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# Communication and Decision-Making About Reproductive Health Issues Within Couples in Kwara State, Nigeria

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**Abstract**

**Context:** Communication on reproductive issues within couples is important for sound decisions and support for reproductive health actions.
**Objective:** This study was undertaken in order to determine the attitudes and practice of decision-making among couples and the level of spousal communication on reproductive health issues.
**Methods:** Data was collected through face-to-face interview of 300 subjects (150 males and 150 females) who were selected through a multi-stage sampling technique from Yoruba-speaking parts of Kwara State.
**Results:** The respondents' attitudes were generally positive to women's participation in decision-making. The locus of control for decision-making was commonly both husband and wife, rather than male or female dominated. Despite that, only 53.2% of males and 58.1% of females had actually discussed desired family size with their spouses, while even fewer; 36.6% and 35.1% respectively, had discussed family planning methods with their spouses in the preceding six months. Monogynous unions for females; higher education, Christianity, and approval of couples' use of family planning methods for males were predictive of spousal communication on these issues.
**Conclusion:** Strategies to mobilise both men and women for reproductive health promotion are desirable for improved reproductive health.

**Key Words:** Reproductive Health, Couples, Communication

## Introduction

Communication within couples on reproductive health issues is very important. It could enhance female empowerment with respect to taking decisions on fertility and allows them to exercise their reproductive rights[1]. Hitherto, reproductive health programmes had focussed on women with little of men's involvement[2]. Whereas looking at the traditional setting, males play a dominant role in decisions regarding childbearing and fertility regulation[3-5]. If programmes then target only women and there is little communication within couples, the men's decisions could be ill-informed.

Effective spousal communication is an excellent mode of promoting reproductive health. Increased discussion about family planning between partners would lead to long term changes in family planning attitudes and behaviour. Studies have shown that couples who talk about the number of children they desire and about family planning methods are more likely to use contraceptives and achieve their goals than those who do not[3]. Some of the identified predictors of non-use of family planning methods include lack of communication within couples, male-dominated decision-making and men's concerns about fidelity[6-8]. These have led to covert use of family planning services by women[9].

In Nigeria, the Contraceptive Prevalence Rate (CPR) of 9 percent, from the Demographic and Health Survey (NDHS) of 1999[10], is low. For sustainable development and improved quality of life, the national policy on population has targeted the modern CPR for an increase of 2 percent annually[11]. The achievement of this target could be enhanced through interventions that target couples rather than the individual partners.

The quality of spousal communication is important and is said to be influenced by the couples' level of education, type of union (monogynous or polygynous), religious belief and other socio-cultural factors such as rural/urban residence and son preference[12,13]. Also, the level of spousal discussion of family planning methods is an indication of acceptability. Reports showed that 41 percent of married women who knew a contraceptive method had discussed family planning with their husbands in the preceding year of the 1990 NDHS[14]. In terms of family size, the targeted reduction in the Total Fertility Rate (TFR) of 5.2 percent[11] could be better achieved if couples plan their families, through effective spousal communication.

Maternal employment tends to increase a woman's bargaining power within the household thus they would have more control over their reproductive health. Female education has also been shown to increase husband-wife communication and knowledge of family

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planning, as well as improved attitudes and access to birth control, all of which were found to be negatively related to fertility[15]. The channels through which formal education operates have been explained by the authors, through several plausible models of the impact of schooling on the attitudes and later behaviour of girls.

This study was undertaken in order to determine the attitudes and practice of decision-making, and the level of spousal communication on reproductive health issues. The findings will strengthen the argument for male involvement in family planning programmes and sensitize health and social workers to the need to promote spousal communication on reproductive health issues, by working with couples as client units.

## Methodology

*Area of Study*

This study was carried out in three Yoruba-speaking Local Government Areas of Kwara State - Ilorin West, Irepodun and Offa. The main religions are Christianity and Islam. The male and female populations of the selected LGAs were respectively, 92,220 and 92,321; 54,214 and 54,293; and 36,727 and 38,197, by 1991 census. That is, a total population of 367,971 in the study area.

*Study Design*

The study was a descriptive cross-sectional survey. Both quantitative (questionnaire) and qualitative (Focus Group Discussion [FGD] and In-depth Interviews) methods were used. The study population comprised of men and women within defined reproductive ages; 18-65 years and 15-49 years, respectively. This data is part of a larger set collected in 1996 from seven States in Nigeria.

The sample size for the quantitative method was calculated using the Fisher's formula[16]. The prevalence of Female Genital Cutting of 78%[17], in a population of over 10,000, with a precision of 5%, and a correction factor for anticipated non-response[18] of 10% gave the minimum sample size required as 293. Three hundred subjects (150 males and 150 females) were therefore selected, through a multi-stage probability sampling technique, for the main study of women's reproductive health, rights, empowerment and male involvement, of which this study was a subset.

Areas within the selected LGAs were stratified by socio-economic level prior to selection largely high, medium and low. Rural/urban dichotomy was considered as well. Three hundred households were selected with a sampling interval of 2, from 728 households, by systematic random sampling. The first household was selected through the Grid method[19]. One eligible respondent (male or female) was selected through simple random sampling technique from each selected household.

Quantitative data collection was through a pre-tested questionnaire, which was administered by trained interviewers who understood both the local language and the culture. The information included socio-demographic characteristics, attitudes and practice of decision-making within couples, as well as communication on number of children desired and use of family planning. Data analysis was performed using the computer software EPI-INFO version 6.02. Significance level was $p<0.05$.

FGDs were conducted among four homogeneous age and sex groups males aged below 40 years, males aged 40 years and above, females below 40 years and females aged 40 years and above. Each FGD comprised of 7 8 participants. Some leaders women, opinion and religious, as well as policy-makers had In-depth interviews. These qualitative data sets from FGD and II were manually analysed, and used to complement the quantitative data.

## Results

These results are based on the responses of 141 out of 150 males (6% non-response rate) and those of 148 out of 150 females (1.3% non-response rate).

**Table 1:**
**Socio-Demographic Characteristics of Respondents**

| Characteristic | Male n (%) | Female n (%) |
|---|---|---|
| **Age** | | |
| Mean | 36.0 | 33.1 |
| SD | 7.8 | 7.0 |
| n | 141.0 | 148.0 |
| **Educational Level** | | |
| None | 23 (16.3) | 33 (22.3) |
| Qur'anic | 9 (6.4) | 5 (3.4) |
| Adult literacy | 3 (2.1) | 1 (0.7) |
| Primary | 38 (27.0) | 43 (29.1) |
| Secondary | 32 (22.7) | 37 (25.0) |
| Post-secondary | 36 (25.5) | 28 (18.9) |
| Non-response | -- | 1 (0.7) |
| Total | 141 (100.0) | 148 (100.0) |
| **Religion** | | |
| Catholic | 7 (5.0) | 11 (7.4) |
| Other Christians | 61 (43.3) | 73 (49.3) |
| Islam | 68 (48.2) | 56 (37.8) |
| Traditional | 3 (2.1) | 4 (2.7) |
| Non-response | 2 (1.4) | 4 (2.7) |
| Total | 141 (100.0) | 148 (100.0) |
| **Male's Spouses/women's Work Status** | | |
| Employed | 111 (84.8) | 125 (84.5) |
| Not employed | 20 (15.2) | 23 (15.5) |
| Total | 131 (100.0) | 148 (100.0) |

**Table 2: Marital History of Respondents**

| Characteristic | Male n (%) | Female n (%) |
|---|---|---|
| **Marital Status** | | |
| Married | 131 (92.9) | 134 (90.5) |
| Co-Habiting | 3 (2.1) | 8 (5.4) |
| Previously married | 1 (0.7) | 4 (2.7) |
| Single | 1 (0.7) | 2 (1.3) |
| Non-response | 5 (3.5) | 0 (0.0) |
| Total | 141 (100.0) | 148 (100.0) |
| **Type of Union** | | |
| Monogynous | 103 (78.6) | 81 (60.4) |
| Polygynous | 28 (21.4) | 49 (36.6) |
| Non-response | -- | 4 (3.0) |
| Total | 131 (100.0) | 134 (100.0) |
| **Age At First Marriage** | | |
| Mean | 26.4 | 22.5 |
| SD | 4.1 | 3.5 |
| n | 131 | 134 |
| **Who Chose Spouse ?** | | |
| Self | 104 (79.4) | 107 (79.9) |
| Parents | 22 (16.8) | 22 (16.4) |
| Family Members | 5 (3.8) | 4 (3.0) |
| Other | - (-) | 1 (0.7) |
| Total | 131 (100.0) | 134 (100.0) |

*Background Characteristics*

Ages of male respondents ranged from 18 to 63 years, and the mean was 36 years (SD = 7.8 years). The age range of the female respondents was 18 to 49 years, with a mean of 33.1 years (SD = 7.0 years). As shown in Table 1, 23 or 16.3% of male respondents had no education, while 106 or 75.2% had formal western education. More than one in five females; 22.3% had no education, while 108 or 75.0% had formal western education. The two main religions of the study respondents were Christianity (68 or 48.3% of males and 84 or 56.7% of females) and Islam (68 or 48.2% of males and 56 or 37.8% of females). Majority (111 or 84.8%) of the married male respondents said their spouses had jobs while 125 or 84.5% of the female respondents themselves were working.

Majority of the respondents was married; 131 or 92.9% of males and 134 or 90.5% of females; smaller proportion being in polygynous unions - 21.4% of males and 36.6% of females. The mean ages at first marriage among male and female respondents were 26.4 years (SD =4.1) and 22.5 years (SD = 3.5), respectively. Spouses were usually chosen by the individuals themselves. See Table 2.

*Attitudes to Decision-Making*

Also shown in Table 3, almost half of the male respondents (70 or 49.6%) and a larger proportion of the females (68.2%) felt that couples should jointly take decisions about the number of children that they desired. By working to earn money, women could possibly enhance participation in such decision-making, they said (69.5% of male and 87.8% of the female respondents).

According to the male respondents, women were expected to contribute to decisions about their husband's work 92 (65.2%); how income is spent 98 (69.5%) and the number of children to have 91 (64.5%). The female respondents had the same attitudes largely, 67.6%; 69.6% and 67.6%, respectively.

In practice, wives of male respondents actually contributed to decisions about their work (95 or 67.4%); use of their time (87 or 61.7%) and how their income was spent (104 or 73.8%). Female respondents contributed to decisions about their husband's work (94 or 63.5%); how he spends his time (91 or 61.5%) and how his income is spent (94 or 63.5%).

*Power-Relations in Decision-Making*

As shown in Table 3, among the married respondents, the locus of control for final decision-making on some reproductive health issues within couples was usually both husband and wife. For the number of children a couple should have, 73 or 55.7% of male and 83 or 61.9% of female respondents said the couples were the final decision-makers The locus of control for decision-making on family size was not usually the husband alone (38 or 29.0%of males and 30 or 22.4% of females) and rarely the wife alone (wife alone (19 or 14.5% of male and 14 or 10.4% of female respondents).

The locus of control for final decisions on attendance of women at Antenatal clinic was also usually the couples (78 of 58.2% of male and 90 or 67.2% of female respondents) and rarely the women alone. Similarly, the couples rather than either of them alone had the final decisions on attendance at postnatal clinic. Most often as well, the final decision as to whether the couple should use family planning methods or not was jointly controlled, as reported by 73 or 55.7% of male and 85 or 63.4% of female respondents. For use of family planning methods, only 19.4% of the female respondents and spouses of 13.0% of the male respondents had the final decision.

*Communication on family planning methods and family size*

Less than half of the married male respondents (46 or 35.1%) knew whether their wives were using family planning methods or not and 47 or 35.9% had ever encouraged their wives to use family planning methods. Also, 55 or 42.0% of the male respondents said that their wives had ever encouraged them to use family planning methods. Similarly, less than half (59 or 44.0%) of the married female respondents said their husbands had ever encouraged them to use family planning methods (Table 4).

**Table 3 : Attitudes To Women's Participation In Decision -making And Power-relations In Decision-making On Reproductive Health Matters**

| Characteristic | Male n (%) | Female n (%) |
|---|---|---|
| **Attitudes** | | |
| Who should decide no. of children? | | |
| Couple | 70 (49.6) | 117(68.2) |
| Husband alone | 63 (44.7) | 11 (7.4) |
| Wife alone | 1 (0.7) | 20 (13.5) |
| Other | | |
| Non-response | | |
| **Final Decision-maker On:** | | |
| **No. of Children to have** | | |
| Both | 73 (55.7) | 83 (61.9) |
| Husband alone | 38 (29.0) | 30 (22.4) |
| Wife alone | 19 (14.5) | 14 (10.4) |
| Other | 1 (0.8) | 6 (4.5) |
| Non-response | - (-) | 1 (0.7) |
| Total | 131 (100.0) | 134 (100.0) |
| **Attendance At Anc** | | |
| Both | 78 (58.2) | 90 (67.2) |
| Husband alone | 40 (30.5) | 23 (17.2) |
| Wife alone | 8 (6.1) | 17 (12.7) |
| Other | 1 (0.8) | 3 (2.2) |
| Non-response | 4 (3.1) | 1 (0.7) |
| Total | 131 (100.0) | 134 (100.0) |
| **Attendance At Pnc** | | |
| Both | 76 (58.0) | 90 (67.2) |
| Husband alone | 45 (34.4) | 15 (11.2) |
| Wife alone | 7 (5.3) | 24 (17.9) |
| Other | 3 (2.3) | 3 (2.2) |
| Non-response | - (-) | 2 (1.5) |
| Total | 131 (100.0) | 134 (100.0) |
| **Use Of Contraceptives** | | |
| Both | 73 (55.7) | 85 (63.4) |
| Husband alone | 36 (27.5) | 16 (11.9) |
| Wife alone | 17 (13.0) | 26 (19.4) |
| Other | 2 (1.5) | 4 (3.0) |
| Non-response | 3 (2.3) | 3 (2.2) |
| **Total** | **131 (100.0)** | **134 (100.0)** |

**Table 4: Spousal Communication on Family Planning Methods and Family Size**

| Issue | Male n (%) | Female n (%) |
|---|---|---|
| **Ever encouraged spouse To use a method** | 47 (35.9) | 40 (29.9) |
| **Ever encouraged by Spouse to use a method** | 55 (42.0) | 59 (44.0) |
| **Discussed fp method with Spouse in 6 months** | 48 (36.6) | 47 (35.1) |
| **Discussed family size With spouse** | 75 (53.2) | 86 (58.1) |
| **N** | **131** | **134** |

Forty-eight (36.6%) of married males and 47 (35.1%) of married females said that they had actually discussed family planning methods with their spouses within the preceding six months. Higher educational level ($p$=0.01), Christianity ($p$=0.01), and approval of couples' use of family planning methods ($p$<0.001) positively influenced males to discuss family planning methods with their spouses, as shown in Table 5. Whether their wives were working or not ($p$=0.10), and the type of union ($p$=0.19) did not significantly influence male respondents' practice. Approval of couples' use of family planning methods ($p$<0.001), and monogynous unions ($p$=0.04) positively influenced female respondents to discuss family planning with their husbands. Educational level, religion, and employment did not significantly influence this practice among female respondents.

Over half of the respondents 85 (60.3%) males and 117 (79.1%) females approved of couples' use of family planning methods. Nevertheless, 17 or 11.5% of the females said they would use family planning methods without their husband's knowledge or approval. As shown in Table 4, 75 or 53.2% of the married males and 86 or 58.1% of the married females had discussed the number of children that they would like to have with their spouses. As shown in Table 6, higher education ($p$=0.02), Christianity ($p$=0.02), monogynous unions ($p$=0.02), and approval of couples' use of family planning methods ($p$=0.002) significantly influenced the male respondents to discuss family size with their wives. Whether women worked or not did not significantly influence their practice ($p$=0.52). Higher education ($p$=0.03), Christianity ($p$<0.01), and monogynous unions ($p$=0.01) positively influenced the female respondents to discuss family size with their husbands. However, whether they had a job ($p$=0.14) or whether they approved of couples' use of family planning methods ($p$=0.06), did not significantly influence them.**Discussion**

There were generally positive attitudes to women's participation in decision-making among both male and female respondents. The high prevalence of formal western education among the respondents could be partly responsible for this. Although many respondents felt that by working to earn money, women could enhance their participation in decision-making, it was found that women's employment did not significantly increase their communication on family planning and family size with their husbands. This could imply that their attitudes did not significantly influence their behaviour. On the other hand, analysis of the impact of work on women's reproductive decision-making is complex. Work, as a factor should rather be seen as a composite variable, consisting of multiple variables such as type and size of remuneration, type of activity

**Table 5 : Examination of Selected Factors Against Spousal Discussion of Family Planning Methods**

| Factor | Discussed Family Planning Method Frequency | | | |
|---|---|---|---|---|
| | Male | | Female | |
| | Yes | No | Yes | No |
| **Education** | | | | |
| *NFE & Primary | 13 | 34 | 11 | 31 |
| At least Secondary | 32 | 30 | 36 | 67 |
| $\chi^2$ | 6.33 | | 1.05 | |
| *P* | 0.01 | | 0.31 | |
| **Religion** | | | | |
| Christianity | 32 | 30 | 30 | 53 |
| Islam | 15 | 42 | 15 | 39 |
| $\chi^2$ | 7.95 | | 1.04 | |
| *P* | 0.005 | | 0.31 | |
| **Woman's or Male Spouse's Work Status** | | | | |
| Working | 44 | 59 | 37 | 85 |
| Not working | 4 | 14 | 10 | 12 |
| $\chi^2$ | 2.69 | | 1.94 | |
| *P* | 0.10 | | 0.16 | |
| **Approval of Couple's Use Of FP Methods** | | | | |
| Yes | 40 | 34 | 46 | 69 |
| No | 6 | 34 | 1 | 26 |
| $\chi^2$ | 16.45 | | 13.01 | |

* Non-Formal Education (Qur'anic and Adult literacy)

**Table 6 : Examination of Selected Factors Against Spousal Discussion of Number of Children Desired.**

| Factor | Discussed Number of Children Desired Frequency | | | |
|---|---|---|---|---|
| | Male | | Female | |
| | Yes | No | Yes | No |
| **Education** | | | | |
| *NFE & Primary | 24 | 24 | 21 | 22 |
| At least secondary | 44 | 18 | 65 | 31 |
| $\chi^2$ | 5.04 | | 4.48 | |
| *P* | 0.02 | | 0.03 | |
| **Religion** | | | | |
| Christianity | 43 | 21 | 58 | 21 |
| Islam | 30 | 34 | 25 | 28 |
| $\chi^2$ | 5.39 | | 9.36 | |
| *P* | 0.02 | | <0.01 | |
| **Woman's or Spouse's Work Status** | | | | |
| Working | 65 | 47 | 16 | 5 |
| Not working | 9 | 9 | 69 | 48 |
| $\chi^2$ | 0.41 | | 2.23 | |
| *P* | 0.52 | | 0.14 | |
| **Approval of Couple's Use of FP Methods** | | | | |
| Yes | 57 | 26 | 73 | 37 |
| No | 15 | 23 | 12 | 14 |
| $\chi^2$ | 9.22 | | 3.66 | |
| *P* | 0.002 | | 0.056 | |

* Non-Formal Education (Qur'anic and Adult literacy)

and occupation. These would have different relationships with reproductive health behaviour, in terms of strength and direction. It should be noted that even though women bear the burden of reproduction more than men, they were not usually the final decision-makers on reproductive health issues. For instance, despite the fact that most of the family planning methods are female-based, women had final decisions on their use only in few cases.

This study shows that unlike the common practices[3-5], males do not necessarily play a dominant role. Rather, it was a joint responsibility of the couple. The idea of final decisions being the prerogative of some of the couples as found in this study, holds a lot of promise for reproductive health and creates a need for couples to be managed together for reproductive health. This does not suggest that spousal consent should be required. Rather, the participation of the male partner should be encouraged. The joint decision on use of family planning methods within couples is useful, especially when methods such as the rhythm that require understanding and cooperation within couples are considered. Negotiation of condom use, which is an important process in this era of HIV/AIDS pandemic, could also be enhanced through such joint decision-making.

In terms of power relations and household dynamics, efforts should still be made for improvement such that there is some balance in power-relations when decisions on reproductive health issues are taken within couples. The proportions of respondents whose final decisions on reproductive health issues were the responsibility of the couple could still increase, particularly among the males. It should not be too surprising to see that there are some "powerful other", though few, who had the power to take final decisions on couple's reproductive health issues, seeing that this is an African setting with the extended family system (parents-in-laws especially mothers and other kins) wielding their power.

In terms of definite spousal discussion on family planning methods and family size, the prevalence was rather low; even lower than the 41% of the 1990 NDHS[14]. In taking collective responsibility, spousal communication on these issues is paramount. Despite the fact that more than half of the couples have joint responsibility for final decisions, fewer had actually discussed the issues, talk less of jointly taking decisions. Monogynous unions enhanced women's communication with their spouses on family planning and family size. Higher education, Christianity, and approval of couples' use of family planning methods were predictive of males having spousal communication on reproductive health issues. The women who encouraged their spouses to use family planning methods could actually have been negotiating the male condom, which is the commonest male-based method. When women are responsible for final decisions as found among a few of the respondents, it shows some degree of autonomy which if not backed with a good resource base, could still mean poor access to reproductive health services.

Towards achieving the goals of the population policy for sustainable development[11], both men and women should be mobilised for contraceptive method use and family size reduction. Messages should be targeted at them both as individuals and as couples. These pose a great challenge to the service providers who hitherto had worked only with women. These recommendations have implications for training and re-training of service providers, community mobilisation and provision of resources for Information, Education and Communication (IEC) strategy.

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