

The Effect of an Educational Intervention Programme on Reproductive Health Decision Making Among Couples in South West Nigeria.

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Abstract

Context: Decision making process in reproductive health in Sub-Saharan Africa is a complex activity dictated by the customs, religious beliefs, socio-economic factors, and cultural innovations. The central role played by men in this process gives a strong justification for health education intervention with a primary focus on men.

Objective: To find out how educational intervention programme will influence reproductive health decision making among couples.

Study design: This is a quasi-experimental study among couples in 3 towns in Osun State (Ode-Omu, Ejigbo and Otan-Ayegbaju) of Nigeria. Ode-Omu and Ejigbo served as the intervention towns while Otan-Ayegbaju served as the control. The study had 3 phases: baseline survey lasting 3 months, intervention phase of 12 months and post-intervention period of 3 months

Interventions: Imparting information and educating members of the community on issues related to reproductive health with emphasis on the role of men using posters, handbills, public lectures, workshops and films.

Main Outcome measures: Decision making on and timing of pregnancy, seeking of post-abortion care, and husbands' support of wives during pregnancy.

Results: After the intervention, more couples took joint decisions on timing of pregnancies; more husbands supported their wives during pregnancy and seeking of post-abortion care increased significantly in the intervention towns.

Conclusion: Enlightenment of men is a faster and effective short-term measure to improve women's utilization of reproductive health resources.

Key Words: Men's Role, Reproductive Health, Decision-Making [Trop J Obstet Gynaecol, 2005, 22: 4-8]

Introduction

The current concern on male factors in reproductive health in the last couple of years derive from the understanding and greater recognitions that in many cultures men take vital decisions that affect the reproductive health of women as well as their own^{1, 2}. Studies in Sub-Saharan Africa have confirmed that reproductive decision making process is a complex issue dictated and influenced by a multiplicity of factors including local tradition, religious beliefs, norms and values, family structure, household economics, and access to new ideas and cultural innovations^{3, 4}. It is also evident that Nigerian women have little control over their sexuality^{5, 6}. The situation is worsened by the fact that traditional norms tend to sanction men's behaviour while women remain sexually submissive and less assertive. More often than not women suffer from the stigma of divorce, abandonment / neglect or violence^{7, 8}.

Today, the health implications of men sexual activities, their attitudes and perceptions bear significant impacts on maternal morbidity and mortality, child survival and transmissions of Sexually Transmitted Infection (STI) including Human Immunodeficiency Virus (HIV)⁹. The central role played by men in determining women's health status strongly support the need for health education interventions with a primary focus on men.

The focus of the study is to examine the effect of educational intervention programme on the reproductive health decision making among couples using three indicators: decision on, and timing of pregnancy; seeking of post-abortion care; and husbands' support of wives during pregnancy.

Subjects and Methods

The data for this work are a part of the larger study on the "Role of Men in Emergency Obstetric Care (EOC) in Osun State of Nigeria". The study was carried out over a period of 18 months, between July 1997 and December 1998. The study was done in three phases. The baseline survey lasting 3 months was to determine the perception of married men and women on the health needs of the women and the decision making process during pregnancy when emergencies arise. The major objective of the baseline survey was to identify factors that could help in designing an appropriate educational intervention programme. The educational intervention phase lasted 12 months, while the post intervention survey lasted 3 months.

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Three suburban towns that share the same cultural, religious and social backgrounds were selected for the study. The 3 towns: Ode-Omu, Ejigbo and Otan-Ayegbaju were located in different Local Government Areas (LGAs) in Osun State, about 40 km apart. Their population ranged between 20,000 and 30,000 (according to the 1991 Nigeria Population Census). Ode-Omu and Ejigbo served as the intervention towns, while Otan Ayegbaju was the control town (where no intervention was carried out). The 3 towns were selected for the study because they were had not been exposed to previous intervention programmes of other organisations in the State.

Three hundred households were selected from each town using random sampling technique from the general house-listing. A maximum of 1,200 and a minimum of 600 respondents were expected from each town. The baseline survey was carried out using a pre-tested structured questionnaire. In each selected household, the husband and wife in the reproductive age were interviewed separately, and where the set up is polygamous, all the wives were interviewed separately. Women who had passed the internationally accepted limit of reproductive age of 49 years were excluded from the analysis.

The intervention methods employed in Ejigbo and Ode-Omu were as follows: mobilization workshop for men and women living in the towns with distribution of information materials such as handbills and posters. Films depicting the concept of good antenatal and emergency obstetric care were shown. Short seminars and lectures with health workers and the people in the 2 towns, demonstrating how to manage the problems of

gender supremacy as it affects the reproductive health of women were also arranged.

These workshops and seminars were held in Churches, Mosques, Trade Union meetings, and in Town Halls. For the post-intervention survey, the couples exposed to intervention in any form were selected for interview. The inclusion criterion was being a wife, being currently pregnant or delivered within the last 6 weeks of the intervention activities. The sample was compiled from the records of Hospitals, Private Clinics, Government Health Centres, Maternity Centres, the Spiritual Birthing Homes (SBH), and through visits to markets and homes. Three hundred households were selected from each of the 3 study towns using simple random sampling from the compiled list. To determine if a respondent has been exposed to the intervention or not, the interviewers displayed samples of posters and handbills used during the intervention for identification.

Information was collected on the socio-demographic background of the respondents and their obstetric history. The major research questions focus on the basis of decision, on where to seek treatment in acute obstetric emergencies; issues relating to child spacing; the need for more children; timing of pregnancy; and the number of children desired. The data were analysed using both SPSS 9.0 and STATA programmes while the findings were presented in simple percentages, frequencies and cross tabulation tables.

The significance of association was tested using non-parametric measure of association based on chi-square distribution. The observed probability value (*P*-value) lower than 0.05 (5%) level associated with chi-square statistic was considered significant.

Table 1
Comparison of the desirability of the last pregnancy between baseline and post-intervention period.

Town	Total Sample	Desirability of last pregnancy (%)	Total Sample	Desirability of last pregnancy (%)	<i>P</i>
(A) Wanted Pregnancy Then (Baseline):					
Ejigbo	321	287 (89.4)	210	194 (92.4)	0.000281*
Ode-Omu	326	282 (86.5)	280	264 (94.2)	
Otan-Ayegbaju	321	287 (89.4)	237	161 (67.9)	
(B) Wanted Pregnancy Later					
Town					
Ejigbo	321	19 (5.9)	210	10 (4.8)	0.000002*
Ode-Omu	326	29 (8.9)	280	15 (5.4)	
Otan-Ayegbaju	321	19 (5.9)	237	59 (24.9)	
(C) Wanted Pregnancy No More					
Town					
Ejigbo	321	15 (4.7)	219	3 (1.4)	0.003024*
Ode-Omu	326	15 (4.6)	280	1 (0.4)	
Otan-Ayegbaju	321	15 (4.7)	237	15 (6.4)	
Total	968	756 (78.1)	727	619 (85.1)	

* *P* = Significant at < 0.001, *df* is 2

Results

A total of 1,720 married men and 1,957 married women were interviewed altogether in both the baseline and the post-intervention surveys. The ages of the men ranged from 18-74 years with a mean of 31 years, while that of women ranged from 15 to 49 years with a mean of 29.1 years. The women generally had lower educational background compared to men. Only 32% of the women and over 85% of the men ever attended school. Farming is the predominant occupation followed by trading. Table 1 reveal that a significant impact was made by the educational intervention programme as fewer women had unplanned pregnancy when the intervention towns were compared to the control town. Also, more women who wanted to postpone the timing of their pregnancy or stop child bearing were able to do so after the intervention phase.

Table 2 showed a statistically significant reduction in

the level of unilateral decision by the husband (73.7% to 43.6% in Ejigbo, 74.3% to 50% in Ode-Omu compared to 73.6% to 70.6% in Otan-Ayegbaju) when a decision is to be taken on the timing of the next pregnancy. Though, not revealing any significant improvement in ability of the wife to take independent decision on the timing of pregnancy, it showed a significant level of improvement in the level of joint decision-making by the couples (23.4% to 40.9% in Ejigbo, 21.4% to 35.1% in Ode-Omu compared to 18.1% to 19.2% in Otan-Ayegbaju). In Table 3, the proportion of women who sought postabortion care with skilled attendants rose by 27.3% and 21.3% in Ejigbo and Ode-Omu compared to a reduction of 0.9% in Otan-Ayegbaju. This observation was statistically significant ($p = 0.00746$) in Ejigbo and Ode-Omu compared to the initial baseline values. In Otan-Ayegbaju no significant change was recorded in post-abortion care with skilled attendant.

Table 2

Frequency Distribution of the Decision Maker on When to Have the Next Pregnancy in the Baseline and Post-Intervention Period.

Decision Maker	Baseline			Post-intervention			p
	Ejigbo	Ode- Omu	Otan- Ayegbaju	Ejigbo	Ode- Omu	Otan- Ayegbaju	
Husband	202 (73.7%)	222 (74.3%)	276 (73.6%)	115 (43.6%)	174 (50.0%)	269 (70.6%)	0.000942
Wife	6 (2.2%)	2 (4.6%)	19 (5.1%)	16 (6.2%)	20 (6.3%)	30 (7.9%)	0.060350
Couple	64 (23.4%)	64 (21.4%)	68 (18.1%)	108 (40.9%)	113 (35.1%)	73 (19.2%)	0.06914
Husband's Parent	1 (0.4%)	1 (6.3%)	5 (1.3%)	4 (1.6%)	6 (1.9%)	3 (0.8%)	0.106773
Friends or Relations of The couple	0 (0.0)	-	3 (0.8%)	1 (0.4%)	6 (1.9%)	3 (0.8%)	0.102776
Others	3 (1.2%)	-	4 (1.1%)	20 (7.5%)	3 (0.9%)	2 (0.5%)	
Total	275	299	375	254	322	380	

In Table 4, statistically significant improvements in the husbands' support for the wives in pregnancy were noted in the post intervention period. More than 70% of husbands assisted in the compliance of their wives with medication received from antenatal clinics, reminding them of clinic days, financial support and in co-operating to observe the prescribed resting period. Table 5 revealed that despite these observations, the intervention programme did not succeed in improving the ability of wives taking independent decision, when obstetric emergencies arise in the absence of husbands.

Table 3
Frequency of Seeking Post-Abortion Care (PAC) With Skilled Attendants Among Respondents Who Had Spontaneous Abortion.

Town	Baseline		Post Intervention		p
	Sample	Those Seeking PAC	Sample	Those Seeking PAC	
Ejigbo	79	48 (60.8%)	53	52 (98.1%)	0.007459
Ode-Omu	57	39 (68.4%)	39	35 (89.7%)	0.028
Otan-Ayegbaju	56	33 (62.3%)	57	35 (61.4%)	1.000

Table 4
Proportions of Husbands Who Gave Specific Support to Pregnant Wives.

Support Reported by wives	Baseline			Post-Intervention		
	Ejigbo (N=321) N(%)	Ode- Omu (N=326) N(%)	Otan- Ayegbaju (N = 321) N(%)	Ejigbo (N=210) N(%)	Ode- Omu (N = 280) N(%)	Otan- Ayegbaju (N = 237) N(%)
Compliance with medication	94(29.3)	178(54.6)	83 (25.9)	165(78.5)	212 (75.7)	134 (56.5)
Reminder of clinic days	84(26.2)	149(45.7)	39 (12.1)	150(71.4)	205(73.2)	122(51.5)
Financial Support	210(65.4)	257(78.8)	283(88.2)	209(99.5)	242 (86.4)	206 (86.9)
Ensure observance of prescribed resting period	82 (25.5)	132(40.5)	55(17.1)	153(72.9)	175 (62.5)	183 (77.2)

p : Ejigbo = 0.00004194

Ode-Omu = 0.02478

Otan-Ayegbaju = 0.00000

Table 5
Action Taken by Wives When Obstetric Emergencies Arise in the Absence of the Husbands.

Support Reported by wives	Baseline			Post-Intervention		
	Ejigbo (N=321) N(%)	Ode- Omu (N=326) N(%)	Otan- Ayegbaju (N = 321) N(%)	Ejigbo (N=210) N(%)	Ode- Omu (N = 280) N(%)	Otan- Ayegbaju (N = 237) N(%)
Go to husband's parent	55 (17.1)	16 (4.9)	33 (10.3)	38 (18.1)	18 (6.4)	55 (17.1)
Wait for the husband	4 (1.2)	3 (0.9)	16(5.0)	10 (4.8)	6 (2.1)	12 (5.1)
Decide on my own where to go	184 (57.3)	293 (89.9)	274(85.4)	189(90.0)	248 (88.6)	211(86.6)
Go to my relations	12(3.7)	6 (1.8)	6 (1.8)	11(5.2)	3 (1.1)	6 (2.5)

p :Ejigbo = 0.1275

Ode-Omu = 0.4306

Otan-Ayegbaju= 0. 6653

Discussion

This study, like many other studies¹⁰ has proven that the education of men is a crucial step towards increasing men's participation in reproductive health. After the intervention phase, a significant improvement was observed in women's ability to take decisions, especially those relating to determining to get pregnant. Ignorance and lack of education in matters relating to pregnancy and pregnancy care were found to be the

basic factors responsible for some of the men's attitudes towards their pregnant wives. However, this was found to be amenable to enlightenment campaign and re-orientation on gender values¹¹. The intervention succeeded in making a significant improvement in the supports husbands give to their wives during pregnancy. Apart from this, there were more joint decisions on planning the next pregnancy.

Since our intervention towns in the study had never been exposed to a similar intervention programme before it is deducible that the observed changes are attributable to our intervention especially when compared to attitudes of people in the control town. This study did not distinguish between husband's role in monogamous and polygamous relationships, and women living outside the marital homes.

The wide disparity in the basic literacy rate in this study is a reflection of the low status accorded to the female gender in many of the African societies and the preferential treatment often accorded the male gender. In most cases, such differential treatment tends to disempower women socially and economically. One of the effects of women's disempowerment is their inability to make life's choices, including the choice of when to get pregnant and how to care for such pregnancies. It is not surprising therefore that pregnant women tend to record poor utilization of modern health facilities¹².

Many interventions in the developing world aimed at reducing maternal mortality and morbidity, improvement in the reproductive health of the family, utilization of services and infrastructures have failed to yield encouraging dividend, because the attitudes and behaviours of the consumers have not been modified.

Factors which constitute impediments to progress in improving maternal morbidity and mortality are often based on social and cultural environment, which to a

large extent are defended and perpetrated by men^{13, 14}. In most instances, the information that health personnel need to share with couples is passed on to the husbands through the wives and possibly with some distortions where the information does not favour the woman. This might be a cause of delay in giving prompt attention to many of the emergency obstetric conditions, which often heighten the incidence of maternal mortality and morbidity. There is no doubt that basic education for the girl-child and women generally, is the key to women's socio-economic empowerment and improved quality of life despite this to improve women's utilization of health resources, the enlightenment of men will be a faster and short term measure.

In conclusion, the traditional system of male dominance in our culture has conferred on men the position of strength in family decision-making processes. This has been found to often have a negative impact on the health-seeking behaviour of women, and their inability to make appropriate reproductive choices. This exposes women to risks in pregnancy and other reproductive health issues including HIV /AIDS^{15, 16}. It is recommended that more research efforts should focus on the 'male factor' in reproductive health decision making. Men should become the focus of more enlightenment campaign on issues relating to the reproductive health of the family. When this is achieved, interventions programmes targeted at improving women's reproductive health are likely to have better impact.

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