on barriers to effective reproductive knowledge and behaviour. This scale was developed by the researcher to collect information on barriers to effective reproductive knowledge and behaviour. It is made up of one section of 8 items drawn on a modified four point rating scale of strongly agree (SA), agree (A), disagree (D) and strongly disagree (SD). A total of 1300 copies were distributed at the various wards, after five months 1209 was retrieved out of which 1122 were properly filled, valid and used for data analysis. Data was analysed using frequency counts, percentages and bar charts The validity was obtained through examination by some experts to establish the content validity of the instrument. The experts consisted of scholars in the fields of Community Development/Social Welfare and Nursing in the University of Ibadan, Nigeria. They included the researcher's supervisor and other members from the university. The reliability of the instrument was determined through the test, re-test method within an interval of two weeks among 20 respondents in a state university that were not part of the study. This is the result of Cronbach Coefficient of alpha value.

## Results and Discussion

### *Perception on Reproductive Behaviour*

For the perception of community women on reproductive behaviour, frequency distribution was used to ascertain their perception which was anchored on research question 1 of the study which states that: What is the perception of community women to reproductive health behaviour? The result is presented in Table 1.

In this regard, this study was also interested in ascertaining the perception of community women of reproductive age on reproductive health behaviour. When respondents were asked if they had used family planning, overwhelming majority (71.1%) of women indicated yes and a significant proportion 66.1% of the respondents since their last baby had used a family planning method. The most presently used methods by the respondents to avoid unwanted pregnancy were oral contraceptive, condom, injectable, withdrawal, abstinence, implant, foam/jelly, female condom, traditional and IUD indicated by 22.5%, 21.4%, 16.0%, 11.3%, 7.3%, 6.7%, 6.5%, 4.0%, 3.7% and 0.5% of respondents respectively. It is obvious that contraceptives which are the oral pills is the most widely used by community women in the study because it is cheap, easy to use and perhaps the most advertised form of contraceptives for women generally. In this study, about 445 of the sampled respondents which accounts for 39.7% indicated that they stopped contraception because they became pregnant while using, 277(24.7%) indicated they wanted a child, 215(19.2%) indicated side effects/health concerns, 87(7.8%) indicated partner disapproved, 71(6.3%) indicated family disapproved, 9(0.8%) indicated hard to get and 18(1.6%) indicated cannot afford it; The respondents were asked about how often they talk with their spouse on contraceptives ; 340(30.3%) indicated many times, 335(29.9%) indicated a few times, 256(22.8%) indicated once in a while 191(17.0%) said they had never had such discussions.

**Table 1 Distribution of Respondents Perception on Reproductive Behaviour**

| S/n | Statement | Labels | Frequency | % |
|---|---|---|---|---|
| 1 | Have you ever used a Family planning method? | Yes | 798 | 71.1 |
| | | No | 324 | 28.9 |
| 2 | Since last baby, have you used a Family planning method? | Yes | 742 | 66.1 |
| | | No | 380 | 33.9 |
| 3 | Which method are you using presently to avoid unwanted pregnancy? | Oral contraceptive | 253 | 22.5 |
| | | Injectable | 179 | 16.0 |
| | | Implant | 75 | 6.7 |
| | | IUD | 6 | 0.5 |
| | | Condom | 240 | 21.4 |
| | | Female condom | 45 | 4.0 |
| | | Foam/jelly | 73 | 6.5 |
| | | Withdrawal | 127 | 11.3 |
| | | Abstinence | 82 | 7.3 |
| | | Traditional | 42 | 3.7 |
| 4 | Which method are you using presently since your last child | Oral contraceptive | 243 | 21.7 |
| | | Injectable | 171 | 15.2 |
| | | Implant | 60 | 5.3 |
| | | IUD | 17 | 1.5 |
| | | Condom | 53 | 4.7 |
| | | Female condom | 91 | 8.1 |
| | | Foam/jelly | 10 | .9 |
| | | Withdrawal | 116 | 10.4 |
| | | Abstinence | 217 | 19.3 |
| | | Traditional | 44 | 3.9 |
| 5 | Which method are you using presently after your recent baby | Oral contraceptive | 255 | 22.7 |
| | | Injectable | 169 | 15.1 |
| | | Implant | 57 | 5.1 |
| | | IUD | 13 | 1.2 |
| | | Condom | 217 | 19.3 |
| | | Female condom | 94 | 8.4 |
| | | Foam/jelly | 44 | 3.9 |
| | | Withdrawal | 108 | 9.6 |
| | | Abstinence | 114 | 10.2 |
| | | Traditional | 51 | 4.5 |
| 6 | Why did you stop contraception | Became pregnant while using | Wanted a child | 445 | 39.7 |
| | | Side effects/health concerns | | 277 | 24.7 |
| | | Partner disapproved | | 215 | 19.2 |
| | | Family disapproved | | 87 | 7.8 |
| | | Hard to get | | 71 | 6.3 |
| | | Cannot afford it | | 9 | .8 |
| | | | | 18 | 1.6 |
| 7 | How often do you talk with your spouse about contraception | Never | | 191 | 17.0 |
| | | Once | | 256 | 22.8 |
| | | A few times | | 335 | 29.9 |
| | | Many times | | 340 | 30.3 |
| 8 | Who makes the decision about contraception in your family | Respondent | | 342 | 30.5 |
| | | Partner | | 143 | 12.7 |
| | | Joint decision | | 501 | 44.7 |
| | | I don't use family planning | | 136 | 12.1 |
| 9 | I make decisions as regards my family size | Yes | | 365 | 32.5 |
| | | No | | 757 | 67.5 |
| 10 | I make use of contraceptives to prevent unwanted pregnancies | Yes | | 818 | 72.9 |
| | | No | | 304 | 27.1 |
| 11 | I make decisions as regards the number of children we want in my family | Yes | | 329 | 29.3 |
| | | No | | 793 | 70.7 |
| 12 | I make use of contraceptives to enable me space my children | Yes | | 703 | 62.7 |
| | | No | | 371 | 33.1 |

*Source: Fieldwork 2013*

Regarding who makes the decision about contraception in their family, 143(12.7%) indicated their partner, 342(30.5%) indicated themselves, 501(44.7%) indicated joint decision while 136(12.1%) indicated they do not use family planning respectively. Only 30.5 % respondents make decisions on family size by themselves this could be because their husbands do not approve of the use which as a result prompted them to use contraceptives to prevent unwanted pregnancies as only 72.9% of the respondents make use of contraceptives to prevent unwanted pregnancies, 27.1 % do not while 62.7 make use of contraceptives to enable them space their children. Acquiring knowledge about fertility control is an important step towards gaining access to and using a suitable contraceptive method in a timely and effective manner (NDHS, 2003).

This was corroborated by some researchers in their report that women's understanding of good reproductive health included three major themes, which were expressed differently in the three communities (Kaddour, Hafez & Zuray, 2005). Their understanding included good physical and mental health, and underscored the need for activities promoting health. Their ability to reproduce and raise children, practice family planning and birth spacing, and go through pregnancy and motherhood safely were central to their reproductive duties and their social status. Finally, they perceive reproductive health within the context of economic status, good marital relations and strength to cope with their lives. Their findings point to the need to situate interventions in the life course of women, their health and that of their husbands and families; the importance of reproduction not only from a health services point of view, but also as regards women's roles and responsibilities within marriage and their families; and taking account of the harsh socio-economic conditions in their communities. This analysis agreed with the views of the IDI participants for the study. A community woman aged 42 years stated that:

> *I think reproductive health behaviour is everything concerning a woman starting from when one becomes a woman,, knowing what to do during menstruation, as one gets married it reflects on how to go about pregnancy, number of children one wants in the family. I have not reached menopause yet but I still use contraceptives to prevent unwanted pregnancies.*

Women still have different perceptions concerning reproductive health behaviour is, as community woman in the present study reflected:

> *From my experience my reproductive health behaviour refers what to do when one becomes pregnant, understanding related complications during pregnancy what to do and not to do, when to avoid unintended pregnancy and how to go about it.*

A community woman from Sagbe stated that:

> *Reproductive health behaviour for any woman particularly the married ones includes her ability to space, delay or limit children, as well as her experience with infertility, child loss or planned or unplanned childlessness.*

***Knowledge level of Reproductive Health Information***

For the knowledge level of Reproductive Health Information among community women in Akinyele LGA of Oyo state, Nigeria on reproductive health behaviour, bar chart was used to ascertain their knowledge level which is anchored on research question 1 of the study which states that: What is the perception and knowledge level of reproductive health information among community women in Akinyele Local Government area of Oyo state, Nigeria to reproductive health behaviour.

Figure 1 shows the knowledge level of reproductive health information and its sources among community women in Oyo state, Nigeria. From the graph its shows that 11.9% respondents agreed with the statement that reproductive health information is information on menstruation and its management, 8.9% agreed with the statement that reproductive health information is information on pregnancy and child birth, 9.7% believed it to be information on family planning/contraception and appropriate choice, 9.9% sees it as safe motherhood and child health care.

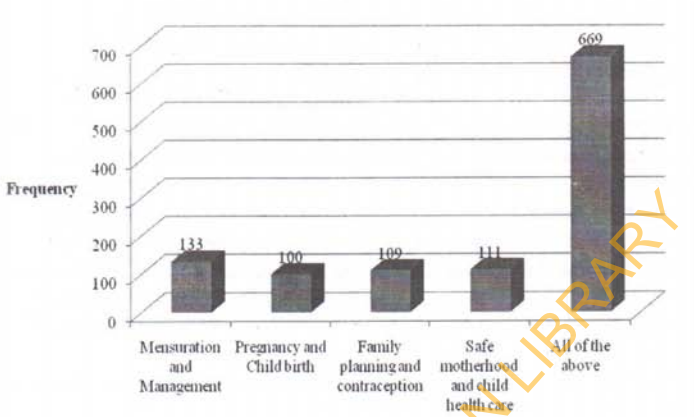


**Fig. 1: Bar Chart Showing the Knowledge Level of Reproductive Health information**

A large portion (59.6%) agreed that its information on menstruation and its management, pregnancy and child birth, family planning/ contraception and appropriate choice and safe motherhood and child health care. In addition, the findings were generally in agreement with the findings of Myer et al (2007) who found that knowledge of contraception was higher among women of high socio-economic status. This shows that community women socio-economic background could have assisted them in having sufficient knowledge on what reproductive health information means. Though, knowledge of reproductive health information could be seen as the first stage to achieving good reproductive health behaviour. This finding is in consonance with that of Langer Farnot, Garaa, Barros, Victoria, Belizen and Villar (1996), and Bello, Hassen, Shehu and Andu (1997) who reported that their respondents exhibited a high level of knowledge on components of safe motherhood initiative. This finding is further corroborated by Awosika (2001) who reported adequate practice of prenatal care among married women. The findings of the study imply that urban community women of childbearing age exhibited sufficient knowledge on meaning of reproductive health information.

Regarding the source of their knowledge, community women gain knowledge of reproductive health information mostly from mass media (26.5%), peers (18.7%), Doctors (17.8%), nurses (13.4%), and literatures (5.9%) respectively while other sources like health workers in health centres in institutions, spouse, relatives, brochures on reproductive health made a minimal contribution. The findings agrees with the works of Tuladhar and Marahatta (2008) that found out that the main source of knowledge of contraceptives was mass media as reported by more than half (55.5%) of the respondents in their study. Most of other studies also have stated print and electronic media to be the common source of public awareness on reproductive behaviour as indicated by 57.7% (Takkar, Goel, Saha & Dua, 2005) and 50.0% (Renjhen, Gupta & Barua, 2008) respondents respectively.

Input from IDI by community women indicated their knowledge level of reproductive health information as:

> *I came to know about menstruation at the age of 12 when I entered into reproductive cycle, I gained the knowledge mostly from my mother and even my friends as at that time, mass media have not provided much knowledge. My mother taught me what to do that is the don'ts and does during menstruation, now am educating my daughter on it as I have gained more knowledge through different sources. Reproductive health information concerns all aspects of reproductive system of a woman starting from when she becomes a woman, the signs and dangers associated to high risk pregnancy, childbirth as well as morbidities related to childbirth* (Community women).

The respondents indicated the barriers to effective women reproductive health knowledge and behaviour among community women. Cultural factors/norms (mean=2.76) ranked highest by the mean score rating and was followed by religious belief (mean=2.71), husband disapproval (mean=2.67), social factor/side effects of using contraceptives (mean=2.57), financial constraint (mean=2.45), lack of awareness on reproductive health (mean=2.37), Lack of knowledge on reproductive health right (mean=2.35) and lastly by lack of facilities/specialist on reproductive health in tertiary institutions (mean=2.33).

The findings is in line with the findings of Schuler, Rottach and Muliri (2009) reported that gender factors such as men's dominance in decision-making and cultural norms that condone a man beating his wife if

she uses contraceptives secretly are barriers to use of modern contraceptives. This result confirms the findings of a Yemen study which identified religious beliefs as a reason for non-use of modern contraceptive method (Ba-Hubaish, 1999: 4). This finding confirms results from a study that women's perception that their husbands oppose family planning is a dominant factor discouraging contraceptive practice in a wide variety of settings (Joesoef, Baughman & Budi, 1988; Khalifa, 1988; Mbizvo & Adamchak, 1991; Koblinsky, Tyan & Gay, 1993; Grady, 1996; Asturias de Barries, Rods, Nieves, Matula, & Yinger, 1998; Elzanary, Sunita, & Casterline, 1999). Husband disapproval of modern contraceptives as a barrier to modern contraceptive use by women was also reported elsewhere in Africa as well as in Asian countries (Dabral & Malik, 2004; Tuloro, Wakgari, Ahmed & Gail,2006; Nwankwo & Ogueri, 2006; Aryeetey, Kotoh & Hindin, 2010; Burke & Ambasa- Shisanya, 2011; Mathe ,Kasonia & Maliro, 2011). Study conducted by Igwegbe, Ugboaja & Monago, 2009 (2009) Husband's disapproval (36.8%), fear of side effects (28.9%) and religious beliefs (14.8%) were the main constraints to the use of contraceptives. Onwuzurike and Ugochukwu (2001) found that 91% of non-use of family planning methods among married women in a community in Enugu State of Nigeria was as a result of their husband against the use of it.

Studies have indicated experiencing of side effects are among the major factors for non-use of modern contraceptives, drop-out and shifting from one method to another among women (Marchant,Mushi ,Nathan, Mukasa,Abdulla, Lengeler & Schellenerg, 2004; Khan, Bradley,Fishel & Mishra,2008; Igwegbe, Ugboaja & Monago, 2009). The result of the present study is aligned with the results of some international studies of Singh, Elena, Florence and Carles (2005) that explored the important barriers that prevent women from practicing of Reproductive Health Method. Among those the important constraints were fear of side effects, cost, inconvenience and the fear that use or even discussions of reproductive health may cause unfaithfulness or lack of commitment to marriage. Lack of knowledge of modern contraceptive methods and their mechanism of action have been cited as one of the major reasons for the women's non-use of contraception (Khan, Humayun, Saba, Anwar, Ahmad, Babar & Gul, 2007; Sajid & Malik, 2010; Wu, 2010). In poor countries, young people's economic constraints affect their ability to buy contraceptives or seek sexual and reproductive services (Chapagain, 2006; Sundby, 2006).

One IDI participants form Akinyele LGA of Oyo state had the following to say:

*There are many barriers to women reproductive health behaviour one of such is the husband sometimes acting as barrier to women's or wives use of modern contraceptives, at times other men may want their wives to give birth all the time and to have many children.*

Additional results from IDI indicate that males are at least partly responsible for ineffective women reproductive health knowledge and behaviour:

*Women do not typically have power over their husbands to freely decide on reproductive health behaviour, sometimes husbands oppose wife use of contraceptives because they think their wives does not want to give birth having the notion that she has an intention to go for another man if the wife does not agree it may lead to marital crisis* (Respondent from Ibadan North LGA)

The following quotes are from some participants:
*Women may not want to use contraceptive because of the pain they experience by the side effect of it. I fear the side effects of the use of methods of family planning as a friend of mine experienced irregularities in her menstrual cycles and sometimes excessive bleeding, some women even say it may cause infertility and one may find it difficult to get pregnant easily again. This discouraged me, I use the withdraw method and sometimes calculate my safe periods because am still young .I ve just had two children and I want to have another baby* (IDI responses).

Another participant from the same IDI added;
*Most women would like modern family planning methods as they are good but there are still some hindrances which may affect their use for example, husband opposition in my friend case her husband disapproved* (Respondent from Ibadan south west LGA).

The findings of this study corroborate those studies carried out in India indicating that reproductive health behaviours of women are greatly influenced by social and cultural barriers (Sankaranarayanan, Rajkumar, Arrossi, Theresa , Esmy & Mahe, 2003; McCaffery, Forrest, Waller, Desai, Szarewski & Wardle, 2003; Basu, Sarkar, Mukherjee, Ghoshal, Mittal & Biswas, 2006). This could be that culture is permeated with norms and values that places high value on childbearing and higher number of births for women in the society as well as traditional view placing importance on male preferences in family particularly in this part of the world, religious doctrines also do have values that discriminate and do not encourage open discussions on sexual health and reproductive health of women. The disapproval by husband is not also encouraging women to exercise their reproductive health rights which World Health Organization (2001) says that:

> *'Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence.*

Cultural beliefs about reproductive health were expressed by the IDI participants as a barrier to effective women reproductive health knowledge and behaviour:

> *Community or culture may at times negatively reject a woman for failing to produce as many children as expected, in the traditional society the grandparents wants their son's wife to give birth to many children as possible and this may discourage woman using contraceptives.*

Another participant argued that:

> *Cultural taboos do not encourage open discussion on reproductive health, in some culture particularly the rural areas and among some traditions, women are not allowed to take contraceptives by her husband family because such women are believed to be promiscuous or wanting to start having extramarital affairs.*

## Conclusion

Evidence from the study has led the researchers to conclude that barriers to effective women reproductive health knowledge and behaviour among community women were many though three out of the barriers had the highest score which were cultural factor/norms, religious belief and husband disapproval. Also the perception of female workers on reproductive behaviour is based on the use of contraceptives to prevent unwanted pregnancies, space and timing of children. For their knowledge on reproductive health is adequate from various sources like mass media, health specialist. It is recommended that information through the mass media on reproductive health rights of women should be provided and this information could be used to design messages targeted at men. This will help remove cultural and religious barriers to reproductive health behaviour and knowledge. Communities should provide information based approaches like talks, group discussions, role play, and drama where health professionals can come together to share their experiences concerning reproductive health. This will provide vast amount of social information that could promote good and positive reproductive health behaviour among women generally.



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