

## Community Leaders' Perception of Reproductive Health Issues and Programmes in Northeastern Nigeria

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### Abstract

**Context:** A faith-based NGO wanted to expand its reproductive health programmes to Northeastern Nigeria in view of its poor reproductive health indices compared to the other parts of the country. In order to make the programme more acceptable, accessible and successful, a rapid needs assessment was conducted.

**Objective:** To assess the perception and acceptability of the various components of reproductive health among community and religious leaders in northeast Nigeria.

**Study Design, Setting and Subjects:** A community-based qualitative study. One community leader and one Islamic religious leader each were interviewed in Ganjuwa, Dass and Shira local government areas of Bauchi state. Similarly, a community leader and a religious leader each were interviewed in Maiduguri, Konduga and Gwoza local government areas of Borno state. In Yobe state, one religious and one community leader were interviewed.

**Results:** The community/religious leaders perceived reproductive health problems as prevalent and contributing to maternal morbidity and mortality. They believe women should seek healthcare services for preventive and curative care preferably from female providers. They suspect reproductive health programmes as Western agenda for population control. They have very strong feelings against the provision of elective abortion services. The only acceptable indications for elective abortion include death of the fetus in utero, gross congenital anomaly incompatible with life and serious maternal health risk. A committee of trusted, and preferably Muslim, God-fearing, doctors should assess and confirm these indications. They accept that women with complications of spontaneous abortion should seek care. The provision of contraceptive services to adolescents or married couples is not acceptable. In case of married couples, the only acceptable indication is on serious maternal health grounds. Even then, only harmless methods of contraception may be used specifically coitus interruptus or calendar method with prior spousal consent. The use and promotion of condoms as a barrier method or for the prevention of STIs is not acceptable. The prevention and care of those with HIV/AIDS is acceptable with emphasis on pre-marital abstinence and faithfulness among couples.

**Conclusion:** The varied perceptions, cultural and religious barriers to reproductive health services need to be articulated in order to structure appropriate strategies that will inform and sensitize people about reproductive health programmes and services. Advocacy, monitoring and involvement in programme planning, implementation and social mobilization are useful strategies for addressing this issue.

**Key Words:** Community Leaders, Perception, Reproductive Health. [Trop J Obstet Gynaecol, 2004; 21:83-87]

### Introduction

Available statistics show that the reproductive health situation in Nigeria is poor. The 1999 Multiple Cluster Survey<sup>1</sup> reported a maternal mortality ratio of 704 deaths per 100,000 live births with a wide geographical disparity ranging from 166 per 100,000 live births in the southwest to a record 1,549 per 100,000 live births in the northeast. Unsafe abortions feature prominently among the major contributors in addition to haemorrhage, infection, hypertensive disease of pregnancy and obstructed labour. Rene cites figures on abortion in Nigeria of between 200,000 and 500,000 per annum and a resulting mortality figure of 10,000 annually<sup>2</sup>.

The level of utilisation of modern contraceptives is still low. 3.5 and 8.6% were reported during the National Demographic and Health Surveys (NDHS) conducted in 1990<sup>3</sup> and 1999<sup>4</sup> respectively. Factors affecting the level of utilisation of family planning services in Nigeria include low level of knowledge, myths and misconceptions, low quality of services including non-availability of contraceptive commodities and poor

attitude of service providers, and low status of women.

The HIV epidemic is spreading rapidly in Nigeria. HIV seropositivity rate projected from sentinel surveillance among antenatal clinic attendees has risen from 1.4% in 1991 to 5.8% in 2001. Young persons between the ages of 20 and 24 years have the highest rate of infection<sup>5</sup>. The other STIs are also on the increase and are known to facilitate the transmission of HIV.

The government published a national reproductive health policy and strategy to achieve quality reproductive and sexual health for all Nigerians in 2001. In order to design an appropriate programme for the provision of services that will be effective, acceptable and relevant to the needs of the communities in north eastern Nigeria-the region with the worst reproductive health indices, a rapid needs assessment was conducted

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by an NGO among the target communities located in three of the six states in northeast Nigeria. One of the objectives was to explore the attitude of community leaders and religious leaders, towards reproductive health issues and services. This paper is extracted from the findings of the study.

## Materials And Methods

### Study Area and Study Population

The inhabitants of the northeast are mainly agrarian and nomadic by occupation. There are many ethnic groups in the zone, with Kanuri and Fulani predominating. Islam is the main religion practiced in the states with a Christian minority. The zone is comparatively very deprived of health and other social infrastructure with resultant high rates of morbidity and mortality. The zone always competes with the Northwest zone in having the worst maternal and child health indices in the country. Selected health and demographic indices of the zone compared to national data are shown in table I.

Three states (Bauchi, Borno and Yobe) were selected for the expansion of an NGO's reproductive health programme. One community leader and one Islamic religious leader each were interviewed in Ganjuwa, Dass and Shira local government areas of Bauchi state. Similarly, a community leader and a religious leader each were studied in Maiduguri, Konduga and Gwoza local government areas of Borno state. In Yobe state, one religious and one community leader were interviewed. The permission of the community leaders was obtained before the commencement of the study.

### Study Design

A qualitative study

### Data Collection Techniques

For this segment of the study, recorded in-depth interviews were conducted in the local language using an interview guide. This was later translated into English, transcribed and common themes extracted into a narrative. Community leaders were asked about the knowledge of signs, symptoms and possible ways of transmission of STDs/HIV/AIDS, their perception of the nature and extent of the problems, treatment providers and ways of prevention. The cultural and religious acceptability or otherwise of the services provided towards achieving the goals of the national policy on reproductive health. Data were collected between 28<sup>th</sup> October and 30<sup>th</sup> December 2002.

## RESULTS

### Community Leaders' Knowledge and Perception of Reproductive Health Issues and Programmes

#### Abortion-Spontaneous And Induced

Community/Religious leaders generally perceived reproductive health issues as serious contributors to maternal mortality and morbidity. They recognized the

existence of cases of spontaneous and induced abortions in their domains and listed several complications resulting there from. Spontaneous abortions were said to be caused by "sudden fright, fevers, evil spirit, hard manual labour, illegitimacy and too frequent pregnancies". They reported that most women do not seek help until complications occur. The husband, his friends and relatives decide on when and where to seek help, women rarely have a say in this matter. The complications of spontaneous abortion mentioned include excessive blood loss, fever, prolonged ill health and sometimes death. Health care is sought from traditional birth attendants, traditional healers and private and public health facilities depending on social status.

They stated that students, hawkers, schoolgirls, prostitutes and married women procure abortion for various reasons. These reasons ranged from shame, poverty, still breastfeeding, spousal hatred and contraceptive failure. Elective abortion is illegal and unacceptable, leaders opined that the only acceptable indications for elective abortion include death of the foetus in utero, gross congenital anomaly incompatible with life and serious maternal health risk, a committee of trusted and preferably Muslim God-fearing doctors should assess and confirm these indications. Induced abortion providers as identified by the leaders include health workers especially in private hospitals or in their homes; chemists shop owners and traditional healers. Decision to abort a pregnancy is usually by the woman involved, the person responsible for the pregnancy, her parents or husband-if a married woman.

Methods used include ingestion of bitter herbal concoctions (mixtures of neem tree leaves & 'madaci'), robin blue, bitter lemon, high doses of oral contraceptive pills and overdose of chloroquine tablets and injections. Other injections mentioned include ergometrine and syntocinon infusion. When some form of bleeding is invoked, they now present as cases of incomplete abortion in health facilities. Dilatation and curettage (D&C) is the most popular surgical method used by quacks and other health workers alike. Women pay exorbitantly to procure abortions from these clandestine abortionists. Reported complications of induced abortions include excessive blood loss,

**Table I: Basic Health Indicators of North East Zone Compared to National Figures**

Indicator	Nigeria	North-East	Source
Infant Mortality Rate	70.8	79.4	NDHS 99
Under five Mortality Rate	133.4	175.2	NDHS 99
Total Fertility Rate	5.94	6.53	NDHS 90
Maternal Mortality Rate	704	1,549	MICS 99
Utilization of ANC	57.9%	NA	NDHS 99
Deliveries Supervised by Trained Attendants	37.3%	11.7%	NDHS 99
Immunization Coverage	16.8%	7.5%	NDHS 99
Tetanus toxoid immunization	44.3%	24.1%	NDHS 99

Vesicovaginal and rectovaginal fistula, intestinal gangrene, infertility, fevers, prolonged ill health and death. The prevention and management of complications of (spontaneous) abortion is acceptable. Provision of safe (induced) abortion services is acceptable only for acceptable indications outlined under abortions above.

### ***Family Planning/Contraception***

Some of the leaders opined that population control is at the centre of the Western countries support for family planning services. Generally, an interval of two years was mentioned as optimal between births for the health of mothers and their children. However, a majority said married women have no business with contraceptives, just as unmarried women have no business with sex. The only acceptable indication for use of contraceptives among married couples was on health grounds-if repeated pregnancies would pose serious health risk to the mother. Moreover, the contraceptive method should be harmless. The methods mentioned include abstinence, coitus interruptus and calendar method-all with prior spousal consent. Exclusive breastfeeding is acceptable, but it shouldn't be compulsory. Extended breastfeeding to 2 years is also acceptable. The limitation of number of births for economic reasons is particularly abhorred as the Almighty God provides for both the parents and their offspring. The provision of family planning information and services to adolescents is not acceptable. Abstinence should be encouraged instead.

### ***Sexually Transmissible Infections***

The STIs known by both categories of leaders are syphilis, gonorrhoea, AIDS and pubic lice. *Strangely, haemorrhoids were mentioned as an example of STI by some of the leaders.* There is a consensus of opinion that STIs are transmitted during sexual intercourse between an infected partner and an uninfected person. Although some believe that gonorrhoea can be acquired through, erotic dreams or caused by sequestered spermatozoa because of a prolonged period of abstinence. In addition, AIDS is known to be transmitted through unscreened blood transfusion, unsterile blades, manicure and pedicure scissors. Some of the leaders are even aware of mother to child transmission. In contrast, *some believe that mosquitoes do transmit AIDS!*

The symptoms of these diseases are fairly well known. Those affected usually buy antibiotics directly from chemists to ensure privacy. Others consult traditional healers that hawk their wares during market days. Hospital consultations for STIs are considered as a last resort or when other treatment methods fail. The prevention and management of STIs including AIDS is acceptable, except the promotion of condom use.

### ***HIV/AIDS***

The level of awareness about AIDS is quite high. Sources of information include radio-BBC Hausa service, VOA Hausa service and Deutsche Welle Hausa service. In spite of the forgoing, the difference between

HIV and AIDS is not known. A leader even said HIV is the early form of the disease and that it is curable, whereas AIDS is the incurable late form of the disease. Participants know the features of AIDS, most of them are aware that it is still incurable. AIDS patients are discriminated against, with suggestions of isolating AIDS patients and the avoidance of any utensils used by sufferers of the disease. Sharing of clothes with HIV positive individuals was mentioned as one of the ways of getting the disease. AIDS is seen as a punishment from God for the increasing level of sexual permissiveness in the society. A religious leader recommended pre-marital HIV screening before contracting marriages. The prevention and management of HIV/AIDS is acceptable. The community leaders welcome the NGO's reproductive health programme. They however, advised it to keep to the tenets of Islam and not to partake in implementing the agenda of enemies of the religion.

### ***Discussion***

The community/religious leaders perceive reproductive health problems as prevalent and contributing to maternal morbidity and mortality. Awareness of reproductive health issues like abortions, family planning and STIs are high, although with some misconceptions. These include evil spirits as responsible for abortion, haemorrhoids as examples of STI and the transmission of HIV by mosquitoes. They believe women should seek healthcare services for preventive and curative care preferably from female providers. They suspect reproductive health programmes as Western agenda for population control. They feel very strongly against the provision of elective abortion services. Leaders opined that the only acceptable indications for elective abortion include death of the fetus in utero, gross congenital anomaly incompatible with life and serious maternal health risk. A committee of trusted and preferably Muslim God-fearing doctors should assess and confirm these indications. They accept that women with complications of spontaneous abortion should seek care. The provision of contraceptive services to adolescents or married couples is not acceptable. In case of married couples, the only acceptable indication is on the serious maternal health grounds. Even then, only harmless methods of contraception may be used, specifically coitus interruptus or calendar method with prior spousal consent. The use and promotion of condoms as a barrier method or for the prevention of STIs is not acceptable. They opined that the prevention and care of those with HIV/AIDS is acceptable with emphasis on pre-marital abstinence and faithfulness among couples.

A qualitative study is best suited in exploring the perceptions of community leaders and religious leaders towards reproductive health issues and programmes. The conduct of in-depth interviews by researchers with similar background as the study subjects have an advantage of access and sensitivity to explore the

feelings of these leaders towards what they see as a western imposition primarily aimed at population control. Nevertheless, a background in sociology and anthropology would have enriched the research team.

The high level of awareness albeit with some misconceptions among the leaders may be related to the common practice of listening to news and programmes broadcasted by foreign stations in Hausa language-the lingua franca of the north. The 1999 NDHS<sup>4</sup> reported 77.6% and 55.3% ownership of radio sets in urban and rural areas respectively. Another survey<sup>6</sup> confirmed the leading role of the radio, followed by television and a much further behind, the printed press. There were regional variations with the south generally ahead of the north. It was noted that the regional variations could reflect differences in literacy levels and poverty among other factors.

The very strong opposition to the provision of induced abortion services among the leaders is similar to the reports of a study conducted among undergraduates from different religious backgrounds in a Nigerian university<sup>8</sup>. The majority of the respondents in that study opposed the liberalisation of abortion laws due to the fear that it would increase promiscuity, sexually transmitted diseases and abortion rates. Religious opposition and the belief that liberalisation would not reduce the level of poverty, ignorance and poor reproductive health facilities were the common factors leading to unwanted pregnancy and unsafe abortion in Nigeria.

Although the community and religious leaders detested family planning among couples based on economic reasons, they said it is only allowed on serious maternal health grounds. This agrees with the report from Egypt by Omran emphasizing the lack of prohibition of temporary family planning in cases of maternal ill health in the Islamic literature though most scholars are opposed to surgical contraception<sup>7</sup>.

Culturally and on religious grounds, women are prohibited from use of health care services operated mainly by men. Women cannot and will not seek any health care services from the male health care providers because they are not suppose to be seen by any male other than their husbands and close relatives, hence this may inhibit the use of services with predominantly male providers<sup>8</sup>. This is an important consideration in selection and training of reproductive health workers in a predominantly Muslim community. This problem is compounded by the low school enrolment of the girl child in the north<sup>9,10</sup>. Some community/religious leaders are known to discourage the education of girls and women and their employment outside the home. Viewing AIDS as a punishment for society's sexual permissiveness has earlier been reported by other workers<sup>11</sup>.

Although community leaders (cultural/traditional and religious) hold the key to the acceptance and utilization of reproductive health services, there is inadequate knowledge and suspicion among this group towards reproductive health programmes. This is largely attributed to ignorance about reproductive health programmes and mistrust for the programme. Majority of the women are in purdah and the decision to seek medical help, is only made by the husband, mother, mother in law, village elders or other senior family members. Thus women's lack of education and decision-making power even during emergencies remains a major barrier to their sexual and reproductive health. The varied perceptions, medical and non-medical barriers to reproductive health services need to be articulated in order to structure appropriate strategies that will inform and sensitize people about reproductive health programmes and services. Advocacy, monitoring and involvement in programme implementation and social mobilization are useful strategies for addressing this issue.

With reference to socio-cultural barriers, there is need for more in-depth social science oriented research to inform policy makers, programme officers and biomedical scientists about religious and cultural preferences. A better understanding of the community/religious leaders' perception will ensure improved programme design and acceptability among communities with strong religious preferences.

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