WOMEN'S PERCEPTION OF HEALTH AND FERTILITY CONTROL ISSUES: A STUDY OF SELECTED RURAL COMMUNITIES IN AKWA IBOM STATE, NIGERIA

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ABSTRACT

This study assessed the women's perception of health and fertility control issues in the rural communities of Akwa Ibom State with evidence drawn from Ekpene Ukpa, Ikot Unya, and Odoro Ikot 1. These are villages in Etinan, Mkpat Enin and Essien Udim Local Government Areas, respectively. The study selected a total of 146 women using a probability based sampling technique, from whom data were collected on their background characteristics, health information and health care sources, attitude towards fertility issues (level of use and knowledge of the effects of contraceptives), and cultural beliefs about child bearing. The data collected were tested using analysis of variance (ANOVA) and pearsons product moment correlation analysis and the results showed a strong influence or effects of income, family size preference, and side effect of contraceptives use, on the women's perception of their health. Consequently, it was recommended among others that women including under-age in these communities should be exposed to health and sex education.

Keywords: *Health, fertility, women control issues*

INTRODUCTION

The past two centuries have witnessed intense actions aimed at improving human health in many countries of the world. There is virtually no country without serious concern over the health status of its citizens in this period. Some empirical findings (APHRC, 2008; UNICEF, 2008; Stockwell, Goza and Balistreri, 2008) have documented efforts of nations and independent organizations, and the various programmes under taken across the world for this purpose. To a reasonable degree, human lives, (particularly of children and pregnant women, initially loss in large numbers have been saved in the developed countries, while the developing world still have the worse experience even in this century.

Statistics concerning infant, child, under-five, and maternal mortality in most parts of the developing world are higher and frightening, especially in the rural areas (Magadi, Zulu and Brokerhoff, 2003; Tawiah, 2005; APHRC, 2002; APHRC, 2008). Only a small reduction is made on infant, child and under-five mortality rates in the urban areas of these countries because of the United Nations and Non-governmental organizations' interests and commitment to the safety and survival of newborns, even as the Programmes are not in any way discriminatory against the women.

For maternal mortality, the rate has remained stubbornly intractable above 500,000 (UNICEF, 2008). The United Nations children's Fund, UNICEF (2008) argues that the lifetime risk of maternal death for a woman in a least developed country is more than 300 times greater than for a woman living in our industrialized country. Beside this, until the 21st century, there was still a wide margin of disparity between men and women in the poor countries. The root cause of women's disadvantaged position in many countries and cultures lie in the lack of attention to and accountability for women rights (UNICEF, 2008).

Women are not freed from certain forms of cultural restrictions despite the 1979 conventions on the limitation of all forms of discrimination against them as ratified by 185 world countries. Unresolved arguments by Leslie (1991), Abasiekong (1997), William (1991), and Ukpong (2007), for instance, persist in most rural parts of Akwa Ibom State, decision on health of women, even in pregnancy, is not solely of the women, such decision with regard to healthcare and source is jointly taken by the husband and relatives. A lot of changes no doubt have taken place in this practice, as well as in areas that women were generally excluded from decisions on major issues in the family; hence, raising questions which answers can be sought in this type of research. The women scarcely eat with their husband, but eat last after satisfying their husband, children, family members, and sometimes the visitors.

Bones often times constitute the major source of protein since pregnant women are traditionally expected to cook their foods with water of cooked bones; eat enough of periwinkle and traditional leaves to improve their store of blood. On average, they depend heavily on traditional sources of food and live in poor socio-economic situations. Similarly, a number of earlier studies conducted by Uyanga (1980), Kar and Talbot (1980), Nicol (1949), Coale (1968), Ekanem et al; (1975) and Etukudo (1999) revealed that higher fertility is highly valued in the rural societies of Akwa Ibom State. Fertility is a fortune: couples comment their marital relationship by force of fertility.

A good health inspires the desire to accept pregnancy and childbirth. Also, the number of pregnancy and childbirth measures the health status of a woman. Thus, to stop or limit fertility is a serious risk: most women believe that controlling fertility means inflicting on a divine gift and such act is believed to lead to bleeding, delayed pregnancy, loss of weight, sterility among other complications which can cost the life of the victim. Emphasis is layed on the benefits of having children in numbers; the dangers and shame of staying barren or living infertile; and terminating the lineage at one's generation and, the unimagined consequences of challenging God's will. But high fertility rates according to UNICEF (2008) increase the risk that a woman will die from maternal causes.

While mortality risks are associated with all pregnancies, the risk increases with the frequency a woman gives birth (UNICEF, 2008). These observations indeed describe the situation in the rural communities of Etinan, Mkpat Enin, and Essien Udim Local Government Areas of Akwa Ibom State, where in addition, women have different perceptions for health and fertility control. This study therefore, is

intended to examine the veracity of the women traditional beliefs and practices relating to their health and fertility behaviour in the context of modern practice, in order to advance recommendations in perspective of improving their health fortune.

METHODOLOGY

This study draws data from 146 women in the reproductive age group of 15 to 49 years. The study uses both descriptive and analytical survey design. It focused on three rural communities in Akwa Ibom State, namely, Ekpene Ukpa, Ikot Unya, and Odoro Ikot I. Ekpene Ukpa community is found in Etinan, Ikot Unya in Mkpat Enin, while Odoro Ikot I is a community in Essien Udim Local Government Area. The three local government areas (Etinan, Mkpat Enin and Essien Udim) have witnessed explosion in their respective populations than the other local government areas in the state based on the 2006 National Census results.

Available statistics (MOED, 2005) indicate that 19 health institutions (comprising both private and public) exist in Etinan, II in Mkpat Enin, and 19 in Essien Udim. But a comparative assessment of the sizes of the areas' populations with the existing health institutions shows that the latter are grossly inadequate to meet the healthcare needs (both diagnosis and treatment), and family planning services desired in time. Beside, there is no single primary or secondary health institution (private or public) in the study rural communities. The distance from these communities to the respective local government headquarters where the health facilities are located are far and discouraging to the women who want to visit the facilities. In Ekpene Ukpa and Ikot Unya rural communities, 50 respondents each were selected whereas in Odoro Ikot 1, 46 respondents were selected. The selection of the respondents was done using a probability based sampling method. The respondents were all interviewed. Information elicited from the respondents disclosed their background characteristics, preferred source of health care, their knowledge, attitudes, use and non-use of fertility control methods. The information collected were coded, discussed descriptively and analyzed with analysis of variance (ANOVA) and Pearson product moment correlation (PPMC) techniques.

RESULTS AND DISCUSSION

In the study, women were assessed based on their background characteristics and the different variables that influence their health status and fertility behaviour. The study observed a strong link between a woman health and her fertility expectation: no one is happy staying barren. It was discovered that the women have full knowledge and appreciated the importance of both traditional and modern methods of fertility control, varying from withdrawal and abstinence to the use of contraceptives. The women agreed that fertility control methods, especially, modern drugs and condom were available everywhere in their communities. Condom is sold in all patent medicine shops, by medicine vendors in community markets, and sometimes distributed at different fora they attained. Again, the study found that although buying

or possessing condom publicly was still avoided by people to escape being nicknamed and catching of shame, it has been institutionalized at least for protection against the much dreaded HIV-AIDS (Udongo nsaad). Condom is both played and joked with using a fond name "itam ette", meaning father's cap; at different social fora, on radio and television, all in attempt to get every category of the population enlightened on the prevalence and devastating effect of the HIV AIDs disease.

Among the study women, using condom while having sex with a spouse is culturally forbidden and is not accepted by their husband no matter the explanation (whether checking unwanted pregnancy or not). The widely known and used type of condom in the study area, the "Cold Circle", which is normally worn by the male sexual partner, is sparingly used with close friends or a designated sex partner. That is why the rate and number of children that men in the study area bear from illegitimate arrangements keep increasing. The women complained that they lacked the power to enforce the use of condom by their husbands or fiancés since they (women) were culturally subject to their husbands who paid for their bride price or fiancés who foot the bills of most of their life needs.

Apart from condom, some other types of contraceptive were accessible and affordable to the study women. Examples of this include pill, injectibles and rhythm. The reasons why the women do not use contraceptives include the fears of ceasing childbirth without having the desired number of children; the side effects in terms of the health of the women and the biblical punishment for terminating life; and cultural belief about childbearing and sterility. The table below presents analysis of the study women based on their belief about the side effects of contraceptives use for fertility control.

Table 1: Perception of consequences of contraceptives use.

Variables	Responses	%
Delayed conception	52	35.6
Miscarriage	NIL	0
Weight loss/gain	18	12.3
Bleeding	3	2.1
Disruption of woman's womb	15	10.3
Distort a woman's fertility at reincarnation	28	19.2
God's punishment	21	14.4
No idea	9	6.2
Total	146	100

Source: Survey 2009

Among the women studied, using contraceptives other than condom to regulate pregnancy is believed to be a major cause of delayed pregnancy in some women. Delayed conception or pregnancy is as risky as sterility. It often leads to broken marriage or the formations of polygamous family. This table shows that more than a quarter of the total respondents reported that they do not use any other type of contraceptives other than condom to avoid delaying their conception or pregnancy. A lesser number of the respondents said contraceptive use normally results in excessive weight loss/gain. Weight loss is dangerous to women particularly as it

affects their health. An insignificant number of respondents said the use of contraceptives causes bleeding in women.

Part of the remaining proportion of the respondents complained that the practice of fertility control can affect the women's womb; that it can affect a woman's fertility status during reincarnation; that they avoid the practice of fertility control so as to escape God's punishment. However, some respondents expressed lack of idea of a particular side effect of fertility control or use of contraceptive, although they admitted there is a side effect.

Table 2: Number of children desired and ever born

NOCD	NO W	%	NEB	NOW	%
-	-	-	1	8	5.6
-	-	-	2	13	8.9
2	13	8.9	3	19	13
3	57	39	4	32	21.9
4	26	17.8	5	51	34.9
5	19	13	6	5	3.4
6	8	5.5	7	16	11
8	-	-	8	2	1.4
Any no.	23	15.8	-	-	-
Total	146	100		146	100

Source: Survey 2009. *N/B: NOCD - Number of Children Desired, NOW - Number of Women, NEB - Number Ever Born*

In the three rural communities, the highest number of children desired by the women studied is six, with no allowance given for the women who will accept any number they may have before completing their childbearing cycle. Altogether a significant number of the total respondents have desired for a number that conformed to the national population policy of 4 children per couple, yet desired for children above the number stipulated in the Policy. Some who appeared to be very religious desired no specific number of children. They accept any number (high or lower) as the will of God for them. However, some of the women desired for children in varied specific number ranging from 2, 3, 4, 5 and 6 throughout their reproductive lives. Despite the desire of the women, table 2 shows that some of the women have no child. This number is less than others who ever born a child each. Some have so far given birth to two children while some three children. It further revealed thath more than a quarter of the respondents have given birth to four children.Very few of the women reported five and two children.Others reported six children.

Table 3: The level of income.

Income level/annum	Responses	%
Below N20,000	41	28.1
N21,000 - N40,000	32	21.9
N41,000 - N60,000	19	13.0
N61,000 - N80,000	25	17.1
81,000 - N100,000	18	12.3
Above N100,000	11	7.5
Total	146	100

Source: Survey 2009

Data collected during the study as shown on table 3 indicates that greater proportion of the respondents live on meager income annually. It is evident from the table that the monthly income of majority of the respondents was less than N10,000.00. However, very few of them earned above N10,000.00.

Table 4: The marital status.

Marital status	Responses	%
Single	17	11.6
Married	62	42.5
Divorced	4	2.7
Widowed	23	15.8
Separated	39	26.7
Cohabited	1	0.7
Total	146	100

Source: Survey 2009

Evidence from the study shows that most of the women studied were married and currently living with their husbands. Some were single parent, although have one or two children unexpected. Few of them had the status of divorce and widow. More than a quarter of the respondents have separated marital status. Altogether, all the respondents irrespective of their marital statuses are fecund and are socially conditioned into childbearing, yet only an infinitesimal proportion of the respondents cohabited. Empirical results got from the test of effect of income on the attitude of the study women towards their fertility expectation show that the number of children desired and knowledge of consequences or side effects of different methods of contraceptives, significantly influenced the study women's perception of health and fertility control. The women annual level of income was measured on their use of modern health care services using the analysis of variance (ANOVA) statistical model. The result shows a calculated value of 5.49. This value when compared with the critical table value at 0.01 level of significance (p); between groups degree of freedom of 4 and within groups degree of freedom of 25, equals 4.18 - leading to the rejection of the negative assumption which argues that there is no significant influence of the women level of income on the use of modern health care facilities. Table six shows the source of variation between the purchasing powers of the study women vis-à-vis the cost of the available health care services.

Table 5: Variation of Variables

Source of variation	D/F	SS	MS	F
Between groups	4	376.2	94.0	5.49
Within groups	25	428.6	17.1	
Total	29	804.8		

Source: Survey 2009

Income (money), it is said has alternative uses. The smaller income earned by the women finances a greater part of their kitchen's needs, subsidizes the children's clothing's and school fees, subsidizes the cost of acquisition of asset for the family, such as landed properly acquire in short term or outright, forms part of the household

savings, and pays for other needs of the woman including health care services. The study women use of modern health care services is low because their annual income is also low. This also applies to the amount and quality of foods taken in the household, especially by the woman who is traditionally bound as a mother to eat last often, the woman later still shares her own small quantity of food with her children and visitors. In the studied communities, as in Nigeria as a whole, the cost of health service is high, sometimes out of the reach of the common man (Jedged in Isiugo-Abanihe et al, 2002). Health care services are given on a "cash-and-service" basis and so the women conception of their illness and the decision to seek medical attention is given concern at a point of duress. Women bother about their health when experience unceased menstruation; have severe headache, pains, premature labour or obstetric complications, in pregnancy and childbirth (lactating) and bleeding after childbirth.

The effects of family size preference or the desired number of children and knowledge of side effects of contraceptives use on the women health and fertility control were measured using pearsons product moment correlation analysis. In each case, the r calculated value (2.6) for second assumption, at level of significance (p)= 0.05, degree of freedom (df) (4); and r (8.1) for the third assumption also at 0.05 level of significance (p) but a different degree of freedom (df) 5 was greater than their respective critical values of 0.81 and 0.75. On the basis of these results, the two assumptions were rejected. However, it has been observed that the negative perception of fertility control by the study women is influenced by their decision to have a maximum of between three and four children via adequate spacing; and their perceived side effects of contraceptive use, that has zero their minds to withdrawal and voluntary abstinence as dependable means of fertility control. For instance, some women argued that using Pills for three months could destroy a woman's womb. It has equally been observed that the 'study women' strictly monitor their menstrual cycle (period) thus, cases of unwanted pregnancies (although not many) only occur among the under age, that is, premature girls below 15 years.

The mature women, especially those who have given birth before, said giving a child each side of the breast to suck for 30 minutes and the other side, the same 30 minutes, will help contract the uterus of the woman such that though involved in sexual affair cannot be pregnant. Accordingly, this is much child friendly, healthy and safe than the use of contraception to prevent unexpected pregnancy while nursing a child or baby. Some women added that apart from the side effects of the use of contraceptive, they often find it difficult to repeat the family planning source for re-administration of contraceptive when the previous one taken has diminished in effect mainly because of the length of time one's has to waste at the Primary Health Care (PHCC). Beside, everything about the use of contraception is regarded and defined as abortion. One who commits or involves in abortion has a "name" (locally described with the slangs: anam utom usinhe idip, meaning fond of abortion or ekpo asana akpara asinihe idip) in the study communities, he or she is remarked to have rubbed "blood" in his or her hands.

Health, to the study women means having God's grace to go to bed at night

and wake up in the morning and fit to go to farm, market, women's forum in the church, family or village; the grace to be fruitful in marriage and live to see grant and great grant children. It was also observed that the study women have no business with "medical check-up", some have not heard about it before. Every form of illness is basically accepted as malaria-related, in which case the services of market and Bus medicine vendors could cure. The women said when one has money, he is healthy. They also admitted that health is life. But for them, God is the sustainer. Thus, whenever ill, they take enema; go to church for counseling, fast and pray and take drugs. It is only at crucial health situations that visit is made to the clinic first before referral to the Hospital.

CONCLUSION AND RECOMMENDATIONS

The state of the women's health is of serious concern given the way they treat their illnesses, the preferred sources of health care services, financial status, and feeding pattern (including food quality). Women in the study communities conceived of health in a way different from the urban resident and wealthy women. Fertility is conceived as important evident of health and control is assumed to be harmful to their health. Future fertility in these societies would be low but for the effect of early marriage. This study observed a high level of early marriage in the study communities but with a desired family size of four children in the ratio of 2:2 or 3:1 for male and female sexes. It is doubtful the possibility of fertility control or reduction in these communities given the fact that early marriage is one strong factor of high fertility in women. The dependence on abstinence, withdrawal, and control of menstrual cycle (period) is less effective in a long run in providing a reliable solution to fertility decrease particularly among young and active men and women with strong instincts.

There is need therefore, for continued efforts in promoting the rights of women and re-emphasizing adequate child spacing using contraceptives. Women including under-age in these communities should be exposed to health and sex education. The status of women should be improved for quality food intake and consumption of medical healthcare services through assistance in loans and subsidies. This could be a better way of reducing the danger of health insecurity and wining the women acceptance of fertility control through modern method of contraceptives in the rural communities of Etinan, Mkpat Enin, and Essien Udim Local Government Areas of Akwa Ibom State.

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