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SOCIO-CULTURAL FACTORS AFFECTING THE AUTONOMY OF REPRODUCTIVE DECISIONS OF MARRIED WOMEN IN NSUKKA L.G.A. OF ENUGU STATE, NIGERIA

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ABSTRACT: *This article focuses on the socio-cultural factors affecting the autonomy of married women in reproductive decisions in Nsukka L.G.A. of Enugu State, Nigeria. Three vital areas of reproductive decision making were discussed namely: decision on the number of children to have in the family, decision on the place to seek care during pregnancy/childbirth, and decision on the use of contraceptives for family planning purposes. The data presented in this article were derived from a study carried out in Obukpa, in Nsukka Local Government Area of Enugu State Nigeria in 2011. Both quantitative and qualitative methods of data gathering were utilized. The instruments for data collection were the questionnaire, in-depth interview and focus group discussions. The findings of the study showed that married women in Obukpa, Nsukka L.G.A. do not have autonomy of reproductive decisions. Socio-cultural factors like residence, age, educational qualification, religion, occupation, did not positively affect the autonomy of reproductive decisions of married women. Their autonomy was basically affected by 'culture', which portrays male dominance. This is typical of a patriarchal society; which includes Obukpa in Nsukka Local Government Area of Enugu State, Nigeria.*

KEYWORDS: Autonomy, Reproductive Decisions, Reproductive Health, Reproduction Rights, Married Women, Family Planning, Contraceptives.

INTRODUCTION

Autonomy is the ability to obtain information and make decisions about one's own concerns (Dyson & Moore, 1983). Women's autonomy in reproductive decision making is extremely important for better maternal and child health outcomes and as an indicator of women's empowerment (Dyson & Moore, 1983). The process of decision making on the place to seek care during pregnancy/childbirth and decision on the use of contraceptives for family planning purposes are the basic reproductive decisions that may reflect the presence of women's autonomy or lack of it. It is important for couples to decide on the number of children they want to have as well as spacing but the final decision should be left for the women as they bear the burden of reproduction.

In sub-Saharan Africa, gender roles and norms are particularly salient, shaping spousal communication and subsequent family planning decision-making in significant ways. Although

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contraceptive methods and services are frequently geared towards women, men are often the primary decision makers in family size and their partners; use of family planning methods (Nzioka, 2002; Oyediran & Isiugo – Abanihe, 2002; Soldan, 2004). In addition, spousal disagreement may serve as a deterrent because women might fear initiating a difficult conversation about family planning (Biddlecom & Fapohunda, 1998).

Onah, Ezamah, and Ugwu (2003), identified that the major health problems women experience in Enugu State, Nigeria, are mainly pregnancy related. The maternal mortality ratio in Nigeria during the seven-year period preceding the 2008 National Demographic Health Survey (NDHS) was estimated at 545 maternal deaths per 100,000 live births. Out of estimated 30 million women of reproductive ages in Nigeria, four in fifteen may die due to causes related to pregnancy (National Population Commission [NPC] & International Children's Fund Macro [ICF Macro], 2009). Adverse pregnancy/childbirth outcomes are often ignored in patriarchal societies because majority of women due to the quest for a male child tend to be pronatalist in nature. Moreover, it is perceived that marriage and child bearing provide social status and respect for women in Nigeria as in other African countries (Karanja, 1987; Osakwe, Madunagu & Usman, 1995). In fact, procreation is perceived as the major role of Igbo women in Nigeria (Amadiume, 1987).

The socialization process makes Nigerian men influential and dominant in all spheres of life, giving them the final say on various family issues. They are at the centre of decision-making in domestic and reproductive health matters. This is portrayed in a study carried out by Ezumah and Oreh (1999) in Obukpa, Nsukka Local Government Area of Enugu State, Nigeria. They reported that patronage of Traditional Birth Attendants was because some women were compelled by their husbands to have their babies at home as was the custom. Moreover, some of the respondents indicated that their husbands felt that going to the hospitals would result to a waste of scarce resources which would be used to meet other pressing matters.

Gender inequality in reproductive decision making is a key element of the social context of pregnancy and the use of contraceptives (Bankole & Singh, 1998). When this discordance occurs in a situation of male authority, men's opinions about these issues may overrule women's even though the women often implement the decisions made on these matters. In some cases, husbands fear that if they approve of family planning and follow their wives to use it, they will lose their role as head of the family, their wives may be unfaithful, or they may lose face in their community (Watkins, Rutenberg & Wilkinson, 1997). Therefore, decision making on the use of contraceptives for family planning, often requires spousal discussion and partner's approval. These are significant in inducing a woman to use modern contraceptives as determinants of spousal communication are varied and complex (Kang, O'Donnell & Sparks, 2010).

Although much of the available literature assumes that financial cost is the primary factor inhibiting contraceptive use various studies around the world suggest that fear of side effect of family planning is more influential in decision-making (Campbel, Nuriye & Makolm, 2006; Sedgh, Rubina, Akinrionola & Susheela, 2007). It is estimated that 59% of unintended pregnancies could be eliminated if method-related reasons for non-use were overcome, and fear of side effects is the most commonly cited reason for such non-use (Darroch, Golda & Haley, 2011).

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Reproductive autonomy manifests when women are fully aware and encouraged to realize their reproductive rights. Reproductive rights was defined in the Beijing Platform for Action (BPFA) (1995), and the International Conference on Population Development (ICPD) (2004), document as "certain human rights recognized in the national and international legend and human rights documents including the basic rights of all couples and individuals to decide freely and responsibly, the number and spacing of their children and to have the information, education, and means to do so, the right to attain the highest standard of sexual and reproductive health, the right to make decisions concerning reproduction free of-discrimination, coercion, and violence". Reproductive right is therefore internationally accepted and is expected to be realized in reproductive health. Reproductive health is a state of complete physical, mental, and social well being and not merely the absence of reproductive disease or infirmity. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide of, when, and how often to do so (ICPD, 2003). Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

McDonald (1996) observed that reproductive health decision making process cannot be properly comprehended if they are examined in the abstract since reproductive health decisions are usually taken in well-defined social and cultural context. It is also observed that crucial aspects of such socio-cultural context are rarely captured in traditional quantitative approach (Dixon – Mueller & Germain, 2000). Therefore, it is against this background that the study adopted both a quantitative and qualitative approaches in examining the socio-cultural factors affecting the autonomy of reproductive decisions of married women in Nuskka L.G.A. The objective of the study was therefore to identify social and cultural factors that impede the autonomy of married women in Nsukka L.G.A; in three vital areas of reproductive decision making decision on the number of children to have in the family as well as spacing, decision on the place to seek care during pregnancy/childbirth, and decision on the use of contraceptives for family planning purposes.

THEORETICAL FRAMEWORK

The empowerment theory formed the theoretical framework for this study. Mark Nogales is regarded as the proponent of this theory (Miley, O'Melia & Dubois, 2001). The empowerment theory best explained the existence of some underlying socio-cultural factors affecting married women's autonomy in reproductive decisions. Empowering women through information on adverse results of frequent pregnancy/childbirth, the essence of seeking appropriate health care during pregnancy/childbirth and the use of contraceptives for family planning purposes are very crucial in addressing the socio-cultural factors affecting married women's autonomy in reproductive decisions. The quest for women's empowerment is not tailored to achieve a reverse discrimination against men but is a challenge to patriarchal relations which encourage men's traditional control in decision making over women particularly over the women of their households (Batliwala, 1994).

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METHODOLOGY

The materials used in this article are derived from an empirical study conducted at Obukpa in Nsukka Local Government Area of Enugu State, Nigeria. Nsukka L.G.A Lies between latitudes $6^0 45^1$ and $7^0 00^1$N and longitudes 7^0 15^1 and 7^0 34^E of the Greenwich Meridian. The mean temperature falls between 27^0c and 28^0c. Both quantitative survey and qualitative methods were used for data collection. Purposive sampling procedure was adopted in the selection of respondents. Out of the sixteen (16) towns in Nuskka L.G.A, one was selected; that is Obukpa town. Obukpa is located in the University of Nigeria environs and is therefore considered to be semi-urban. The quantitative survey method entailed the use of questionnaire, while the instruments used for the qualitative methods were in-depth interviews and focus group discussions. The questionnaire was used to obtain information from married women as well as married men because the opinions of men are important in issues of reproduction. Information was obtained from thirty-seven (37) married women (25 years+) and eighteen (18) married men (25 years +). The respondents for the in-depth interview were purposively selected; one community leader and one key opinion leader were selected. Information was also obtained from married women (31 years +) and married men (31 years +) using the focus group discussion. The overall number of respondents for the FGD was twenty four (24), consisting of twelve (12) respondents from each category of married women and married men. Statistical Package for the Social Sciences (SPSS) was used for analysis of quantitative data. Analysis of qualitative data was done using notes taken during the interviews and transcriptions from tapes recorded during the sessions.

RESULTS

Decision making on fertility patterns:

The study examined decision making patterns of the family on the number of children to have as well as spacing among the Obukpa of Nsukka L.G.A. of Enugu State, Nigeria. The view of 75% married male respondents was that this type of decision should be done jointly. Among married female respondents, 68% said that such decisions should be made by their husbands. The major reasons for the response given by married males was that such issues should be discussed together in order to avoid any misunderstanding. Married female respondents indicated that their husbands should make the decision as they are heads of their families. From the qualitative data (both IDIs and FGDs) majority of married male respondents indicated that decision making concerning the number of children to have in the family as well as spacing should be done jointly. This opinion corresponded with the opinions of married male respondents in the quantitative data but their reasons differed. The major reason given by married male respondents in the qualitative data was that "women should never make such decisions alone". The implication is that women have no stake in deciding on the number of children to have in the family as well as spacing.

According to an Obukpa community leader:

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> "A woman should not decide on the number of children to have in her husband's house because she does not have right to do so"… (IDI Respondent; Community Leader; Married Male; FSLC; 92 yrs).

A participant in the FGD for married men commented thus:

> "A married woman should always seek her husband's opinion before embarking on anything in her husband's house they should always discuss issues together. A married woman should never decide on the number of children to have alone. It is an abomination…." (FGD Respondent: Married Male; NCE: 46YRS).

Majority of the married female respondents from the qualitative data indicated that decision making on the number of children to have in the family as well as their spacing is the sole decision of the husband. This opinion given by married female respondents also corresponded with that given by married female respondents in the quantitative data.

A female opinion leader commented thus:

"What is a woman doing in her husband's house if not to bear children? The woman should be praying to have children and as many as possible. She should never participate in the decision on the number of spacing of her children because she is not marrying herself" (IDI Respondent; Married Female FSLC; 86yrs).

However a female FGD participant mentioned that women sometimes covertly use manipulation to achieve their desired number of children. She commented thus:

"The only way a woman's decision concerning child bearing will succeed is by tricking her husband. For example, my husband said we will have only two children. After the second child, I decided to have a third one. I tricked him into having sex with me without a condom on his birthday. Luckily for me, I conceived but paid my way through antenatal and hospital bills… " (FGD Respondents; Married Female; First Degree; 43yrs).

Decision Making on the Place a Woman should Seek Care during Pregnancy/Childbirth:

The study examined how married men and women make decisions on where a woman should seek care during pregnancy/childbirth. Among the married male respondents, 76% indicated that a woman should make the decision on the place she would like to seek care during pregnancy/childbirth. On the other hand, 68% of the married female respondents said that such decision should be done jointly. However, the reason male respondents indicated that decision on the place a woman should seek care during pregnancy/childbirth should be done by the woman herself may actually be due to the fact that males might think that where a woman goes to seek care during pregnancy/childbirth is supposed to be a woman's issue; which may be because of their lack of understanding about male responsibility in reproductive health.

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A majority of both married female and married male participants in both IDIs and FGDs indicated that decision making concerning the place a woman should seek care during pregnancy/childbirth should be done jointly and that a woman should never make sole decisions on such issues. The reasons adduced are that: (a) culture demands that women should not make sole decisions in the family; but should always discuss matters with their husbands, (b) respect, demands that a married woman should always inform and discuss the place to seek care with her husband, (c) women who make sole decisions in the family are often regarded as ill behaved women, (d) joint decisions help women; as their husbands would be compelled to assume responsibility in case they encounter problems at the place of care.

According to an Obukpa community leader in an IDI:

> "A woman should not decide on the hospital to attend in her husband's house because she does not own herself …. " (IDI Respondent; Male Community Leader; FSLC; 92yrs).

In the same vein a male FGD participant said that:

> "A woman who makes decisions in the family is a bad woman. She is not worthy to be called a "Mrs"…." (FGD Respondent; Married Male; First Degree; 52yrs).

A female IDI respondent in support of joint decision making concerning the place a woman should seek care during pregnancy/childbirth said that:

> "There should be joint decision on the issue of decision making on the place a woman seeks care. Consulting her husband is also a sign of respect" (IDI Respondent; Married Female; Opinion Leader; FSLC; 86yres).

Similarly, a female FGD respondent opined that:

> "No matter how important a married woman is, she is under her husband and should not make the decision of going to register for antenatal alone. She should never do that without the knowledge of her husband" (FGD Respondent; Married Female; OND; 48YRS).

Decision on the use of contraceptives for family planning purposes:

The study examined the extent married couples use contraceptives for family planning. It was found that 75% of married females do not use any form of contraceptive for family planning purposes. Their reasons for non-use of contraceptives are that: (a) it is against their belief, (b) it has side effects, and (c) that married couples do not need contraceptives (The later response implies that they perceive that contraceptive is meant for singles). Majority of married male respondents

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(66%) do not use any form of contraceptive for family planning. Their reason of non-use of contraceptives is that it is not necessary as they give their wives space when they are in their unsafe periods.

The qualitative data show that majority of both male and female respondents indicated that they did not use contraceptives for family planning purposes. Their reasons for non-use of contraceptives are that: (a) contraceptive use is not culturally acceptable, (b) children are fights from God and so child bearing should be the sole decision of God, (c) the use of contraceptives by married couples is a taboo, and (d) that contraceptives are not good because they have side effects.

This position of non-acceptance of the use of contraceptives is variously expressed as follows:

> "Contraceptive is not good at all. We used natural spacing method instead of contraceptives. Married couples should not use contraceptives to stop child bearing or space children" (IDI Respondent; Community Leader; Married Male; FSLC; 92yrs).

> "A married couple using contraceptives to regulate childbearing is a taboo and it can even affect a woman's body system" (FGD Respondent; Married Female; OND; 49yrs).

> "I have never used contraceptives with my husband. My husband will not even like to use it because married people should not use it. I have also soon a woman that used contraceptives (the pill) and she started bleeding and even got extremely fat" (FGD Respondent; Married Female; OND; 34yrs).

> "Women should allow God to decide on the number of children they will have. He is the one that gives children" (FGD Respondent; Married Male; NCE; 48yrs).

- **Discussion of Findings:**

The discussion focuses on the major findings of the study in relation to three themes namely: decision-making on number and spacing of children, decision-making on the place a woman should seek care during pregnancy/childbirth, and decision-making on the use of contraceptives for family planning.

- **Decision-making on number and spacing of children:**

United Nations and World Bank (2010) report revealed that 144 women die in Nigeria everyday from pregnancy and childbirth complications. Onah, Ezumah and Ugwu (2003), identified that the

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major health problems women experience in Enugu State are mainly pregnancy related. The traditional gender roles and seemingly low status of women often constrain their ability to regulate their fertility (Ankrah, 1994). In Obukpa, Enugu State, Nigeria, women do not have autonomy in deciding the number of children to have in the family as well as spacing, but in most cases, women may get pregnant frequently in order to have many children who would grow up and provide for them. Again, in patriarchal societies, majority of women due to the quest for a male child who would be the heir to his father, tend to be pronatalist in nature in search of a male child. Moreover, marriage and child bearing provide social status and respect for women in Nigeria as in other Africa countries (Karanja, 1987; Osakwe, Madunagu & Usman, 1995). In fact, procreation is perceived as the major role of Igbo women in Nigeria (Amadiume, 1987).

There is no where the culture of male control and supremacy is better felt than in the home. The patriarchal traditional system confers on men a superior position in the family decision-making process (Aina, Adewuyi & Adesina, 2002). In most cases, husbands decide on when to have sex with their wives, the number of children to have sex with their wives, and other reproductive experiences (Orubuloye, Caldwell, P. & Caldwell, C, 1992). A baseline study done in South Eastern Nigeria confirmed the primacy of male supremacy in homes. Wives generally reported that husbands have over riding decision-making power on issues relating to their health. Fourteen (14) out of the eighteen (18) focus group discussions recorded the opinion that "wives cannot decide the number of children to have", while four FGDs remarked that "men have the last say" in matters relating to women's sexuality. In fact, eleven (11) FGDs commented that "only free women (prostitutes) have total control on sexuality matters" (Aina, Adewuyi, Adesina & Adeyemi, 2003).

Information collected in a qualitative research (Focus Group Discussion) with men and women from the three dominant ethnic groups in Nigeria on the societal norm regarding decision on the number of children showed that majority believe that the husbands have absolute say as the head of the household. Some believe that it should be a joint decision of the partners while a few think the decision should be taken by the woman. The last group premises their opinion on the fact that it is the woman that goes through all the pains and suffering of giving birth. The first response came more form the North, South-East and South-West (Ibisomi & Odimegwu, 2011).

- **Decision making on the place a woman should seek care during pregnancy/Childbirth:**

Men have a potentially positive role to play in the health-seeking behaviour of their wives, and in cases where decisions are made jointly; men usually have the final say. The Obukpa people of Nsukka Local Government Area of Enugu State believe that pregnancy is not a disease condition (Ezumah & Oreh, 1999). This might explain the seemingly non-chalant attitude displayed by men in the quantitative data from the study. In the study, 76% of the males indicated that decision making on the place a woman should seek care during pregnancy/childbirth should be done by the woman herself. However, the reason male respondents indicated that decision on the place a woman should seek care during pregnancy/childbirth should be done by the woman herself may actually be due to the fact that males might think that where a woman goes to seek care during

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pregnancy/childbirth is supposed to be a woman's issue; which may be because of their lack of understanding about male responsibility in reproductive health.

In the qualitative data, married women said that such decisions on where a woman seeks care during pregnancy/childbirth should be done jointly and that women should never make sole decisions. Their comments showed that men have the final say and women do not have autonomy in decision-making in the family. This result buttresses the result of an earlier study in Obukpa (Ezumah & Oreh, 1999), where 80.6% of the women reported that they had been delivered by traditional birth attendants because their husbands insisted that they would be best handled by TBAS because their own mothers delivered them safely through those means. It may therefore be due to such perceptions that many of the men regard attendance to antenatal clinics as un-important and as a mere waste of scarce resources.

It has been opined that education is a major determinant of women's status and autonomy (Woldemicael & Tenkorang, 2010). Again, the result from a study done in a North Indian city showed that education was positively associated with all factors related with women's autonomy but it gains strong significance with the autonomy of freedom in mobility like going to seek health care during pregnancy/childbirth (Bloom et al, 2011). This study refutes the above literature because even the educated married women in Obukpa, Nsukka L.G.A. of Enugu State do not have autonomy in deciding on where to seek care during pregnancy childbirth.

- **Decision on the use of contraceptives for family planning:**

It has been documented that because men tend to be pronatalist, they contribute immensely to low contraceptive prevalence in Sub-Saharan Africa (Adewuyi, 1999; Biddlecome & Fapohunda, 1998).

Although a study done among the Ogu of Southwestern Nigeria by Onipede and Isiugo-AbaniHe (2003), revealed that the views of participants in the FGDs were contrary to the position of Adewuyi (1999) and Biddlecome and Fapohunda (1998). The majority in all the groups agreed that men do not oppose contraceptive use; rather they frown at not involving them. The majority of the respondents opined that women usually favour a larger family size than men. It is argued that because women usually favour this idea, they fail to avail themselves of the opportunities to control the number of children they have. Hence, the persistence of high ferity in the society is not due to male pronatalism but due to that of females.

The above views call for reflection because majority of both the married male respondents and the married female respondents in this study do not use contraceptives for family planning puroposes. This entails that the study can be said to support the views of men being pronatlist in nature and also women being pronalist; maybe due to some cogent reasons like absence of a male-child in the family. Since married men in Obukpa, Nsukka Local Government Area of Enugu State do not use contraceptives for family planning purposes; married women invariably may not have autonomy or even discuss family planning with their husbands. Any woman who wants to make use of the services of family planners must do it secretly to avoid repercussions.

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CONCLUSION

Men play an important role as heads of households, they are custodians of the interests of their lineage, protectors and providers of their families, and they are, therefore, the ones who make the majority of decisions pertaining to family life and the society in general (Isiugo–Abanihe, 1994). Therefore, deliberate efforts should be made towards empowering women autonomy in reproductive matters. Women are the ones who occupy a fragile position in issues of reproduction and encounter negative consequences on their reproductive health outcomes.

Men should also benefit in the empowerment process through enlightenment. This will help them (men) realize and understand why women's autonomy should be supported in matters of reproduction. Without involving men; the process of empowering women might be thwarted.

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