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# Factors Influencing Reproductive Health Behaviour of Female Non-Academic Staff in the Nigerian Universities

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## Abstract

It has become imperative that there is the need to tackle reproductive health problems in Nigeria because many women die due to pregnancy related complications. However, previous studies on women's reproductive health behaviour had focused majorly on adolescents, rural and non-literate women without due consideration for females in the formal wage system. Thus leading to a dearth of literature on reproductive health behaviour of the working class women particularly those in Universities. This study examined the influence of some factors on reproductive health behaviour among female non-academic staff in the Nigerian universities.

The study adopted descriptive research design of an ex-post facto type. The simple random sampling technique was used to select 217 female non-academic staff from purposively selected five Nigeria universities. The instruments used were Reproductive Health Behaviour Scale ( $r=0.81$ ), Age at marriage and Reproductive Health Behaviour Scale ( $r=0.79$ ), Socio-economic status and Reproductive Health Behaviour Scale ( $r=0.79$ ), Educational attainment and Reproductive Health Behaviour Scale ( $r=0.75$ ). These were complemented with three sessions of Focus Group Discussions (FGDs) and two sessions of In-depth interview (IDI) with female non-academic staff from each of the five Nigerian universities. Three hypotheses were tested at 0.05 level of significance. Data were subjected to Pearson's Product Moment correlation and content analysis.

The findings indicated that there was significant relationship between reproductive health behaviour and age at marriage of female non-academic staff in the Nigerian Universities, ( $r = .568^{**}$ ,  $p < .05$ ). There was significant relationship between reproductive health behaviour and socio-economic status of female non-academic staff in the Nigerian Universities ( $r = -.449^*$ ,  $p < .05$ ). There was significant relationship between reproductive health behaviour and educational attainment of female non-academic staff in the Nigerian Universities ( $r = .511^*$ ,  $p < .05$ ). Age at marriage, socio-economic status and educational attainment strongly influenced reproductive health behaviour of female non-academic staff in the Nigerian Universities.

However, to ensure improved reproductive health behaviour of female non-academic staff, there is the need to strengthen the use of mass media complemented with women's networking groups and religious institutions aimed at promoting better reproductive health behaviour.

**Keywords:** Reproductive health behaviour, Female non-academic staff in the Nigerian Universities,

## Introduction

One of the fundamental components of development is promoting and achieving the health of women most especially on reproductive health. Reproductive health behaviour is seen as decision-making which are embedded in social relations and institutions that operate from the macro to the micro level (Price & Hawkins, 2007). Reproductive health behaviour issues among women in the Nigerian context relates to access to information and services for family planning, child birth, prevention and treatment of Sexually Transmitted Infection (STI), freedom to

regulate one's fertility and sexual health (Osakinle, 2007). The author further implied that reproductive behaviour means a positive approach to women sexuality since it is a description of somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and enhancing to personality of individuals thus gearing women toward physical, mental and social well-being and not merely being free from disease. Meanwhile, Olukoya (1998) noted that reproductive behaviour of women is focusing more than before on prevention of unsafe abortion, treatment of reproductive tract

infections, sexually transmitted diseases and especially prevention of HIV/AIDS in individuals. These are some of the factors which determine the status of women to a large extent and which in turn affect their reproductive behaviour. Thus reproductive behaviour of women can be understood as the result of co-evolution of the cultural, socio-economic and biological systems, which each population develops according to the environment it lives in (Bernis, 2005).

Age at marriage is of particular interest because it marks the transition to adulthood in many societies; the point at which certain options in education, employment, and participation in society are foreclosed; and the beginning of regular socially acceptable time for sexual activity and childbearing (Palamuleni, 2011). He stated that age at marriage is one of the most important factors in population dynamics as it affects fertility, mortality and migration. Early marriage is associated with early childbearing, as in most cases particularly in developing countries; the main purpose of marriage is to have children. Early childbearing is also related to low status of women and adverse health risks on the mother and child. As such, marriage is not only the most predominant context for childbearing but also one of the most important determinants of fertility (Lesthaeghe, Kaufmann & Meekers, 1989). Among socio-demographic indices, age is very central to reproductive health issues. Thus the age at first sexual intercourse, first marriage, and first birth are important determinants of woman's risk of getting pregnant and the number of children she would have (Adebimpe, Asekun-Olarinmoye, Bamidele & Abiodun, 2011). Among socio-demographic indices, age is very central to reproductive health issues particularly on reproductive health behaviour of women beginning from puberty and through childbearing. Thus the age at first sexual intercourse, first marriage, and first birth are important determinants of woman's risk of getting pregnant and the number of children she would have (Adebimpe, Asekun-Olarinmoye, Bamidele & Abiodun, 2011). Differences in age at entry into marriage, access to family planning services and their ability to utilize these services effectively and efficiently, economic status of the household (that is possession of wealth to invest on offspring), and cultural and traditional norms in which the woman lives appear to play

significant roles in creating variation in the level of reproductive behaviour (Mirza, Kovacs & Kinfu, 2001; Gibson & Mace, 2002).

The impact of women's education levels on fertility, contraceptive behaviour, and contraceptive method choice has been extensively studied by various researchers; Stash, 2001; Moursund and Kravdal, 2003; Al Riyami, Mustafa and Mabry 2004, Saleem and Bobak, 2005; Omariba and Rasugu, 2006 all concluded that higher education levels in women have consistently been shown to have a significant negative effect on fertility levels and a positive effect on the use of contraceptives, although the exact mechanism through which education influences such behaviours and the direction of the relationship have not been identified. Education is also closely linked to the use of contraceptives, more educated women are more likely to use family planning (Saleem & Bobak, 2005). More adoption of family planning is associated with educational level of women (Furuta & Salway, 2006). In this connection, McNay, Arokiasamy and Cassen (2003) claim that the education of some women in a community initiates social and ideational changes that undermine traditional patriarchal power and reduce men's interest in having large numbers of children as it becomes difficult for them to devolve the costs of childbearing to their wives. Benefo, (2006) avers that a number of empirical studies support the claim that the presence of educated women in a community is associated with reduced fertility for women, regardless of their individual characteristics.

Many studies suggest that net of a woman's own education and the average education of women in a community have been shown to have a negative association with individual fertility in Thailand, Malaysia, Indonesia and the Philippines (Hirschman & Young, 2000), sub-Saharan Africa (Kravdal, 2002) and South India (Moursund & Kravdal, 2003). Corroborating this fact some other studies were of the view that in the contexts of extreme poverty, for example, lack of resources to meet the rising cost of children are often taken to indicate a decline in demand for children, despite evidence that, in such contexts, children are valued as a source of social, economic and political security (Barker & Rich, 1992; Berglund, Liljestrand, de Maria Marin,



Salgado & Zelaya,1997; Kambou ,Shah & Nkhama,1998, Thomas & Price,1999; Price & Hawkins,2001). The researchers further stressed that the outcome under such conditions may not be increased demand for modern contraceptive services, but changes in the contexts in which children are conceived and in which they grow up, increased poverty in many parts of the world combined with globalization of capital provides the context for increased entry of children into the workforce as an economic resource to their families and as a cheap source of labour, and into economically-based sexual relations.

However, in the last few decades, women reproductive behaviours have undergone important changes, and its basis can be found in the modification of both the woman's social role, and the family- related values system (Bernis, 1997). Women's role and status in the family, society and participation in paid employment greatly affects the degree of control she has over her own reproductive health behaviour because the possibility to decide when and whether to conceive children is a crucial element to be able to choose the kind of life she wants to live (Ergocmen, 2011). Among the important indicators and cause of changes in women's status is their participation in the labour force. Women who work outside the home, are presumed to have more control over household resources, increased awareness of the world outside the home, and consequently greater control over reproductive decisions (Gage, 1995; Mason, 1986 in Woldemicael,2007). Employment has some "transformational effects" on women, like providing direct access and control over financial resources, enabling them to function in the non-domestic sphere and in this way having access to the world outside the home, and having autonomy and control inside the home (Kishor, 1995). Paid employment also brings women into contact with new role models and new ideas and values that enhance a woman's self-worth and autonomy and exposes them to knowledge of women with small families and practicing modern family planning (Uchudi, 2001).

The participation of women in the labour force has also increased over the years in Nigeria now that women are engaging more in paid labour, women in Federal Universities are seen as role model due to the nature of their work, yet not all of these women are

aware of their reproductive health rights and knowledge of reproductive health. The situation among female **university non-academic staff in Nigeria** is not completely different from the above statement. These women earn some level of income and as such do not totally depend on their husbands financially but there are still cultural factors that limit their ability to take decisions even when their lives are involved which could be attributed to limited knowledge, lack of personal hygiene and sanitation, access to services; risk misperceptions, and negative social norms around sexual activity and pregnancy. Essentially the achievement of good reproductive behaviour among women of all categories depends largely on the interaction of several factors in any given human societies. Apart from the conditions of women themselves the factors that affect their use or non-use of adoption of family planning (contraceptives), the culture of the people, environment where they live and the socio-economic status of women is also strongly associated with reproductive health behaviour outcomes. Therefore, the understanding of reproductive health behaviour of female **non-academic staff in the Nigerian universities**, deserve more attention due to the nature of their work particularly in an academic environment. As previous studies indicated that these predisposing factors are intrinsically tied to the prevailing social, cultural and economic history of these developed and developing countries

Most studies on reproductive health behaviour for example Moronkola and Idris, (2000) Johnson-Hanks, (2002), Okere, (2010) had concentrated on female adolescents, uneducated and non-literate women and rural women. There is a gap in literature on reproductive health behaviour of female **non-academic staff in the Nigerian universities** as studies have not focused on these women working in paid sector. Hence, the need for this study. This now raises the salient questions: If previous findings is true of the uneducated and non-literate women in the rural areas will this be applicable to the educated urban female workers, particularly non-academic staff in the universities. It is on the basis that the study examined some factors influencing reproductive health behaviour of female **non-academic staff in the Nigerian universities**.



### Objectives of the Study

The main objective of this study was to find out the factors influencing reproductive health behaviour of female non-academic staff in the Nigerian universities while the specific objectives are to:

- i) determine the extent to which age at marriage influence reproductive health behaviour of female non-academic staff in the Nigerian universities.
- ii) examine the relationship between socio-economic status and reproductive health behaviour of female non-academic staff in the Nigerian universities.
- iii) assess the extent to which educational attainment affects reproductive health behaviour of female non-academic staff in the Nigerian universities.

### Research Hypotheses

H<sub>01</sub> There is no significant relationship between age at marriage and reproductive health behaviour of female non-academic staff in the Nigerian universities

H<sub>02</sub> There is no significant relationship between socio-economic status (income) and reproductive health behaviour of female non-academic staff in the Nigerian universities

H<sub>03</sub> There is no significant relationship between educational attainment and reproductive health behaviour of female non-academic staff in the Nigerian universities

### Methodology

The descriptive research design of an ex-post facto type was adopted. The population for this study consisted of married female non-academic staff that had spent nothing less than two (2) years of service on employment of the selected universities in Nigeria. A simple random sampling technique was used to select two hundred and fifty respondents from various Faculties, Registry, Admissions Offices and Post graduate schools.

### Instrumentation

A self-designed questionnaire tagged **Reproductive Health Behaviour Scale** was the main instrument used for data collection. This instrument was developed by the researcher to collect information on reproductive health behaviour of female university non-academic staff; on family size, timing and spacing of children; number of children and use of pattern of contraception to prevent unwanted/unplanned pregnancies and safe sex relations. It was made up of a section of 18 items

drawn on closed ended questions respectively.

### Age at marriage and Women Reproductive Health Behaviour Scale

This scale was developed by the researcher to collect information on female non-academic staff at marriage influence on reproductive health behaviour. It is made up of 6 items drawn on a four point rating scale. Responses for all questions ranged from strongly agree (SA), agree (A), disagree (D) to strongly disagree (SD). The validity of the instrument was ascertained. The reliability of the instrument was determined through test-re-test method within an interval of two weeks among 20 respondents in state university that would not be part of the study. The alpha coefficient for the scale was 0.79.

### Socio-economic Status and Women Health Reproductive Behaviour

This scale was developed by the researcher to collect information on the influence of socio-economic status on reproductive health behaviour of female non-academic staff. It is made up of 11 items drawn on a four point rating scale of Strongly agree (SA), Agree (A), Disagree (D) and Strongly disagree (SD). The validity of the instrument was ascertained. The reliability of the instrument was determined through test, re-test method within an interval of two weeks among 20 respondents in state university that would not be part of the study; the result of Cronbach Coefficient of alpha value showed 0.79

### Educational Attainment and Women Reproductive Health Behaviour Scale

This scale was developed by the researcher to collect information on female non-academic staff educational attainment influence on reproductive health behaviour. It is made up of 7 items drawn on a four point rating scale. Responses varied from Strongly agree (SA), agree (A), and disagree (D) to strongly disagree (SD). The validity of the instrument was ascertained. The reliability of the instrument was determined through test, re-test method within an interval of two weeks among 20 respondents in state university that would not be part of the study; the result of Cronbach Coefficient of alpha value showed 0.75

### Method of data analysis

The data collected in this study was analyzed using Pearson Product Moment Correlation Coefficient, at 0.05 level of significance. Content analysis was used for the In-depth Interview (IDI) and Focus Group Discussion (FGD).

### Results

To determine the relationship between age at

marriage and reproductive health behaviour of female non-academic staff in the Nigerian universities as raised by H<sub>0</sub>, There is no significant relationship between age at marriage and reproductive health behaviour of female non-academic staff in the Nigerian universities.

**Table 1 Relationship Between Age At Marriage and Reproductive Health Behaviour of Female Non-academic Staff in Nigerian Universities**

Variables	Mean	SD	N	r	p	Remark
Reproductive Health Behaviour	13.0193	10.1058	217	.568**	.000	Sig.
Age at Marriage	15.4436	3.0362				

\*\* Sig. at .05 level

It is shown in the above table that there was significant relationship between reproductive health behaviour and age at marriage among of female non-academic staff in the Nigerian Universities ( $r = .568^{**}$ ,  $N = 217$ ,  $p < .05$ ). The findings of the study indicated that age at marriage and reproductive health behaviour of female non-academic staff in the Nigerian universities were significantly related. Hence the null hypothesis was rejected, while the positive/alternative upheld. The findings revealed that age at marriage influences reproductive health behaviour. Age at marriage could affect female non-academic staff reproductive health behaviour by spacing their children for good healthy living. Age at marriage helps them to practice safe sex relations and the number of children they have or will have. This findings support the position of UNICEF, (2001), that age at marriage is an important factor in childbearing.

In southwestern Nigeria, most families give out their children at an early age owing to the belief that the early marriage of a woman increases her chances of conceiving early before she reaches menopause and makes chances of child survival higher. This could mean that early marriage may be related to early childbearing of women. Age at marriage makes couples to cohabit and have regular sexual intercourse

to produce children. This is socially approved by all communities in the world. Women who have early marriage are less likely than others to delay children and use one method of family planning to avoid unintended pregnancies. Age at first marriage has been recognized as a crucial determinant of fertility because it marks the beginning of exposure to the risk of childbearing in societies where pre-marital sex is uncommon and where there is little deliberate effort to control fertility (Blanc & Rutenberg, 1990).

A female non-academic staff used in the In-depth Interview asserted that most women in their early 40s now got married at early age:

*It is appropriate for a woman to get married after the age of 20 years, because, by that time, she has both mental and physical maturity. I got married at the age of 22 years, had my children one after the other within a period of 8 years, and now I'm enjoying good health by taking good care of them*

A female non-academic staff respondent during the In-depth interview submitted that:

*It is better a woman gets married in*



*her early twenties. She would be able to plan her future well. I married at the age of 28 years, my children are now grown up. They can take care of themselves. My husband has been understanding, encouraging me to strive ahead in my career now that it's only the two of us at home*

She concluded that:

*Though, women are responsible for bearing the burden of pregnancy, childcare and the domestic side of things. My age at marriage has really helped me in managing my home as I have given birth to the total number of children I want already.*

Several participants in the Focus Group Discussion in revealed that they already had between 2 and 3 children. One of them stated that:

*To me, it could be good and not good. Good in the sense that early marriage helps women to end childbearing early, as it promotes good health. Early marriage may also expose women to various reproductive health problems. Late marriage, on the other hand, affects fertility, as year for childbearing may be too small for such woman leading to complication during childbirth.*

*could be good and not good. Good in the sense that early marriage helps women to end childbearing early, as it promotes good health. Early marriage may also expose women to various reproductive health problems. Late marriage, on the other hand, affects fertility, as year for childbearing may be too small for such woman leading to complication during childbirth.*

The above information supports the assertion that age at marriage is important in understanding reproductive health behaviour of women. This may be as a result of female non-academic staff preferring to have babies early in life.

Although the number of children born per woman may indicate the pattern and pace of change in reproductive health behaviour, such changes has social development implications for the woman and her family. This is supported by the view of Hinde and Mturi (2000), that the rising age at first marriage has a lowering effect on the level of fertility. Generally, the age at which a woman enters to her first nuptial life is directly related to number of children she will bear, because it affects the length of time she will be at risk of becoming pregnant. Although unmarried women may also have children, but the vast majority of childbearing takes place after marriage, making age at marriage a valuable indicator of a woman's lifetime fertility (Acharya, 2010). However, some research findings, for example those of Balk (1994) and Niruala and Morgan (1995), found no association between women's age at marriage and their decision-making power as regards their reproductive behaviour.

The In-depth Interview complemented the main instruments used for the study, helping to gather relevant information on the age at which female Muslim and Christian workers got married and its implication for their reproductive health behaviour. A female Muslim non-academic staff had this to say;

*I'm a Muslim and my religion teaches one to worship only the Allah Almighty and believe upon him and his attributes. That is the reason Muslims believe in early marriage, I got married early at the age of 25.*

A female Christian non-academic staff noted that

*Being a Christian does not have anything to do with whether one marries at any age. The most important thing is marrying according to will of God, whether at 20 or 30 years of age, it does not matter. I got married at the age of 29 years and it determined the number of children I had. I have stopped childbearing*

Nagi (1983) explored the effect of demographic

factors on reproductive health and fertility. He claimed that age at marriage has substantial effect on fertility in Muslim countries as compared with non-Muslim countries, ultimately affecting the health of women. In the Muslim countries, when the age at marriage, increases the fertility level decreases.

To determine the relationship between socio-economic status (income) and reproductive health behaviour of female non-academic staff as raised by H<sub>0</sub>. There is no significant relationship between socio-economic status (income) and reproductive health behaviour of female non-academic staff in the Nigerian Universities.

**Table 2 Relationship between Socio-economic Status (income) and Reproductive Health Behaviour of Female Non-academic Staff in the Nigerian Universities**

Reproductive Health Behaviour	23.5820	15.4678				
			217	-.449*	.000	Sig.
Socio-economic Status	27.8886	15.0805				

\* Sig. at .05 level

It is shown in the above table that there was significant relationship between reproductive health behaviour and socio-economic status of female non-academic staff in the Nigerian Universities ( $r = -.449^*$ ,  $N = 217$ ,  $p < .05$ ). The null hypothesis was, therefore, rejected. The result in table above shows that socio-economic status (income) significantly influences reproductive behaviour of female non-academic staff in the Nigerian Universities. Socio-economic status, which refers to income level is the female non-academic staff earnings. It is an economic indicator whereby the respondents have various level of income which reflects on their source of income generation.

Occupation is, perhaps, one of the most important social economic characteristics, having a job enables female non-academic staff who are married women to make decisions regarding their family size, timing and spacing of children in order to provide better health care, education and proper care for their children. This finding supports the claim of Sarwat et al. (2003), that occupation of the respondents plays a pivotal role in fertility regulation and reproductive health behaviour of women in households. Changes in economic status of women in households lead to changes in reproductive behaviour. They added that low socioeconomic conditions, like unemployment of women, increase the burden of expenditure, as low income households have more members and more young children, with high dependency ratio, which reflects high fertility rate. As a result the majority of them are in poor conditions. This finding is similar to

Yohannes (2013) claim of women's employment for cash income having a strong association with their reproductive health-seeking behaviour. Women who are employed for earnings may be exposed to information, knowledge and new attitudes about modern health care at their workplaces or through the media. Female non-academic staff are not housewives that would be dependent totally on their husbands. They are working, earning a source of livelihood, though occupying different posts within the Nigerian Universities. Income is an important indicator of one's social standing. Income affects the social behaviour of the social system, particularly the use of contraception (Bogue, 1983). Employment has some "transformational effects" on women, like providing direct access and control over financial resources, enabling them to function in the non-domestic sphere and, in this way having access to the world outside the home, and having autonomy and control inside the home (Kishor, 1995). Female non-academic staff socioeconomic status is an important indicator of social standing. An In-depth Interview respondent in one of the Universities said;

*I had decided on the number of children I wanted in life even before I got married. Though I have been working for several years, I have few children, as children are expensive to take care. I want to give them the best and take proper care of them, that is reason I gave birth to the number I can cater for based on my income.*



In the Focus Group Discussion conducted on the influence of socio-economic status on reproductive health behaviour particularly on contraceptives usage. Few women believe that

*the usage of contraceptive depends on the economic status of the family.*

*The comment below reveals this:*

*I also want to take care of the housework, but I have to consider the reality that if both of our salary can't cover the daily expenditure of the family, we must stick to limiting our family size*

This result is consistent with State of South Africa Population Report (2000) and Owuamanam and Alowolodu (2010) that there is significant positive relationship between family size and income. A change in income may have a variety of effects on parents' demand on children. The findings are in consonance with previous findings that indicated a positive relationship existing between working women (paid and not paid work outside the home) and their health-seeking behaviour (Elo 1992; Basu 1992; Abdalla 1993; Swenson, Thang, Nham, & Tieu 1993; Govindasamy 1994; Khan, Soomro, & Soomro 1994; Barlow & Diop 1995; Ahmed & Mosley 1997; Regmi & Manandhar 1997). This positive relationship empowers women with greater decision-making power regarding matters concerning themselves and their children. In every society, the woman provides critical economic support to her own family's continued survival, whether such woman is in a self-paid job or is earning certain income in the informal or formal labour market. Therefore, female non-academic staff participation in paid jobs is considered as one of the significant indicators of their socio-economic status, which influences their reproductive health behaviour. This is because their income level makes them to be on the economically productive side, as this has some positive effects upon their lives, particularly their reproductive health.

Khan, and Manan (2010) assert that income from job is considered as personal income. Such income

increases women's financial authority, which is the most important element of women autonomy after education and it enhances women's assertive power and raises their social status through financial independence. Paid job outside home also increases women mobility. They learn from the experiences of fellow workers, seniors and all others with whom they interact during the discussion of various responsibilities. Frequent interactions outside home broaden women knowledge, contributing towards confidence-building measures. Income increases women's autonomy, which ultimately yields positive bearing on their decision-making authority, increases mobility; enhances social status and financial independence; and improves decision-making by improving women's control on their fertility. This motivates them to bear lesser burden of childbearing and child rearing. Studies abroad also report that the level of family income is one of the influencing factors on the use of contraceptives (Bagheri & Nikbakshesh, 2010; Nanda, Adak & Bharati, 2011). These studies reported that an increase in the rate of the use of contraceptives is a factor of increase in income.

The foregoing submission shows that any woman would prefer to adopt preventive measures to avoid unplanned and unintended pregnancy and birth after she has had the desired number of children. A woman's autonomy through labour participation enhances her knowledge and adoption of family planning services by building consistence to cultural pressures and empowering her to exercise better control on fertility (Ahmed, 2002 in Khan & Manan, 2010). Such financial empowerment improves her access to the use of health and family planning services.

To determine the relationship between educational attainment and reproductive health behavior of female non-academic staff in Nigerian Universities as raised by H0, There is no significant relationship between educational attainment and reproductive health behaviour female non-academic staff in the Nigerian Universities,

Table 3 Educational Attainment and Reproductive Health Behaviour of Female non-academic staff in Nigerian Universities

Reproductive Health Behaviour	11.5091	9.1727	217	.511**	.000	Sig.
Educational attainment	05.5137	04.1307				



\*\* Sig. at .05 level

It is shown in the above table that there was significant relationship between reproductive health behaviour and educational attainment of female **non-academic staff in the Nigerian Universities** ( $r = .511^{**}$ ,  $N = 217$ ,  $p < .05$ ). The null hypothesis was, therefore, rejected. The coefficient of correlation and the significance level amply demonstrates that educational attainment is extremely important to reproductive health behaviour. The higher the level of education attainment, the better the reproductive health behaviour of female non-academic staff. This finding is in accordance with results from several previous studies conducted in other parts of Africa and Asian countries (Oye-Adeniran, Adewole, Augustine, Oladokun, Gbadegesin, Ekanem, Yusuf, Odeyemi, Iwere & Mahmoud, 2006; Nwankwo & Oguer, 2006; Bhandari, Premarajan, Jha, Yadav, Paudel & Nagesh, 2006.; Khan, Bradley, Fishel & Mishra, 2008; Adanu, Seffah, Hill, Darko, Duda & Anarfi, 2009; Mturi & Joshua, 2011). Education attainment of female **non-academic staff** not only enhance their capacities and capabilities to a large extent it also influences their life style, occupation and adjustment pattern. Female **non-academic staff** behaviour pattern and thinking is different from illiterate or semi-educated women. Likewise they are assumed to be well-off when compared to the semi educated or illiterate women in all respects especially in the area of general awareness and health related matters. Their education attainment may be associated with later entry into marriage, preferences for smaller families, spacing, and planning the second childbirth, increased awareness, acceptability and use of contraception.

Education can have an empowering effect on women, broadening their horizons, choices and opportunities and enabling them to take personal responsibility for their health and that of their children (Paul & Rumsey, 2002). Good educational attainment for the female **university non-academic staff** makes them knowledgeable. Hence, they are more likely to possess good ability to understand message in health promotion materials (such as posters and brochures), including those involving family planning (Mgabo, Mugane & Lwelamira 2010). Education is an important predictor of the reproductive health behaviour. This analysis pertains

to information collected from women aged 19-49, who had given birth to at least a child. Nevertheless, education may operate through other variables like information and access to reproductive health behaviour. It is important to stress here that the educational attainment analyzed in this study is interrelated with reproductive health behaviour of female workers. For instance, education will determine one's occupational status, which also influences one's income and marriage type. Educational attainment of female **non-academic staff** appears to be an important determinant of reproductive health behaviour, perhaps, because more educated women are more likely to appreciate the advantages of having fewer and better educated children.

Kirk and Pillet (1998) submit that women employed in the formal sector have usually been noted to have fewer children, being unemployed denies women the access to resources with which to prepare for marriage and child rearing immediately after leaving school. Education could be seen as a powerful force against reproductive behaviour because, in terms of economic consequences, educating children is costly, as parents must provide books, supplies, appropriate clothing, and frequent transportation in order for their children to attend school. The educational attainment of female workers exposes them to issues concerning their reproductive health behaviour which makes them to be aware of various methods of contraception that would help limit their family size, space and time their children and practise safe sex relations.

Educational attainment enables women generally to be well informed on matters relating to reproductive health behaviour. Also the level of educational attainment of female non-academic staff could be seen as one of the most important factors influencing reproductive health behaviour observed in this study. The sampled staff had varying levels of educational attainment. Without educational attainment, it may be difficult for these women to understand what good reproductive health behaviour means. This could also affect rationality in decision making on family size, number of children as well as adoption and use of contraceptives.

Schultz (2008) supports the result of this study, that women's education is associated with



smaller desired family sizes across the world. Therefore education should be given priority, because achieving good reproductive health behaviour depends heavily on the educational attainment of women on how to obtain effective birth control methods as well as the acceptance of family planning. This appears to be a powerful force for reproductive change in any country of the world. This finding confirms the relevance of education to reproductive health behaviour, as educated women are more likely to afford family planning methods for child spacing. Their being educated determines the number of children they want. Educated women are exposed to knowledge of preventing unwanted pregnancies.

Table 3 in support of previous studies that found that socio-economic characteristics of women, notably educational levels, explain differences in reproductive behaviour and contraceptive choices (Anju, Vanneman & Kishor, 1995; Kazi & Sathar, 2001). The effectiveness of this view is supported by several previous studies on female education and reproductive behaviour which claim that female education leads to a decrease in fertility, that is with higher levels of education, the number of children born per woman reduces (Schultz, 1973; 1974; 1993 & 2008; Vavrus & Larsen; Sackey 2005). This result is consistent with Population Reference Bureau (2000) and Owuamanam and Alowolodu (2010), which state that formal education has been a major determinant of family size.

The foregoing corroborates the importance of education attainment on reproductive health behaviour as regards family size. One of the participants of In-depth Interview revealed that:

*My educational attainment has somehow influenced my reproductive health behaviour. It has made me to understand what I want in my marriage, particularly the number of children I want, how to go about it and how to take care of my children.*

A female **non-academic staff** expressed her views thus:

*I'm of the opinion that education background of a mother is important not only that it is good for the*

*woman's health, it makes her to understand her health particularly as it related to childbearing, the number of children she wants and the means to prevent an unwanted child rather than going for abortion, which is risky.*

Similarly, another female participant summed up the discussants view on educational attainment and remarked that:

*Education influences reproductive health behaviour, being educated may make a woman to delay her marriage, increases her knowledge and exposes women to beliefs and values on childbearing and rearing. When women are educated, they are likely to have the ability to relate better with their husbands on decision to adopt contraception and it may affect the number of children they want*

This finding is consistent with previous findings by Bbaaleand Mpuga (2011) that better educated women were more likely to use contraceptives. Studies conducted in other countries by Arokiasamy, 2002, Iyer, 2002, Khan and Khan, (2007) all indicated that women's education had a strong positive effect on their current use of contraception. Education is considered essential in improving women's status since it provides real and lasting improvements in women's lives. Generally, more educated women have better health, living conditions and life opportunities than their less educated counterparts. Education, by providing the possibility of gainful employment, puts women in a relatively better position, economically and socially. Education, besides making women more open to new and modern ideas, it also gives the possibility of establishing an egalitarian status within the marital relationship. Moreover, educated women are expected to control their fertility more safely and

effectively (Ergöçmen, 2011).

Different respondents in the Focus Group Discussion expressed concern about educational attainment as a factor affecting reproductive health behaviour of married women in a positive way:

One of the Focus Group Discussion discussants stated that:

*Educated mothers were likely to be gainfully employed and have enough money to purchase contraceptives*

The FGD participants noted that educational attainment increases knowledge of reproductive health, as it removes fear associated with their use of contraceptives. They believed that educational attainment of couples have effect on the use of contraceptives

Similarly, finding by Espejo, Tsunehiro, Osis, Duarte, Bahamondese and De Sousa(2003) supports this finding that higher educational level and better socio-economic status have been shown to be associated with better knowledge about contraception in a study from Brazil. This could be due to the fact that educational attainment makes women to able to articulate their reproductive health desires. Female non-academic staff who are women, however, still try to reconcile their family roles with outside roles which are their job responsibilities. But how easy or otherwise it is performing these roles may have a substantial effect on reproductive health behaviour.

### Conclusion

Reproductive health behaviour of female non-academic staff determined by some variables such as age at marriage, socio-economic status and educational attainment which enhance reproductive health behaviour on decision making on activities and decisions on family size, timing and spacing of children, number of children, and use of pattern of contraceptives to prevent unwanted/unplanned pregnancies and safe sex relations.

### Recommendations

Employers of female university non-academic staff could also provide reproductive health services in the medical clinics at the place of work to achieve better reproductive health behaviour. Also, there is the need to strengthen the use of mass media complimented

with women's networking groups and religious institutions aimed at promoting better reproductive health behaviour.

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