# CULTURAL PATTERNS OF CONTRACEPTIVE USAGE AMONG RURAL WOMEN IN URHOBO LAND, NIGERIA

**BY**

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***SUMMARY***

*The study examined the cultural patterns of contraceptive usage among rural women in Urhoboland, Nigeria. The basic objectives of the study were to find out the traditional methods of contraceptive, the reasons for the use or non-use of the methods, the barriers to modern contraceptive usage and the likely effects of contraceptive practice on rural women in Urhoboland. The study was a descriptive cross sectional study, using multi-stage sampling procedure. The Health Belief model provided a guide to the study. The study revealed that the older women of age bracket 30-41 use contraceptive than the younger age bracket and the basic reason given was to limit family size. The commonest traditional contraceptives were waist band, ring, gin concoctions, abstinence from sex after last birth as well as prolonged breast feeding. There is high misconception by the women on modern contraceptive method mainly due to perceived side effects and opposition by their husbands. The paper argued that there is need for sexuality and sex education among the rural women to disabuse their minds on the misconception of modern methods of contraception and mass campaign by the State and Federal Ministries of Health on control of family size.*

## INTRODUCTION

Nigeria is regarded as the most populous country in Africa. The majority of this population live in the rural areas. According to 2006 Population Census, Nigeria had a population figure of 140 million and it showed that men are more than the women (NPC, 2006). If we go by the annual growth rate of 2.5% by the United Nations, the population of Nigeria would hit 180 million by 2016. According to NPC (2006) fertility rate in Nigeria is 5.7 children by women and fertility in rural areas is three times higher than that of urban areas due to socio-economic reasons. Similarly, the Nigeria Fertility Survey reported completed fertility of 5.84 children ever born for all women and 5.85 children for currently married women (World Population, 1996). The Nigerian Demographic Health Survey in 1981/1982 showed that contraceptive knowledge and use increased. While 6% were currently using a method, 45.7% of the women did not know any method and only 3.1% were using modern methods. However, the Nigerian

Demographic Survey (2008) put the contraceptive prevalence rate of women between 15 – 49 years to 14.6%, but by 1999 the prevalence rate increased to 15.3%.

In their study of a rural community in Osun State, Olugbenga – Bello ,Abodunrin and Adeomi (2014) reported that there is high prevalence rate of contraceptive usage of 66.3% by women and they attributed this to cost and availability factors. But Ugal and Ushie (2012) pointed out that there is low knowledge of contraceptive use among women in Ogoja and Obudu Local Government Areas of Cross Rivers State in both the rural and urban areas. Otiode, Oronsaye and Okonofua (2001) found out that both men and women in Nigeria displayed misconceptions and negative attitude towards family planning via contraceptive.

The practice of contraceptive by women is limited in some parts of the world. For instance, Fakeye (1989) in his study of family planning in Ilorin attributed the non-use of family planning to cultural barriers and taboos. The National Population Commission (2004) listed the reasons for non-use of family planning in Nigeria to include women's perceived lack of need for contraception, fear of side effects and opposition to contraception on personal or religious grounds. In similar vein, in Swaziland, Ziyami, Ehlers and King (2003) conducted a study on the socio-cultural deterrents to family planning practices among the women. The study revealed that cultural practices such as bride price (Lobola), religious beliefs, gender issues, health care practices and marital status such that single women use contraceptive and married women do not constitute main barriers to the use of contraceptive among Swazi women. Asiimwe, Ndugga and Mushomi (2013) found out that the main factors associated with contraception in Uganda include women age, education and socio-economic status. Using two groups of 15 – 24 and 25 – 34 years, they concluded that level of modern contraceptive use is much lower among younger women compared with older women.

The above scenario is an indication that use of contraceptive is common not only in Nigeria but also in other African nations for as Osemwenkha (2004) noted traditional contraception is widely used in Southern Nigeria, but that modern contraception is a recent phenomenon. He emphasized that contraceptive use has the power to reduce fertility and ultimately reduce maternal and child health issues. In Nigeria, different cultural practices are carried out to prevent pregnancy. For example, among the Yoruba of South-West Nigeria, waist beads are used for birth control as the beads are often laced with charms and worn by women to prevent contraception (Olade, 2009). Similarly, Oyebola noted that among the Yoruba, contraceptive methods involve medicinal ring, medicinal waist band, scarifications, medicinal soup, medicinal soap, concoctions, Ako and Argunmun. This present study is therefore another contribution to the discourse on the use of contraceptive by women in rural areas of Nigeria with Urhoboland as focal point.

## AREA OF STUDY

The territory of the Urhobo speaking people is located in the central part of the present day Delta State, Nigeria. It is the sixth largest ethnic group in Nigeria ( Erivwo,2007).They share common boundaries with the Bini, Itsekiri, Izon(Ijaw), Isoko and Ukwuani speaking people. The Urhobo people live in a territory bounded by Latitudes $6^0$ and $5^0$ $15^1$ North and Longitudes $5^0$ $40^1$ and 60 $25^1$ East (Onokerhoraye, 1995:6). There are twenty-two autonomous Urhobo communities otherwise known as clans or polities (Otite, 1980). These clans now assume the appellation of kingdoms in the light of political changes in the socio-political landscape (Odivwri, 2008). Today, there are twenty-four kingdoms in Urhoboland. These are Agbon, Agbarho, Agbarha, Arhavwarien, Agbarha-Warri, Evwreni, Ewu, Orogun, Oruarivie-Abraka, Umiaghwa-Abraka, Ughelli, Idjerhe, Okpe, Olomu, Okparabe, Udu, Uwheru, Ughievwen, Uvwie, Effurun- Otor, Ogor, Okere, Mosogar and Oghara (UPU, 2013).

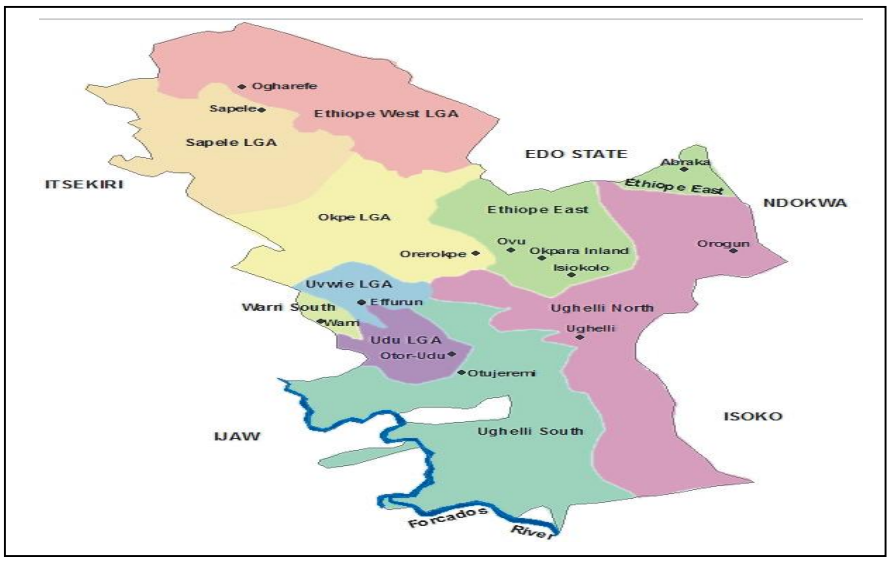


**Fig. 1 Urhoboland and its Local Government Areas in Delta State (After Odemerho. F. 2008)**

## OBJECTIVES OF THE STUDY

The general objective of the study was to examine the cultural patterns of contraceptive usage among rural women in Urhoboland. However, the specific objectives were

1. To find out the traditional methods of contraceptive in use among rural women in Urhoboland,
2. To find out the reasons for the use of traditional contraceptive and the reasons for the non-use among rural women in Urhoboland;
3. To examine the extent of barriers to modern contraceptive use by rural women in Urhoboland and
4. To analyse the likely effects of traditional contraceptive use among the rural women in Urhoboland.

## METHODOLOGY

The study was conducted in Ten (10) kingdoms out of the twenty-four (24) kingdoms that make up Urhoboland between June 2014 and March 2015. Total samples of 185 respondents were interviewed. The study adopted the cross-sectional survey using the multi-stage sampling procedures to sample the respondents. Pre-coded questionnaires labelled 'Contraceptive Questionnaire Focus (CQF)' was designed and distributed to respondents by the author and his research assistants. The data gathered from the field were analysed using SPSS version 14.

## THEORETICAL FRAMEWORK

The theory that provided a guide to the study is the Health Belief Model. The Health Belief Model (HBM) is a psychological model that attempts to explain and predict health behaviour. It was developed by Rosenstock in 1966 and later improved upon by Becker in 1974. Rosenstock perception was based on four constructs; namely perceived susceptibility, perceived severity, perceived barriers and perceived benefits. A filth one which is cues to action (external influences promoting the desired behaviour) was later added by Rosenstock and others in 1988.

According to this theory, an individual perception of seriousness of a health risk, the barriers and benefits are likely to affect preventive actions. The theory looks at the benefits and the way an individual can make changes in the face of health risk such as HIV/AIDS, termination of pregnancy, contraceptive etc. Thus, the focus is on the attitude and beliefs of individuals towards determining health related actions. The Health Belief Model is a framework for motivating people to take positive health action that uses the desire to avoid negative health consequences as the prime motivation. The model was used for the study because it is capable of motivating the rural women into accepting modern contraceptive methods without disastrous consequences which they see in the traditional methods. This is in line with Herold (2009) postulation that Health Belief Model can be applied to family planning in general and in particular to the use of non-use of contraception among sexually active young females.

## RESULTS

A total of 185 women were sampled. The socio-demographic characteristics of the respondents are presented in Table 1. The mean age of the respondents was 34.4 with the Standard Deviation of 8.3. Most of the respondents were 34 years and above. 24.3% of the respondents fall within the age bracket of 34 – 37 years; 27.6% within age range of 38 – 41 years while 8.6% of the respondents fall within the age range of 42 years and above. 33.5% of the respondents were married while 20.5% of the respondents were single. Divorcees constitute 18.9%, widowed 13% while separated and cohabiting were 6.5% and 7.6% respectively. In terms of education, only 25.4% of the respondents have no formal education. On the other hand, 12.9% of the respondents have secondary education whereas 15.1% of the respondents have only primary education. For family setting of the respondents, 57.3% of them were from

polygamous background while 42.7% of the respondents were from monogamous background.

**Table 1: SOCIO-DEMOGRAPHIC HARACTERISTICS OF THE RESPONDENTS BY AGE, MARITAL STATUS, EDUCATION, OCCUPATION AND FAMILY SETTING**

**(N = 185)**

| **Age Group** | **F** | **%** |
|---|---|---|
| 18 – 21 | 6 | 3.2 |
| 22 – 25 | 14 | 7.6 |
| 26 – 29 | 15 | 8.1 |
| 30 – 33 | 38 | 20.5 |
| 34 – 37 | 45 | 24.3 |
| 38 – 41 | 51 | 27.6 |
| 42 and above | 16 | 8.6 |
| | | |
| **Marital Status** | **F** | **%** |
| Single | 38 | 20.5 |
| Married | 62 | 33.5 |
| Divorced | 35 | 18.9 |
| Widowed | 24 | 13 |
| Separated | 12 | 6.5 |
| Cohabiting | 14 | 7.6 |
| | | |
| **Education** | **F** | **%** |
| No Formal Education | 56 | 46.6 |
| Primary School | 28 | 15.1 |
| Secondary School | 24 | 12.9 |
| Tertiary Education | 47 | 25.4 |
| | | |
| **Occupation** | **F** | **%** |
| Farming | 49 | 26.5 |
| Trading | 41 | 22.2 |
| Civil Servant | 24 | 13 |
| Teaching | 22 | 11.9 |
| House Wife | 32 | 17.3 |
| Others | 17 | 9.1 |
| | | |
| **Family Setting** | **F** | **%** |

| | | |
|---|---|---|
| Monogamy | 79 | 42.7 |
| Polygamy | 109 | 57.3 |

**Table 2: COMMON CONTRACEPTIVE METHODS USED BY THE WOMEN**

| Method | F | % |
|---|---|---|
| Prolonged Breast Feeding | 48 | 25.9 |
| Long Abstinence from Sex After Child Birth | 34 | 18.2 |
| Ring (Isa) | 15 | 8.3 |
| Padlock | 9 | 4.8 |
| Waist band (Idaji) | 31 | 17.2 |
| Armlet | 11 | 5.8 |
| Local Gin Concoctions | 37 | 20 |
| **Total** | **185** | **100** |

Table 2 indicates that 25.9% of the respondents make use of prolonged breast feeding method; 20% of the respondents use local gin concoctions; 18.2% practise abstinence from sex whereas 17.2% of the respondents wear waist bands and 8.1% of the respondents wear rings in hands. The commonest methods which can be regarded as traditional are drinking of local gin concoctions, wearing of ring, waist band and padlock.

Table 3 shows the reasons for contraceptive usage. The main reasons adduced by respondents for contraceptive practices are for child spacing and for prevention of unwanted pregnancy; 44.3% of the respondents gave prevention of unwanted pregnancy while 27.6% of the respondents gave child spacing as their reason. In the same vein, 20.5% and 7.6% of the respondents gave reduction of family size and health reasons respectively for the practices of contraception.

**Table 3: REASONS FOR CONTRACEPTIVE USE BY WOMEN**

| Reason | F | % |
|---|---|---|
| To Prevent Unwanted Pregnancy | 82 | 44.3 |
| For Child Spacing | 51 | 27.6 |
| To Reduce Family Size | 38 | 20.5 |
| To be Wealthier | 14 | 7.6 |

| | | |
|---|---|---|
| **Total** | **185** | **100** |

**Table 4: DECISION ON CHOICE OF CONTRACEPTIVE USE**

| Decider | F | % |
|---|---|---|
| Husband | 101 | 54.6 |
| Wife | 26 | 14.1 |
| Both | 58 | 31.3 |
| **Total** | **185** | **100** |

Table 4 indicates that it is the husband who is the major decider on whether to use contraceptive and the method (54.6%) and this is followed by an agreement by both the wife and husband 31.3% while 14.1% of the respondents indicated that the wife takes the decision.

**Table 5: READINESS OF USE MODERN CONTRACEPTIVE**

| Readiness | F | % |
|---|---|---|
| YES | 44 | 23.8 |
| NO | 141 | 76.2 |
| **Total** | **185** | **100** |

Table 5 and Table 6 show the number of respondents who were not ready to adopt modern contraceptive method and their reasons. Most of the respondents n = 141 (76.2%) are averse to use of modern contraceptive. The reasons adduced by the respondents range from high cost (39.7%); fear of effects on health (14.2%); opposition by husband (27%) to difficulty in getting modern contraceptive which constitute 19.1% of the total respondents.

**Table 6: REASONS FOR NON-READINESS FOR USE OF MODERN CONTRACEPTIVES**

| Reasons | F | % |
|---|---|---|
| High Cost | 56 | 39.7 |
| Fear of Effects on Health | 20 | 14.2 |
| Opposition by Husband | 38 | 27 |
| Difficulty of Getting Them | 27 | 19.1 |
| **Total** | **141** | **100** |

## DISCUSSIONS

Rural women in Urhoboland are aware of modern methods of contraceptives, but they have high preference for the traditional methods. The reasons adduced included the issue of high cost, the difficulties involved in procuring the drugs, the fear of aftermath of use and in some cases opposition by their husbands. From the study, the commonest traditional methods of contraceptive are the use of waist bands, rings, local gin concoctions, prolonged child breast feeding and abstinence from sex after

the last child birth. All these have little cost in acquisition and easily available from local traditional medicine dealers or doctors. This collaborated the result of earlier study conducted by Olugbenga – Bello, Abodunrin and Adeomi (2011) among women in rural communities in South-West Nigeria in which they identified traditional methods in practice to include armlet, ring, padlock and waist band.

Although the idea of contraceptive use is well known to the rural women in the study area, there is no much enthusiasm in usage by them. Those who use the identified methods do so to prevent unwanted pregnancy, for child spacing, to reduce family size as well as to look healthier. To this end, local gin concoctions are easily available which are taken early in the morning and in the evening before going to bed.

The study revealed direct relationship between level of education and traditional methods of contraception. Those with no formal education among the women constitute the larger users of traditional methods, about 46.6%. While those that are literate are fewer. Therefore, their level of education tends to dictate their desire to embrace the cultural patterns of contraception. Similarly, the younger married women and older married women in the study area are less prone to local contraceptive but a greater number of respondents fall within the age bracket of 30 – 41 years.

## CONCLUSION

The study showed that there is high knowledge of cultural patterns of contraception among rural women in Urhoboland. The basic reasons for use are to reduce family size and prevent unwanted pregnancy but from the interview held this has not reduced the family size, for many of the rural women studied have average of six (6) children. There are cases of 10 or 12 children per woman. On the other hand, those who oppose modern methods of contraception do so on ground of high cost, fear of likely effects and strong opposition by husbands. The attitude of rural women in the area towards local contraception is positive while it is negative for method contraception as clearly pointed out elsewhere in the paper. It is a cultural taboo among the Urhobo people for a woman to terminate a pregnancy. Instead traditional contraceptives are approved. The health belief model explained earlier is therefore applicable to the behaviour of rural women on attitude towards both traditional and modern contraceptives methods. However, because of increasing level of education and health facilities, the cultural patterns of contraceptive usage in Urhoboland are gradually giving way to modern methods such as use of condom and injection, particularly among the educated women.

## RECOMMENDATION

Based on the findings, it is therefore recommended that the State and Federal Ministries of Health should embark on enlightenment campaign on the need to reduce family size by embracing modern methods of contraception rather than relying on the traditional methods which may record high failure rate. Sexuality and sex education of women should be done by the relevant government agencies and to disabuse the

mind of rural women on use of modern contraceptive. Religious and traditional rulers should be involved in educating the rural women on the need to adopt modern contraception.

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