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FERTILITY BEHAVIOUR, SEXUAL NEGOTIATION AND CONTRACEPTIVE USE AMONG MARRIED COUPLES IN OSOGBO, OSUN STATE, NIGERIA

FASINA, F. F.
OGUNNAIKE, O. O.
OGBARI, M.

ABSTRACT

The study on the fertility behaviour, sexual; negotiation and contraceptive use among married couples was undertaken in Osogbo Community of Osun State. It was aimed at examing how reproductive decisions and outcomes are negotiated within sexual unions and also to determine the factors that inhibits discussion of contraception among couples. A multi-stage probability sampling procedure was adopted to select the sample using the enumeration maps prepared by the National Population Commission for the 1991 census. Freqency distribution table was employed, also the multi-variate logistic regression analysis techniques was employed to determine the pattern and degree of relationships between the variables. It was observed that contraceptive use among couples are significantly affected by sex, religion, ever given birth and newly married. The recommended strategies for enhancing couple communication include attempts to enlist the cooperation of man by providing them with family planning, communication and educational services.

INTRODUCTION

As family planning and reproductive health programs increasingly emphasize strategies designed to meet the needs of individual women, information on the circumstances under which women make and implement reproductive decisions is crucial (United Nations, 1995a; United Nations, 1995b; Oppong, 1996). Knowledge of the realities of women's everyday life and identification of the obstacles that they may face in achieving their reproductive and health goals are necessary if programs are to be formulated that are responsive to women's needs for particular types of information or services (Dixon-Muller, 1993). At the same time, the role and needs of men are recognised as crucial in understanding the dynamics of reproductive decision-making. Such information is essential for the monitoring and evaluation of programs that seek to provide user-centred family planning and reproductive health services to couples.

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Much of the recent literature that endeavours to explain fertility behaviour, especially in sub-Saharan Africa, suggests that an exclusive focus on individual women omits important explanatory factors and may actually be misleading (Bruce *et al,* 1995; Rutenberg and Bledsoe, 1996; Biddlecom *et al,* 1996; Ntozi, 1993). Clearly, women's social interaction with male partners, family members, friends, health professionals, religious leaders, and others influence their attitudes and behaviour with respect to fertility and related matters, such as sex and contraceptive use.

At a minimum then, an explicit examination of the role of male partners in reproductive decisions is essential to a full understanding of fertility behaviour. Thus, for both programmatic and theoretical reasons, studies are needed of the reproductive decision making process and its outcomes for women and men. Relatively, little is known about the processes by which decisions about reproductive matters are made or even whether they may be categorized as "decisions".

Standard surveys, such as those conducted under the Demography and Health Survey (DHS) and the World Fertility (WFS) programs, have provided a great deal of information about the outcome of decisions that affect fertility levels in developing countries for example, DHS Survey data provide estimates of contraceptive prevalence, the percentage of women who want more children, ideal family size, and the length of postpartum abstinence. While both partners in a sexual union may express the same fertility preferences, however, it has not been possible with standard DHS data to determine whether these preferences were negotiated, whether they changed overtime, and what factors influenced the decision. Even less is known about how the status of women and gender inequality within sexual union affect the ability of women to negotiate the reproductive outcomes they desire, although there is some recent work on this topic (Gage & Njogu, 1996).

Women's ability to control their own sexual activity is central to control over reproduction and the transmission of disease (ULIN, 1992; WHO, 1993). Sexuality, especially female sexual activity, is governed by a complex set of social norms. These norms do not only define the boundaries of acceptable and negotiable behaviour, they may also constrain individual action with respect to social activity. In settings where HIV/AIDS is prevalent, these norms and their relationship to reproduction and, particularly, to the use of condoms - are complex and evolving (Balner *et al,* 1995; Orubuloye, *et al,* 1996; Havanon, 1996). Explicit consideration of gender inequality is thus important component of the study of reproductive outcomes.

These trends have differed widely among regions and countries, with some populations completing the transition from high to low fertility very rapidly

(example, Hong Kong, Korea, Singapore, Taiwan), while others (mostly in sub-Saharan Africa) have seen little change. On average, the pace of fertility change in the developing world has been substantially faster than it was in Europe and North America in the late nineteenth and early twentieth centuries. Despite these encouraging trends in reproductive behaviour, high fertility - both wanted and unwanted --- and its contribution to rapid population growth remain a concern of governments in many part of the developing world.

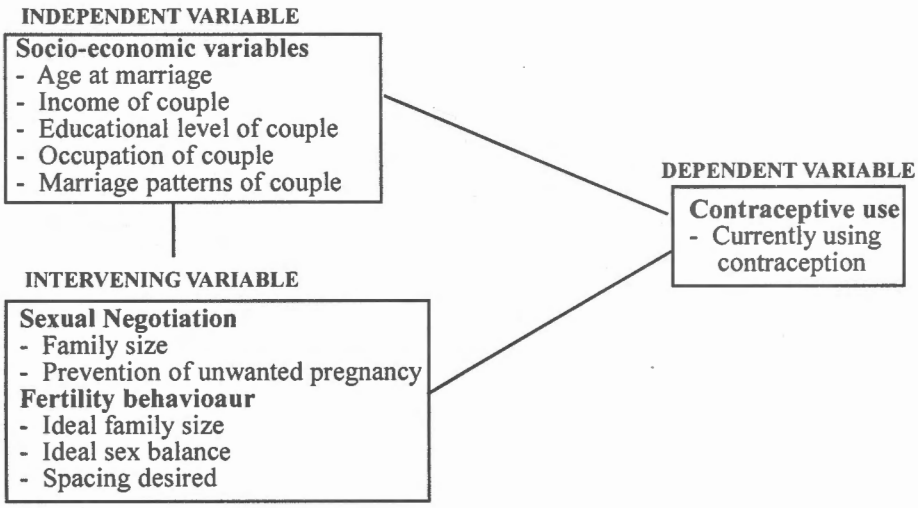
On the issue of how "a man and his wife decide on the number of children to have", responses varied from "jointly" to the response that "men took the decisions unilaterally". The point was made by the male groups, in particular, that in the past men and their wives did not discuss family planning. It is clear; therefore, that current male perception of the family planning springs from this historical background. The women also reported that the decision was taken jointly although they noted, in addition, that many marital pregnancies were "by accident" and were not planned at all.

The decision to use one contraceptive method over another is influenced by personal choice, perceptions of efficacy, personal risk, access, age, cost, gender, education, ethnicity, marital status, current number of children, sexual orientation, and pattern of sexual activity and level of co-operation between partners. From the foregoing, the purposes of this study are to; examine how reproductive decisions and outcomes are negotiated within sexual unions, determine the major individual, household and community characteristics that influences the negotiation process, determine the factors that inhibits discussion of contraception among couples and it will also investigate how the position of women influences their ability to negotiate the outcomes they desire.

The theoretical approach acknowledges the fact that individual fertility behaviour takes place within a particular socio-economic and cultural context. Basically, decisions on fertility are viewed as a function of the proximate determinants, which in turn affect socio-economic variables (Anker *et al,* 1982; Billsborow, 1985; Casterline, 1985). Adoption of contraception is therefore perceived as a function of the balance between motivations to regulate excess of potential fertility over desired fertility and fertility regulation costs, which are both psychosocial and economic variables.

In explaining this theory, couples socio-economic and psychosocial variables determine their fertility behaviour. Therefore, adoption of the use of contraception is being influenced by these variables comparing the individual women involved and that of the male partners. These variables include educational attainment of couples, income level, marriage pattern, and religious affiliation of

couples among others. These variables help to enhance the frequency of discussion among couple, which helps to facilitate couples' use of contraceptives.



PARTICIPANTS AND PROCEDURES

Osogbo local government area in Osun state was used for the study. The study population consisted of married couples between the ages of 15 and 45 years. Questionnaires were administered to 430 eligible respondents comprising 215 married men and 215 married women. These respondents were selected from varying socio-economic and religious backgrounds.

A multi-stage probability sampling procedure was adopted to select respondents for the survey, using the enumeration maps prepared by the National Population Commission for the 1991 census. The location will be stratified into three clusters based on the residential patterns that reflect the socio-economic status of the respondents at the first stage. At the second stage, supervisory areas were randomly selected, and enumeration areas were selected within the supervisory areas at the third stage. Therefore, households were systematically selected within the enumeration areas.

The study comprises two samples married women between the ages 20 - 44, living together with a partner or in a stable sexual relationship for at least six months, and men who were married to or living successfully with interviewed women. In order to be eligible for the individual interview, a woman must pass two eligibility criteria: she has to be regular resident of the household, and she has to be between 20 and 44 years of age. Eligible women were asked series of introductory questions about marital status, and those who reported themselves to

be "married" will be automatically considered eligible to complete the full questionnaire.

Different eligibility criteria were set for men. They were required to be partners of eligible women, either formally married or living together. There were no age limits, and residence criteria depend on marital status. Any married or unmarried partner living in the same household with an eligible woman is consider eligible to answer the male questionnaire.

Information from the questionnaire were analysed at three stages. The simple statistics of frequency distribution and tabulation were employed to examine the distribution of the respondents according to their demographic and socio-economic characteristics. The second stage involved the use of cross-tabulation to establish the relationships that exist between variables. The multivariate logistic regression analysis was employed at the third stage of the analysis to show the pattern and degree of relationships that exist between the dependent variable and the independent variables and also to determine whether these relationship are significant or not.

RESULTS AND DISCCUSION

The variables that were considered for analysis include the distribution of the survey respondents' responses according to sex, religion, ethnic group and occupation.

Table 1: Percentage Distribution of Respondents by Sex

Sex	Frequency	Percentage
Male	171	39.8
Female	259	60.2
Total	**430**	**100.0**

Source: *Field Reports, 2007*

Table 2: Percentage Distribution of Respondents by Ethnic Group

Ethnic Group	Frequency	Percentage
Yoruba	382	88.8
Igbo	25	5.8
Hausa	23	5.4
Total	**430**	**100.0**

Source: *Field Reports, 2007*

Nigeria is ethnically heterogeneous, with as many as 374 ethnic groups (Otite, 1990), of which three, the Hausa, Yoruba, and Igbo are disproportionately large. According to the table above, the study area is a Yoruba speaking dominated

area. Majority of the respondents are Yorubas. This is shown by the higher percentage of 88.8%. Other two major ethnic groups, the Igbos and the Hausas are in the minority with a percentage of 5.8% and 5.4% respectively.

Table 3: Percentage Distribution of Respondents by Current use of Methods

Methods	Frequency	Percentage
Pill	18	4.2
Iud	45	10.4
Injection	14	3.2
Implant	15	3.5
Condom	33	7.6
Rhythm	10	2.3
Withdrawal	15	3.5
No response	280	65.3
Total	**430**	**100.0**

Source: *Field Reports, 2007*

It is clear from table 3 that levels of contraceptive usage in the study area is low. The distribution of respondents by currently using contraceptive is very minute. A greater proportion of 65.3% who declares no response shows also that their exposure to the use of various contraceptive is low, or that they just don't want to disclose their methods probably on grounds of confidentiality.

Earlier works have shown that relationship exist between such factors as inter-spousal communication on reproductive issues, attitude, children ever born, ethnic group, currently working, and contraceptive use. However, attempts are made in this study to examine the effect of each of the independent factors on contraceptive use and to test the various hypotheses proposed for the study. The general model of the logistic equation is of the form:

$Log/(1-p) = b_o + b_1 x_1 + b_2 x_2 + b_3 x_3 + \text{----------} b_n x_n$. Where, $x_1 x_2 x_3 \text{----} x_n$ are sets of independent variables and P is the probability of current use of method.

A positive co-efficient indicates that the higher the value of covariate, the greater the likelihood of contraception. To facilitate better understanding of the test of the hypothesis; three models were estimated. The first model examines the effect of various independent variables on current use of contraceptive. The independent variables: sex, religion and currently married. The second model includes other explanatory variables such as attitude towards contraceptive use and doing something to delay pregnancy that may likely influence or affect the independent variables while the third model accesses the effects of all the independent variables such as opinion on fertility desired and number of children desired on contraceptive use.

Table 4: Logistic Regression Results of Effeect of Various Independent Factors on Contraceptive Use

Variables	Logistic Regression		
	Coefficient	Significance	Odds Ratio
Sex: Male	I.150	0.102	3.160*
Female	R.C		
Religion: Christianity	-1.235	0.083	0.291**
Islam	R.C		
Ever Given Birth (Ceb): Yes	-1.375	0.078	0.253**
No	++R. C		
Currently Married: Yes	1.528	0.097	4.611
No	R.C		

* *Significant at 1%*

** *Significant at 5%*

RC- Reference Category

In table 4, the regression results of the various independent variables on contraceptive use are reported. It could be observed from the table that contraceptive use among couples are significantly affected by sex, religion, ever given birth and currently married. The finding implies that male respondents are more likely to use the contraceptive than their female counterparts. This is so because the males play dominant role in decision making. Religion also has an inverse relation due to individual belief. It is shown in table 4 that the Christians are less likely to use contraceptive as it is against their doctrine.

We observe from the table that children ever born and contraception are inversely related. That contraceptive use declines with greater number of children ever born is hardly surprising; the inverse relationship between children ever born and contraceptive use may be an indication of prohibiting cost of rearing children in the study area.

So far, an attempt has been made to describe how contraceptive use varies according to various independent variables. Since all these factors cannot work alone to influence contraceptive use, there is need to control for effects of some other explanatory variables (that is, inclusion of all the socio economic and demographic variables). The next model is devoted to an examination of

relationship between the independent variables (contraceptive knowledge) and contraceptive usage.

Table 5: Logistic Regression Results of Effects of Some selected Independent variables on Contraceptive Use

Variables	Logistic Regression		
	Co-efficient	Significance	Odds Ratio
Will You Do Something To Delay Pregnancy:			
Yes	8.584	0.859	5344.285
No	9.473	0.845	13004.412
Undecided	R.C		
Attitude Towards			
Contraceptive Use:			
Agree	9.457	0.852	12792.793
Disagree	8.943	0.860	7652.708
No Opinion	R.C		

Significant at 1%
Significant at 5%
R.C = Reference Category

Table 5 indicates, the odds of couples doing something to delay or avoid a pregnancy at any time in future. From the odds ratio, the respondents are more likely to use and have a positive attitude towards contraceptives in future. Respondents who claimed to agree are more likely to yield to the use of contraceptive than those who claimed to disagree. Model three examines the effect of various independent variables (fertility preference) on contraceptive use among the couples in the study area.

Table 5: Logistic Regression Results of Effects of Independent variables on Contraceptive Use

Variables	Logistic Regression		
	Coefficient	Significance	Odds Ratio
Number of Children Desired:			
Yes	7.301	0.864	1482.395
No	R.C		
Opinion On Fertility Desired:			
Yes	-8.123	0.829	0.000
No	R.C		

Significant At 1%
Significant At 5%
R.C = Reference Category

The table indicates that couples are more likely to influence the number of children desired to have than the reference category. With respect to contraceptive use by spousal communication on use of contraceptive, indicates that couples are less likely to discuss on contraceptive issue.

CONCLUDING REMARKS

There is evidence that men in this study area have considerable knowledge and use of family planning and they indicates considerable control over the decision making process. When contraception was practised, the vast majority practiced it for spacing only, thus fertility level is still high. Although, couple's communication was high in the study area, male dominance seems to have been institutionalised. Thus, men strongly appeared to control important decisions, including fertility and contraceptive use in the family.

In order to promote their health, and welfare, the following measures are recommended that strategies for enhancing couple communication include attempts to enlist the cooperation of men by providing them with family planning, communication, and educational services. Another strategy is an empowerment workshop that will encourage the discussion and use of condoms among married women and their spouses.

An aspect of marketing that should be encouraged by the government is social marketing. Social marketing has been described to embrace everything from the spread of useful information such as that required in a metrification campaign to the subsidized sale of beneficial products such as contraceptives.

Social marketing and other innovative approaches will help to make available contraceptives and other health care products to far-flung and remote villages in the country. Social marketing of contraceptives aims at making contraceptives more aspirable, affordable and accessible to the common people. It employs the techniques of commercial marketing such as segmentation, brand building for inducing a planned change in society towards a socially beneficial cause.

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