



*The African Anthropologist*, Vol. 19, Nos 1&2, 2012, pp. 43–65  
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2014 (ISSN 1024-0969)

## **Reproductive Health Aspirations and Unmet Needs in Urban Slums in Ibadan and Kaduna, Nigeria: A Qualitative Exploration**

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### **Abstract**

Reproductive health issues of urban slum dwellers are among the most challenging in Africa. Studies have generally examined this issue across the rural-urban dichotomy, without specific focus on urban slum dwellers. Many of these studies are also mostly quantitative. We utilize the qualitative approach to fathom the aspirations and challenges of urban dwellers in the domain of reproductive health. The results confirm that they aspire for smaller-sized families and healthy sexual and reproductive lives but are constrained by religious and socio-cultural factors. Idioms associated with their aspiration and experiences were well documented. There is the need to intervene in order to improve the sexual health of urban dwellers.

### **Résumé**

La santé de la reproduction des habitants des bidonvilles sont parmi les problèmes les plus difficiles en Afrique. Des études ont été généralement menées sur cette question à travers la dichotomie

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rurale-urbaine, sans un accent particulier sur les habitants des bidonvilles. Plusieurs de ces études sont également la plupart du temps quantitatives. Nous utilisons l'approche qualitative pour comprendre les aspirations et les défis des citadins dans le domaine de la santé reproductive. Les résultats confirment qu'ils aspirent à des familles de plus petite taille et à une vie sexuelle et de reproduction plus saine mais sont limitées par des facteurs religieux et socio-culturels. Les idiomes associés à leurs aspirations et expériences ont été bien documentées. Il est nécessaire d'intervenir afin d'améliorer la santé sexuelle des citadins.

### **Introduction**

Sexual health is a state of physical, mental and social well-being in relation to sexuality. It requires a positive approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences free of coercion, discrimination and violence (WHO 2002). Unfortunately, indicators from many developing countries particularly in sub-Saharan Africa suggest otherwise.

According to World Health Organization (WHO) Technical Consultation Definitions (2004), sexual health is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors. Similarly, the World Association for Sexual Health (1999) suggested that human sexuality is constructed through interactions between the individual and wider society. These assertions provide the platform for the intellectual discourse on the understanding of sexual health of urban-slum dwellers as well as the distinctions between their sexual patterns and that of other urban dwellers. These distinctions are related to their social space and boundaries, language, opportunities, and challenges. Previous evidence on measurement of the unmet need for family planning has been purely quantitative (Ashford 2003; Becker, 1999; Bankole and Ezeh 1997; Westoff and Bankole 1996). Besides, the depths of understanding provided by previous numerical estimates and analysis considered urban dwellers as homogenous groups.

The theoretical underpinning to this analysis is guided by the environmental theories which posit that the attributes of larger social units such as neighbourhoods may have an influence on sexual behaviour, above and beyond the impact of factors impinging on a person from his/her immediate social context of family and friends (Leventhal & Brooks-Gunn 2000). The environmental factors may include civil and organizational elements as well as policy and economic issues (Cereal 1997; Sweat 1995). Studies have found that sexual behavior may be influenced by neighbourhood variables including the overall level of

poverty and residential instability, and the prevalence of crime and aggressive behaviour (Hawkins et al. 1992). The depth of these constructs therefore, requires a thorough understanding of issues and the interconnectedness of these factors as they relate to sexual health in urban-slums. This is the gap identified in this article. The current analysis is therefore focused on assessing the sexual and reproductive health needs of urban slum dwellers, and also to examine the challenges at individual, household and community level attaining their sexual and reproductive needs. This is with a view to understanding languages associated with their aspirations, desire, unmet needs and sexual behaviour.

According to the UN-Habitat (2003, 2006) definition, an urban slum is a heavily populated urban area characterized by substandard housing and squalor. Beside these characteristics are issues of deprivation of basic social amenities and infrastructure. The living arrangement patterns in many urban slums are mostly considered as over-crowded and often unfavorable to healthy sexual living. These explain in part the high frequency of sexual anomalies and their consequences such as rape, early sexual initiation and high vulnerabilities to unwanted pregnancy and unsafe abortion associated with such living arrangements (Gary-Webb, Baptiste-Roberts et al., 2011; Jones, Sivarajasingam et al. 2011; Kabiru, Beguy et al. 2011; Greif 2012).

Compared to urban centres, evidence has shown that there are very poor sexual and reproductive health outcomes among women in urban slums. Studies have confirmed that women in urban slums have very little or no ability to communicate effectively on their sexual needs and to resist sexual demands (Bojko, Schensul et al. 2010). Also, men in urban slums have a higher likelihood to accompany socializing with alcohol use and there are very high tendencies to sexual risk taking (Singh, Schensul et al. 2010). Studies have also documented that social factors in urban slum areas influence to a large extent the sexual orientation and behaviour of youth (Adedimeji, Heard et al. 2008).

In Nigeria, the total fertility rate is estimated at 5.7 children per women, with over one-third reported as mistimed or unintended births (NDHS, 2008; Akinyemi et al. 2010). The unmet need for family planning is quite high with a very low prevalence of contraceptive use estimated at less than 15 percent. There are obvious rural/urban differentials across these outcomes, mostly in favour of urban residence and for those with higher social status, including education (Bankole et al. 2007; Akinyemi et al. 2010; Babalola and Fatusi 2009; Akinyemi and Felix 2011; Omideyi et al. 2011). However, such evidence is over-generalized and conceals some important aspects related to the typology of 'urban conglomeration'. A ma-

for neglected group in research is the urban-slum dwellers. This group of people are mostly neglected and usually concealed as urban dwellers. Current evidence has shown that they are different in social configuration and exposure compared with other urban dwellers (NURHI 2012).

## **Methods**

### ***Study Setting and data***

The study utilized a qualitative approach with data collected through the use of focus group discussions (FGD) in two towns (Ibadan and Kaduna) in Nigeria. The justification for the selection of these urban centres is the metropolitan nature of these areas and slum areas which fit into the study objectives. In Ibadan, Agbowo community was selected while Tudun Wada community was selected in Kaduna. The study was part of the Nigerian Urban Reproductive and Health Initiative (NURHI) study which was carried out in collaboration with the School of Public Health, Johns Hopkins University, and the Population and Reproductive Health Programme (PHRP) of the Obafemi Awolowo University, Ile Ife, Nigeria. The broad aim of the project is to understand the constraints for family planning utilization among the poor and middle class people in Nigeria.

### ***Study participants***

Recruitment of participants for the focus group discussions took place at the community and the health facility levels. Key-informants included both heads of facilities and traditional political structures in both communities. The community heads ('Baale' in Ibadan and 'Mai-ungwa' in Kaduna) were very useful in mobilizing participants at the community levels while the heads of the health facilities helped in recruiting eligible participants (especially females) at the facility levels. However, a systematic strategy was worked out such that all gatekeepers worked together to ensure that eligible participants were recruited. Based on the objectives of the study, only married and unmarried men between the age of 18 and the age of 49 years and married and unmarried women between the age of 18 and the age of 35 years (Users and Non-Users of Contraceptives) were included in this study. The participants were purposively selected to ensure that they met the age categories and were actually residing in the communities. Thus, a two stage procedure was used starting with pre-FGD questionnaire administered to community members. The questionnaire specified the criteria for the selection of the FGD participants. The participants who met the criteria for the study were then selected and invited for participation.

The FGD guide was translated into the local languages (Yoruba and Hausa) of the participants. The focus group discussions involved the use

of photo elicitation, vignette (story telling) and card ranking. The photo elicitation was done by presenting two families, one with six children and a pregnant wife in an unattractive environment while the second family had two children in a beautiful and attractive environment to elicit the views of the participants on advantages and disadvantages of large and small families. The vignette related the story of a woman faced with some decisions crucial to her sexual and reproductive health. The story was related in the relevant cultural context and it led to some questions that examined participants' attitude to vital reproductive health issues. The card ranking exercise involved a scenario where participants were asked to state their attitudes and perceptions of certain sexual and reproductive health indicators using three colours (red, yellow, and blue,) representing 'most risky', 'somewhat risky', and 'least risky' respectively. The sexual behaviours ranked by the participants include getting pregnant soon after having a baby, having six or more children, giving birth below 18 years, and abortion. Also, the contraceptives ranked include pills, injectibles, IntraUterine Device (IUD), fertility awareness, sterilisation and condoms. Sixteen FGDs were conducted (eight in each community) in the selected urban slums. The groups were younger married females (users and no-users of contraceptives) (two groups), older married females (users and no-users) (two groups), young unmarried females, older married males, young married males and young unmarried males. Each focus group comprised of participants ranging from between eight to twelve people.

### **Ethical considerations**

The research instrument was approved and certified by an institutional review board at Johns Hopkins University, the Obafemi Awolowo University Ethical Board, and the State Ministry of Health of the Republic of Nigerian in Ibadan and Kaduna. Informed consent was obtained from all participants prior to the FGDs while the anonymity of the participants were guaranteed. All FGDs were audio-recorded and a note-taker was also present during the FGD sessions. Permission was obtained from the participants prior to audio-recording of the sessions. The recorded data were later transcribed verbatim using standard transcription techniques. All informed consent documents, audio recordings and transcripts were kept under lock and key at the study site.

### **Data Analysis**

The analysis of the data was in two stages. A rapid analysis of the field notes was done first and this showed a clear pattern of the data and helped in developing themes and codes for the second phase of the

analysis. In the second phase of the analysis, data collected were transcribed and the transcripts were edited for accuracy. The transcripts were imported to the Atlas.ti software for qualitative analysis and themes were developed in line with the objectives of the study. Grounded theory approach was used to analyze the data. Hence, the data were coded for new categories until the level of saturation was reached. Analysis and presentation include content analysis with frequency counts of identified theme/codes, illustrative quotations as well as aggregated and disaggregated thematic and network mapping of family planning desires and challenges confronting the slum dwellers in family planning utilization.

## Results

### *Sexual and Reproductive Health Desires among the Participants*

The sexual desires of participants were assessed through indirect methods of the vignette and storytelling. Presented with two photographs – one depicting a large family and the other a small family – participants were asked to express their views on the two photographs. Table 1 presents the general description of the large and small family among the FGD participants. This is necessary in order to understand the participants' perception of large and small families which could eventually influence their fertility expectations and consequently their desire for family planning or otherwise. The figures in the cells (0 – 9) in the table refer to the number of quotations per coded theme per FGD. The large family was predominantly described in a negative way with 52 different quotations from the participants as against 11 quotations describing it as good and admirable. The participants described the large family as turning their family into a baby factory. In their words, some participants related:

The large family was just producing kids anyhow without adequate spacing in between them. 'Won mbimo bi elede' (Yoruba language) i.e. they were just mass producing babies like pigs. [Older Married Woman, 32 years, Current User, Trading, Primary, Christian, Ibadan Agbowo]

The second family (large family) does not seem to have the capacity to cater for the number of children they had. When the children are grown, you might see them in the motor parks selling pure water (water in small sachets), gala (Snacks) to trailer drivers. Though some may eventually go to school but they have to source for money themselves. The females among them may become house helps and have to depend on their benefactors to send them to school or learn a trade. [Young Married Woman, 24 years, Current User, Trading, Senior Secondary, Muslim, Ibadan Agbowo]

The large family is just producing children one after the other. If they continue that way, it is going to be very tough for them because there is a need to be spacing children so that the mother can rest and even if she will be pregnant again, it should be later. [Older Married Woman, 32 years, Current User, Housewife, Quranic Education, Muslim, Tudun Wada, Kaduna]

This family looks poor and they might yet be ignorant of the role that the large family size is playing in their poverty. They already have five kids, and the wife is already carrying the sixth child in her womb. I don't think they can be happy in such a situation. [Older Married Woman, 30 years, Non-User, Trader, Senior Secondary, Christian, Agbowo Ibadan]

On the other hand, the small family was predominantly described as good looking, well kept and enviable (65 reports). Among most of the FGD participants, it is believed that the small family would be happy with their condition (33 as against 6 reports) stating that they may not be happy with the number of the children they have, while the large family will not be happy with their condition (31 respondents as against for believing that there is joy in having many children). A participant noted:

With a small family, your stress can be minimized and your life may be better off [A 32 year old woman in Kaduna]

The need to satisfy basic needs such as food and clothing will pre-occupy the large family and this will make the aspiration for a better future difficult for the children (62 reports) while the children from a small family have the potential for a better future since the family will be able to invest in their education and health (60 reports). Many participants therefore believed that the larger the family size, the more difficult it is for both parents and children to aspire for a better future and vice versa. There were 26 quotations supporting this view as against 11 expressing that the individuals' future is determined by God and not the factor of family size.

Although there is the desire for family planning across the entire group (61 quotations), there is also a high fertility desire among the participants across the different groups in the two slums selected for this study (28 quotations desiring an average of four children). Most of the participants rejected the Nigerian family planning logo which contains a family with one child as they argued that it is anti-cultural and that an average of four children should be displayed in the logo. Table 1 also reflects the unmet needs for family planning across the entire group in both locations for this study (34 quotations).

Table 1: Frequency of Selected Codes/Themes across the FGD Participants

Codes	Primary Documents												Totals				
	Ibadan						Kaduna										
	Om	ofc	ofn	uf	um	yfc	ym	ofc	ofn	uf	um	yfc		ym			
Largef-	0	2	3	1	5	4	2	5	4	5	2	3	3	52			
Largef+	0	0	0	3	0	6	1	1	0	0	0	0	0	11			
LFasp-	2	1	6	0	7	5	3	3	9	3	2	9	3	62			
LFasp+	1	2	2	2	0	5	0	1	0	2	0	0	1	16			
SFasp+	1	2	7	2	8	7	2	2	4	3	3	9	1	60			
BothfAsp+	0	1	1	0	0	2	0	3	0	0	0	0	0	10			
LargefH	0	1	0	1	0	0	1	0	0	0	0	0	0	4			
LargefUh	0	0	3	1	3	2	1	2	2	3	1	3	1	31			
Smallf-	0	0	1	0	0	0	0	0	0	0	0	0	0	1			
Smallf+	5	5	3	5	4	5	2	5	5	7	2	4	2	65			
SmallfH	3	1	5	3	1	1	1	2	3	3	2	2	1	33			
SmallfUh	0	0	2	0	0	4	0	0	0	0	0	0	0	6			
BothfamH	0	0	0	0	0	0	0	0	0	0	2	0	0	2			
Fsasp+	1	0	2	0	0	2	0	3	2	1	3	5	2	26			
Fsasp-	0	2	0	2	0	0	2	0	3	0	1	0	0	11			
Fertdesire	3	0	3	0	5	3	2	0	2	2	2	1	3	28			
Fpdesire	0	2	2	2	6	4	3	7	3	5	3	5	7	61			
Unmetneedforfp	3	2	1	2	1	0	1	1	3	2	2	0	1	34			
<b>Totals</b>	<b>19</b>	<b>21</b>	<b>41</b>	<b>24</b>	<b>40</b>	<b>50</b>	<b>21</b>	<b>37</b>	<b>35</b>	<b>39</b>	<b>31</b>	<b>33</b>	<b>24</b>	<b>44</b>	<b>23</b>	<b>31</b>	<b>469</b>



**Key:** OM = Old married males, Ofc = Old Married females Current Users, ofn = Old Married females Non-Users Uf = Unmarried females, um = Unmarried males, yfc = Young Married females Users, yfn = Young Married females Non-Users, ym = Young Married males Largef-= Negative description of large family, Largef+= Positive description of large family, LFasp-= Large family aspiration for better future difficult, LFasp+= Large Family aspiration for better future could be achieved, LargefH=Large family will be happy, LargefUh= Large family will not be happy, BothfAsp+=Bothe families aspiration could be easy to achieve, Smallf-= Negative description of small family, Smallf+= Positive description of small family, SmallfH= Small family will be happy, SmallfUh= Small family may not be happy, BothfamH= Both families will be happy, SFAsp+= Small family aspiration for better future would be easy, Fsasp+= there is relationship between family size and aspiration, FSasp-=there is no relationship between family size and aspiration, Fertdesire= Fertility desire, Fpdesire= family planning desire, Unmetneedforfp= Unmet needs for family planning, Fpdesire= Family Planning desire.

It is evident in this study that there were many participants who desired safe sex and sound reproductive health. They therefore desired family planning for child spacing for the sake of their education and health and that of the children in order to secure a bright future for the family, to satisfy their sexual urge and that of their husbands without being pregnant and to avoid past experiences of difficulties they encountered in pregnancy and child birth. The participants noted various problems associated with being pregnant soon after having a baby. They believed that the woman's health is not yet fully restored and a new pregnancy could affect the health of the mother, the unborn baby as well as the last baby.

Although there were divergent views among the FGD participants on having up to or more than six children and underage pregnancy, many participants were able to recognize the dangers associated with such acts. While there were 20 quotations supporting having six children or more, there were also 17 quotations condemning it. On the other hand, 22 quotations reflect the participants' rejection of underage pregnancy as against 15 quotations supporting it.

### ***Fertility and Sexual Experiences of the Participants***

Despite the participants overwhelming description of large families as not being attractive, their pattern of support for having six or more children, rejection of pregnancy soon after a delivery and intolerance of underage pregnancies, their personal experiences seem to contradict what they desire. It is evident in this study that many of the participants' current fertility and sexual behaviour were at variance with what they

describe as good and enviable life of the small family. Table 2 shows that quite a number of the participants were married before the age of 18 years. This is more pronounced among the participants from Kaduna than in Ibadan. Since women are culturally expected to begin procreation immediately after marriage in Nigerian culture, it is then evident that these categories of women have also experienced underage pregnancy. This is clearer in the young married women group, where the maximum age of the participants was 24 years and some of them already had 4 or more children at that age.

The number of children by the participants also shows that quite a number of them had large families especially, among the older married women groups where many of the participants had four or more children. It is also important to note that if the fertility trend among the young married women especially in Kaduna is sustained, the majority of them would also end up having large families. It can be deduced that with some of the participants having four or more children at the age of 24, some of them would have experienced short pregnancy intervals which the majority of them rejected and described as very risky for the health of the mother as well as the last baby and the unborn baby.

### ***Unmet Need for Family Planning***

The unmet need for family planning is the discrepancy between the expressed fertility desire and the use of contraceptives to limit or space births either due to non-availability or inaccessibility of any effective family planning method. The unmet need could also arise as a result of the poor quality of family planning services available, thereby leading to preventable failures of family planning methods. According to Casterline et al., (1997), women with unmet needs for family planning constitute a significant fraction of married women of reproductive age in developing countries. This position was reiterated almost a decade later by Bhattacharya et al., (2006), McCarraher et al., (2008) and McCarraher et al., (2006). Hence, the need also to understand the unmet need for family planning for the urban slums dwellers in this study.

Despite the high fertility desire expressed by some participants, there were still many slum dwellers in this study who desired to use family planning but were unable to do for various reasons. These include the proliferation of fake and expired pills, fake condoms and the lack of qualified medical workers who could administer appropriate family planning treatments. Some participants expressed themselves as follows:

There is no original condom that common people can afford. The ones available are not good enough and HIV/AIDS virus can penetrate through the sub-standard ones especially when they break. Even

**Table 2:** Group Characteristics of FGD Married Women Participants

Location	Group	No. in Group	Age Range in Years	Ager at first Marriage		Education			No. of children	
				Less than 18	18 and above	Primary or Quranic	Post Primary	Secondary	3 or less	4 and above
Ibadan	OO.M.W.C*	13	26 -35	None	All	2	9	2	7	6
	O.M.W.N**	9	30 - 35	None	All	1	7	1	9	0
	YY.M.W.C***	9	20-24	3	6	1	8	0	7	2
	Y.M.W.N****	8	21 - 24	1	7	2	3	3	8	0
Kaduna	O.M.W.C	9	25 - 35	8	1	9	0	0	4	5
	O.M.W.N	10	25 - 32	9	1	8	2	0	3	7
	Y.M.W.C	8	21 - 24	4	4	2	5	1	6	2
	Y.M.W.N	8	18 - 24	8	0	8	0	0	6	2

OO.M.W.C\* = Older Married Women Current Users

O.M.W.N\*\* = Older Married Women Non-Users

YY.M.W.C\*\*\* = Young Married Women Current Users

Y.M.W.N\*\*\*\* = Young Married Women Non-Users

many homes have been scattered due to condom failure [Older Married Male, 35 years, Teacher, B.Ed, Christian, Agbowo, Ibadan.]

Another participant in the women group opined: 'I once used it (Injectibles) and yet got pregnant' [Older Married woman, 32 years, Current User, Trader, Primary, Christian, Agbowo Ibadan.]

In the light of these unmet needs for family planning, many of the slum dwellers confirmed that they were involved in many unreliable and often disappointing traditional methods and other practices they believed could prevent pregnancy. These included the use of salt solution, lemon, potash and other traditional concoctions to avert pregnancy.

### ***Challenges Confronting the Urban Slums in Utilizing Family Planning***

Challenges have the potentials of undermining the usefulness of a programme meant to provide solutions to a problem. It is therefore essential to examine the challenges confronting the proper utilization of a programme meant to improve health and living conditions of people as this could give an insight into appropriate steps that could be taken for proper implementation of such programmes for successful delivery of the mission mandates. In the light of this the FGD participants in this study were asked about the various challenges they face in the utilization of family planning methods using a vignette story of a woman, confronted with the decision of using family planning after two children.

Three main categories of challenges were identified. These challenges had negative effects on their willingness and ability to access family planning methods despite admitting their need for family planning. The challenges include those that were personal, the patriarchal structure of their households, as well as some cultural/religious beliefs in the societies. Some personal challenges include poverty and various misconceptions about family planning. Some participants believed that the ointments used to lubricate condoms could destroy a woman's womb leading to permanent infertility, ailments or death while others opined that if condoms should fall inside a woman's vagina during sex, it would need a surgical operation to remove it, which might lead to death. Similarly, there are beliefs that injectibles and pills contain chemicals that could damage a woman's womb causing permanent infertility, disease or death. Some participants stated:

She may not have enough money and she knows the state of things in her home [Unmarried Female 20 years, student, Senior Secondary]

She might also be scared that if she continues for a long time she might not be able to have another child again because there is the

general belief that some family planning methods can spoil a woman's womb causing permanent infertility in some women. There are also side effects associated with pills which can cause the woman to stop using it. [Unmarried Female 16 years, Student, Senior Secondary, Muslim, Tudun Wada, Kaduna, Christian, Agbowo, Ibadan]

Also, some challenges in the household preventing women from utilizing family planning methods are largely related to the position of the husband as the head of the house and the need for the woman to obey his instructions, despite the fact that such instructions might not be for the good of the wife in some instances. The participants believe that 'he is the head of the family and whatever he says is final and there is nothing anybody can do'. This puts women who desire to use family planning in a difficult situation since any attempt to disobey the husbands' instructions and adopt family planning in order to protect themselves may result in maltreatment including physical violence. A participant affirmed that:

A woman, after having three children, went to the hospital on her own to do family planning. Her husband was expecting her to conceive again but she didn't. Later, the husband discovered while having sex with her one day that she had been doing family planning without his consent. He was angry. He even beat her. He told her to go and remove it and she later gave birth to one more child. If she had told her husband, she would not have had to go through that kind of experience. [Older Married Woman Non-User, 35 years, Teacher, National Certificate of Education, Christian, Agbowo, Ibadan]

At the community level, cultural beliefs and religious orientation were found to be powerful in shaping participants decision to use family planning. Many participants believed that the use of family planning is a sin to God and must be avoided while there are those who also believe that if a woman through family planning prevents any of the children God has destined to come into the world through her, she will suffer the health consequences. Others also insisted that the need for a woman to have children of both sexes would prevent her from resorting to family planning because of the cultural demand for the sexes. Some participants noted:

With the couple being 'Yorubas', from my own view, the husband will not agree because they have just two kids both of who are both girls! It's not done. [Young Married Male, 23 years, Trader, Senior Secondary, Muslim, Agbowo Ibadan]

In Islam, having children is a form of wealth, just like riches is wealth; you are trying to have them. They believe that children are wealth,

the more your children, the more your wealth. [Older Married Man, 28 years, Trader, Ordinary National Diploma, Muslim, Tudun Wada, Kaduna]

### **Discussion**

This study has examined the sexual and reproductive health challenges of urban slum dwellers in two towns in Nigeria. There was generally a high understanding of the implications of unprotected sex, ill-timed births, high fertility, and other reproductive health concerns were expressed by the participants. Many of them understand and expressed the importance of a healthy sexual and reproductive lifestyle. They also expressed the health, economic and social implications of risky sexual relations. Despite this, the evidence observed underscores the wide discrepancy between their expressed understanding and their sexual behaviour. There is therefore an obvious concern for high levels of unmet needs among this group of people. In appraising their challenges in optimizing services that can help them to attain a healthy sexual lifestyle, there were concerns related to religion and personal beliefs, socio-cultural beliefs and factors as well as gender issues. Many of the participants are strongly of the view that the future is in the hands of God who ordains the number of children for individuals.

On the other hand, there are also many of these slums dwellers who desire to resort to family planning but have unmet needs. There is therefore the need for the Nigerian governments and development partners to strategize on how to eliminate the unmet needs for those who desire family planning. Such efforts will require the provision of quality family planning services among the urban slums as current conditions are deplorable, as shown in this study. The current situation of high fertility and low contraception has implications for maternal and child health in Nigeria (Walker et al. 2008). It will also require the provision of free, regular and quality condoms in all health facilities and public facilities in the slums for spacing and limiting births as well as combating the spread of Sexually Transmitted Infections among the slums dwellers in the country.

It is also evident in this study that many participants have a very poor knowledge of family planning with a lot of misconceptions about family planning. Although it is true that some family planning methods have side effects, these side effects may have been highly exaggerated by the participants, most of whom had never used them. There is therefore the need for serious and targeted family planning education for these people. This will improve their understanding and allay their fears about

family planning methods and will also allow them to make the choice of methods preferable to them.

The patriarchal family structure has also been found as a major barrier for women who desire family planning among the participants. Thus, many women could not resort to family planning due to the demands that they should obey their husbands. Women who went out of their way to use contraception without their husbands' consent are suspected of being promiscuous and are subjected to maltreatment in the family. This calls for conscious efforts to target men in urban slums in family planning education. This will improve women's freedom on their sexual and reproductive health needs and choices and encourage those who desire family planning to utilize it without any fear or molestation.

The cultural demand for male children among the slum dwellers in this study is also one of the challenges for family planning utilizations. Couples who have only female children are therefore not likely to be favourably disposed to family planning use while there are also various religious beliefs inhibiting the use of family planning methods. This calls for the inclusion of the traditional leaders and religious leaders who are the custodians of people's culture in family planning utilization in Nigerian urban slums. This has the potential of changing the people's perception and eventually enhancing their willingness to adopt family planning methods. It is therefore important to intensify campaigns that target fertility desire reduction among the urban slums in the light of the revelation in this study, which is in line with the findings of Magadi et al., (2003), Stephenson and Hennink (2004) and the African Union (2006).

### **Acknowledgments**

This study was made possible by the generous support of the Bill and Melinda Gates Foundation. The contents are the responsibility of the Nigerian Urban Reproductive Health Initiative (NURHI) and do not necessarily reflect the views of the Bill and Melinda Gates Foundation. The research was made possible by the leadership and staff of the NURHI project – Dr Mojisola Odeku, Director; Bola Kusemiju, Deputy Director; and the entire NURHI team. The authors wish to thank Dr Marc Boulay and Hilary Schwandt at Johns Hopkins University, USA.

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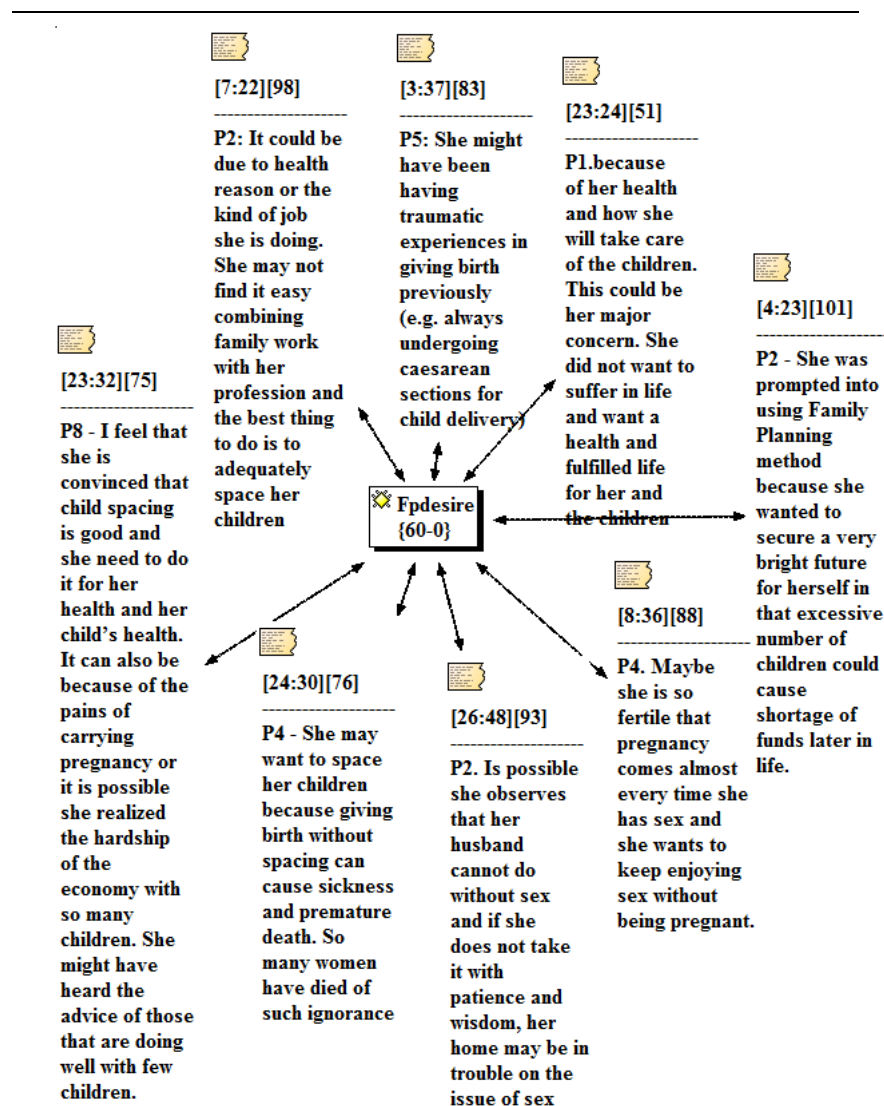
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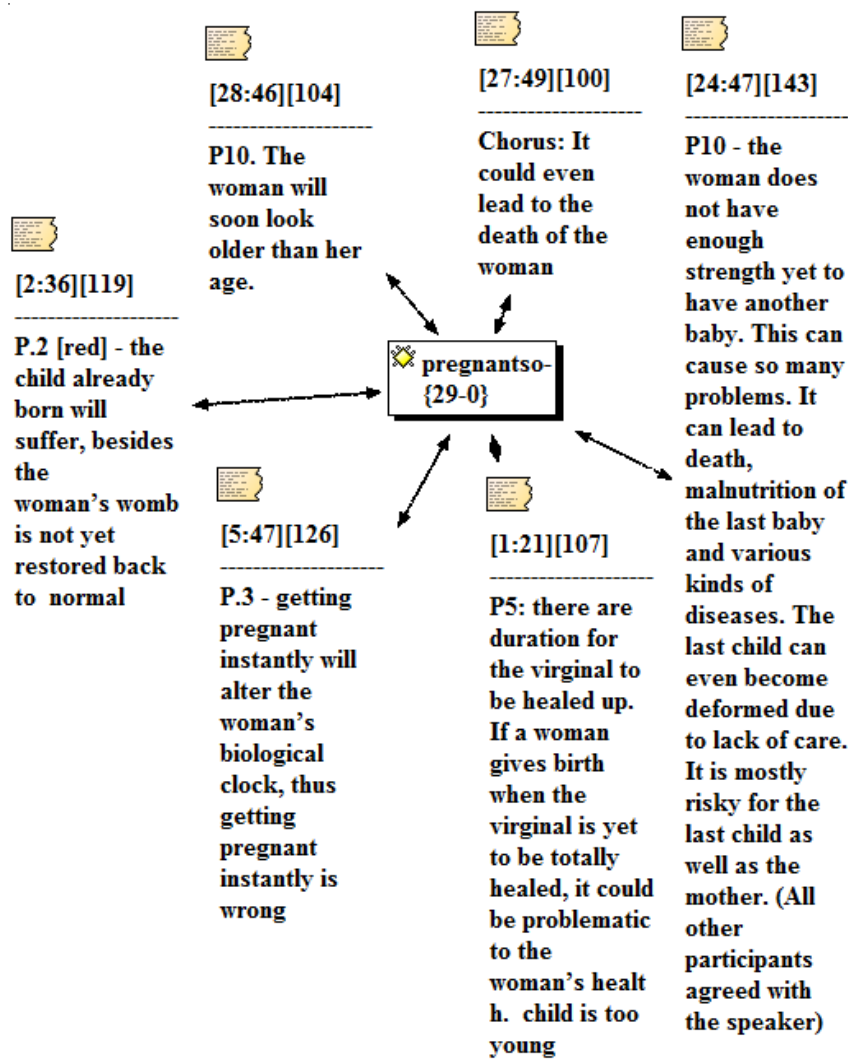
# Appendices

Figure 1a: Pattern of Family Planning Desires



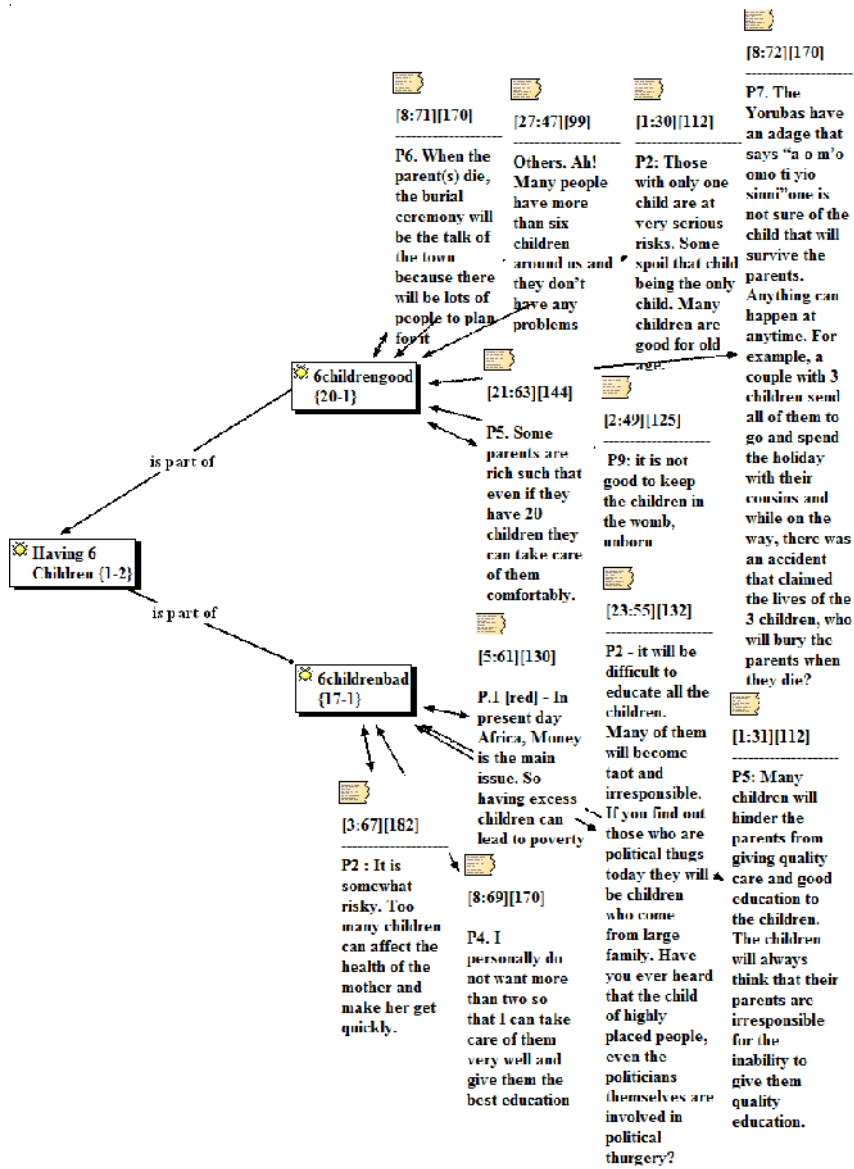
Key: Fpdesire= Family Planning desire

**Figure 1b:** Participants Rejection of Pregnant Soon after having a baby



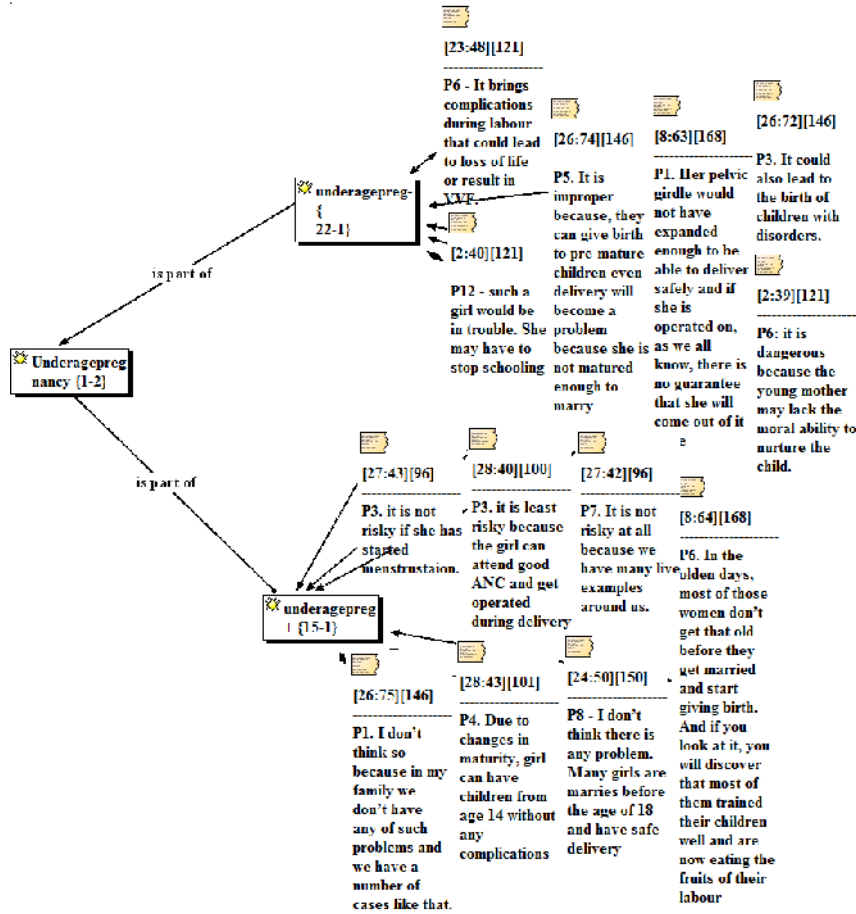
Key: Pregnantso- = Against pregnant soon after having a baby

Figure 1c: Pattern of Supports for Having 6 children or more



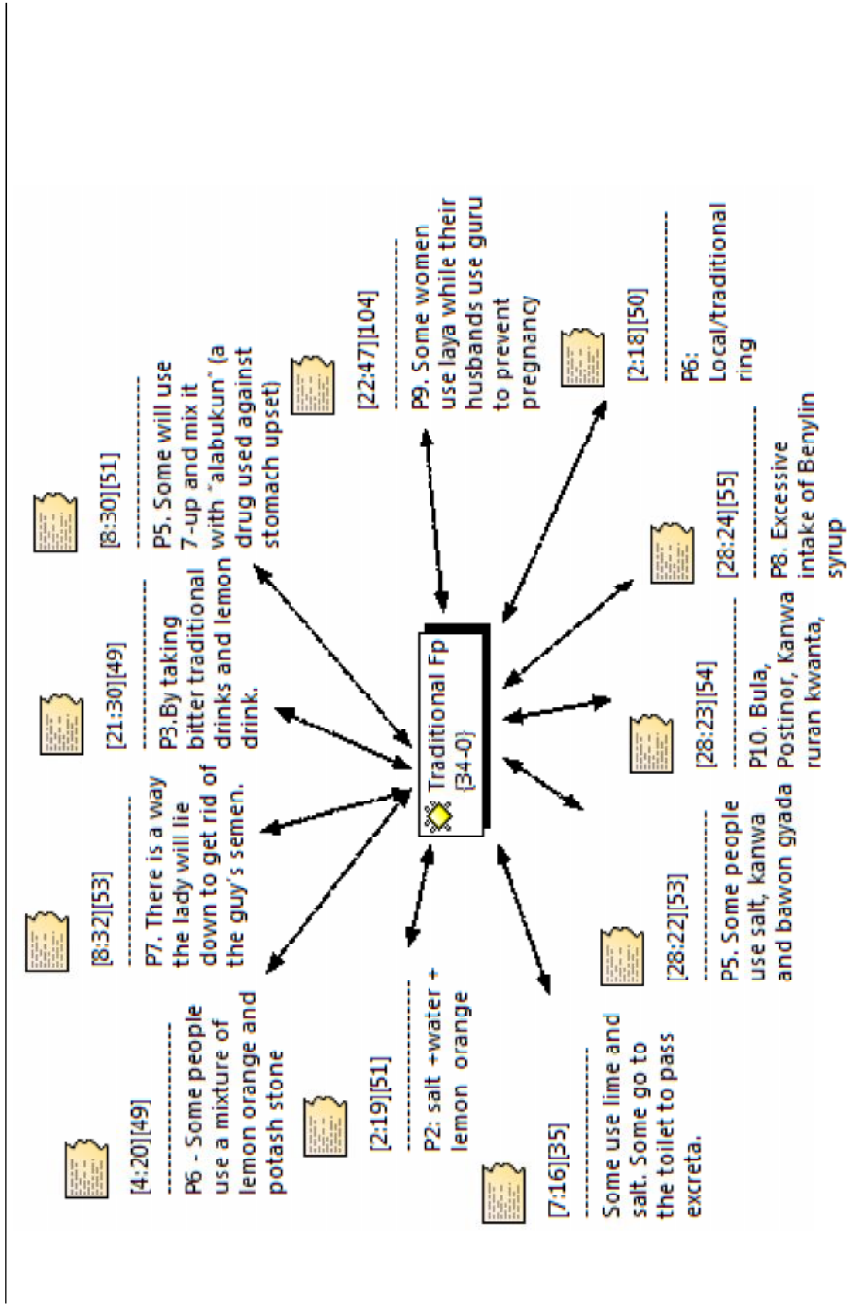
Key: 6 children good = Supports having 6 or more children,  
 6 children bad = Against having up to 6 children

Figure 1d: Pattern of Supports for Underage Pregnancy

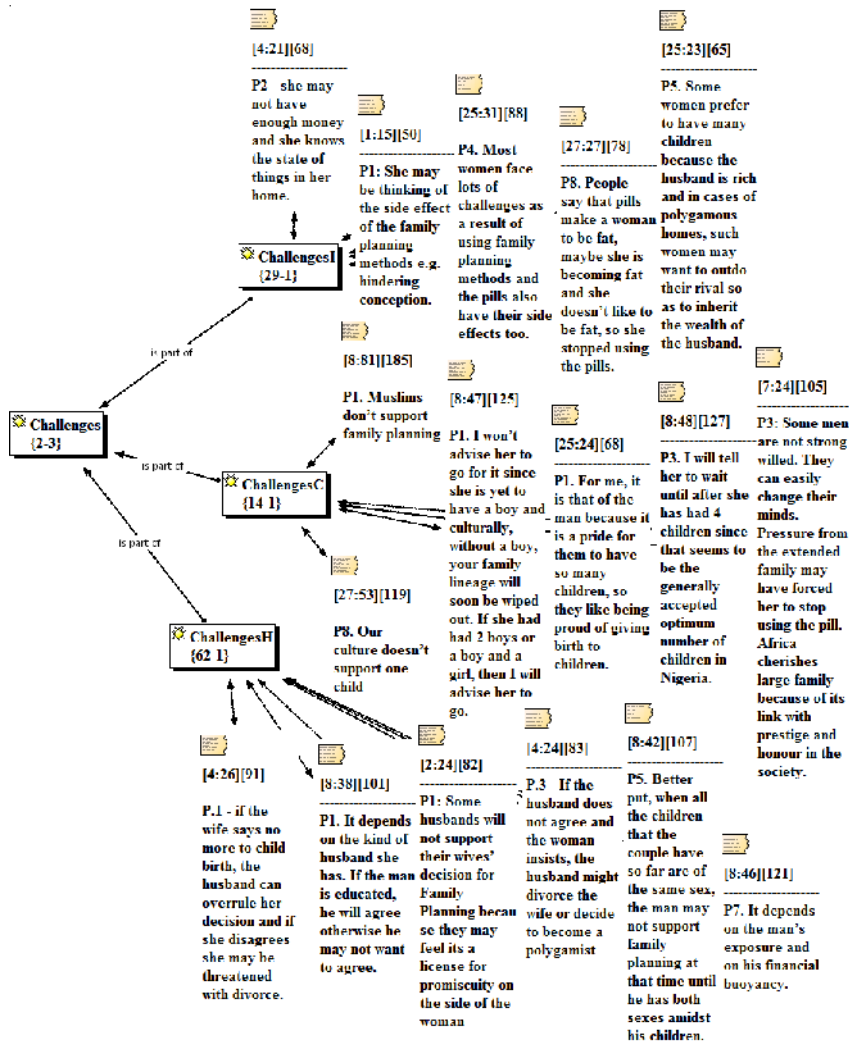


Key: Underagepreg+ = Supports underage pregnancy,  
 Underagepreg- = Against underage pregnancy

Figure 2: Traditional Methods Used to Prevent Pregnancy in Urban Slums



**Figure 3: Challenges Confronting the Urban Slums in Family Planning Utilization**



**Key:** ChallengesI = Individual/Personal Challenges,  
 ChallengesH= Challenges of their household structure,  
 ChallengesC= Challenges in their communities/societies

