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# Misconceptions and Spousal Communication about Family Planning among Women of a Rural Community in Ekiti State, Nigeria

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## Abstract

**Purpose:** Communication between the spouse on family planning issues predisposes to the approval of the man for the wife to use contraceptives. Most don't even initiate communication as a result of misconceptions surrounding family planning. This study examined how misconception and spousal communication affect the use of family planning.

**Methods:** The study was a cross sectional study carried out in a rural community. Multistage sampling technique was used in selecting 464 women of reproductive age group. A semi-structured questionnaire was used to collect information from the participants by trained research assistants. Data was entered into SPSS version 25 and analysis was carried out. Univariate analysis was done using mean, and tables, bivariate analysis was done using chi square and level of significance was set at $p < 0.05$.

**Results:** The mean age of the respondents was 32.5 ± 8.1, 110 (23.7%) had ever used contraceptive. Out of the respondents, 150 (32.3%) agreed that family planning can cause infertility and 188 (40.5%) agreed that it makes women gain weight. One hundred and seventy-six (37.9%) had discussed family planning with their husbands out of which 167 (94.9%) got approval from them. Among respondents that discussed family planning with their husband, 66 (37.5%) of them had ever used family planning and those that didn't discussed only 44 (15.3%) ever used contraceptive. This difference is statistically different with p value of $p < 0.05$.

**Unique Contribution to Theory, Policy and Practice:** Spousal communication increases the utilization of family planning therefore; women should be encouraged to discuss with their husbands. This study will contribute to policy on improvement of family planning utilization when married couples are allowed to attend joint session focused on educating couples on the need, benefits and misconceptions surrounding family planning.

**Key words**: *Spousal Communication, Misconceptions, Family Planning, Reproductive Health, Rural Medicine, Nigeria.*

## BACKGROUND

Family planning is one of the greatest public health achievements, it's a cost-effective intervention that impact the live of the woman and her family. [1] Family planning is defined as the practices that help individuals or couples to avoid unwanted births, bring about wanted births, regulate the intervals between pregnancies, control the time at which births occurs in relation to the age of parents and determines the number of children in the family. [2] Family planning programmes provide women with universal access to sexual and reproductive health services and counselling information. Family planning in the lives of women is a way of achieving some of the SDG goals 1, 3, 5, 8 and 10. Additionally, it enhances gender equity and equality for the women. [3]

Freedom of women to determine the number of children and the interval at which the children should come will contribute a great deal to their health, quality of life and who they eventually become in life. [4] Attainment of this freedom appear as a mirage, due to inadequate discussion between women and their partners and a lot of myths and misconceptions surrounding family planning. Some women are not using any contraceptive at all because they believe that their community, religion, family, or partner is not in support of contraceptive use. Some don't use because of misconception about the short and long-time complications they will experience or what they believe that someone had or is experiencing. [5] Fear of the side effects is a great hindering factor to the acceptability of family planning. These side effects include bleeding, headache, weigh gain, delay in conception etc. [6, 7]

It has been documented that husband's approval of contraceptive use is crucial to the woman's utilization, and so also is the communication between the spouse about contraception. [7] There is low rate of contraceptive use in the rural communities promoted by social norms such as early marriage and high fertility. The rural women lack the autonomy to take decision on contraceptive use or even discuss with their husband on the topic due to gender inequality. [8] It has been documented that involving men in family planning counselling increases utilization, clients' satisfaction and continuous use, and there is an association between spousal communication and contraceptive use. [8, 9]

In Sub Saharan African Countries, knowledge of family planning is high with different prevalence depending on geographical location within the country and from one country to the other. The range is from 75% to 95% respectively. [2,10] It has been equally documented that there is adequate access to short-acting contraceptive methods within Nigeria from both non-profit health sector and entrepreneurial profit health sector. [11] In spite of the high knowledge and good access to the family planning commodities the contraceptive utilization prevalence is still very low. [2] The following values had been documented 15.0%, 19.0%, 27.3%,45.0%, and 42.2% for Nigeria, Ghana, Ethiopia, Rwanda, and Malawi respectively. [2, 12]

Unmet need for contraception in women of Sub-Saharan African lead to 19 million unwanted pregnancy, 2 million miscarriages, 5 million abortions, 8 million unplanned births, 255,000 newborn deaths and 555,000 infant deaths. Nigeria Demographic Survey of 2018 gave maternal mortality rate of 512 per 100,000 live births which is one of the highest globally. [1] Neonatal mortality rate in Nigeria was reported to be 36 per 1000 compared with 27 per 1000 live births in Sub Saharan Africa. [13]

If there is knowledge and access to family planning commodities and uptake is poor, then there is need to know what the possible barriers are and how can they be overcome. Increasing the coverage of effective contraceptive use is important to meet the sustainable developmental goal for 2030. [14] To increase the acceptability of family planning by the women, there will be need for their partners to be involve. To achieve this, we need to establish the level of communication and its effect between the spouses and what are the likely misconception that the women of this rural community experience. Hence this study seek to look at misconceptions and spousal communication among rural women of reproductive age group in Southwest, Nigeria.

## METHODOLOGY

### STUDY AREA

The study was conducted in Igbemo Ekiti, a rural town in Irepodun/Ifelodun Local Government Area, Ekiti State. Igbemo has 21 wards and is bounded in the west by Afao, in the north by Ire, in the east by Ikole and in the south by Ijan. The people are predominantly Yoruba and mainly practice Christianity and Islam. The major occupation of Igbemo people is farming and Igbemo is one of the leading producers of rice in South-Western Nigeria.

### STUDY DESIGN

The study design was cross-sectional descriptive in nature.

### STUDY POPULATION

This consisted of females within the reproductive age group (15 to 49 years).

### SAMPLE SIZE DETERMINATION

The sample size was determined using the formula for calculating single proportions by Abramson and Gahlinger. With a normal standard deviation z, set at 1.96, prevalence p, of 33.9% from a previous study, [1] and degree of accuracy d set at 5%, a minimum sample size of 270 was obtained. There was oversampling done on the field resulting in total sample size of 464.

### SAMPLING TECHNIQUE

Multistage sampling technique was used in selecting six wards, streets, houses, and households where eligible respondents were selected by simple random sampling**.**

### DATA COLLECION INSTRUMENT

A semi-structured questionnaire was developed in English language and translated into Yoruba for those that didn't understand English. It elicited information about the socio-demographic characteristics of respondents, attitude (misconception), spousal discussion and practice of family planning. Data was collected by trained research assistants.

## DATA ANALYSIS

Data was analyzed using the Statistical Package for Social Sciences (SPSS) version 20. Univariate variables was presented in form of tables while bivariate variables was resented in form of two-by-two tables. Association between socio-demographic variables and the expected outcome measures (ever use of family planning and spousal discussion) was determined using the Chi-square test. Level of significance was put at p value < 0.05.

## ETHICAL ISSUES

Ethical clearance was obtained from Ekiti State University Teaching Hospital Ethics and Research Committee. The questionnaires were filled anonymously, and confidentiality of information collected was ensured by the researchers.

## RESULTS

Among the respondents, 70.3% of the women were between the age of 20 – 39 years and the mean age was 32.5 ± 8.1, 265 (57.1%) had 0-3 children, 213 (45.9%) had primary education, 167 (36.0%) had no education at all and 101 (21.1%) of their husbands had no education also. Two hundred and eleven (45.5%) were traders, 168 (36.2%) were artisans. Table 1

**Table 1**

*Sociodemographic Characteristics of the Respondents*

| SOCIO-DEMOGRAPHIC VARIABLE | FREQUENCY (n = 464) | PERCENTAGE |
|---|---|---|
| **Age in years** | | |
| 15-19 | 15 | 3.2 |
| 20-29 | 151 | 32.5 |
| 30-39 | 175 | 37.8 |
| 40-49 | 123 | 26.5 |
| Mean Age ± SD | 32.5 ± 8.1years | |
| **Parity** | | |
| 0-3 | 265 | 57.1 |
| 4-6 | 170 | 36.6 |
| 7-9 | 29 | 6.3 |
| **Educational level** | | |
| None | 167 | 36.0 |
| Primary | 213 | 45.9 |
| Secondary | 84 | 18.1 |
| Tertiary | 0 | 0.0 |
| **Spouses' Educational Level** | | |

| | | |
|---|---|---|
| None | 101 | 21.1 |
| Primary | 214 | 46.1 |
| Secondary | 142 | 30.6 |
| Tertiary | 7 | 1.5 |
| **Occupation** | | |
| Trader | 211 | 45.5 |
| Artisan | 168 | 36.2 |
| Farmer | 39 | 8.4 |
| Civil Servant | 46 | 9.9 |

Looking at ever use of contraceptive among the respondents in table 2, 110 (23.7%) had ever used and 354 (76.3%) had never used. Out of those that had never used, 271 (76.6%) didn't use for fear of side effects and 16 (4.5% because their husbands didn't approve of it. Those that discussed family planning with their spouses were 176 (37.9%), out of which 167 (94.9) approved the use of family planning.

**Table 2**

*Ever Use and Spousal Communication of Family Planning among Respondents*

| **Variable** | **Frequency** | **Percentage** |
|---|---|---|
| Has used contraception before | 110 | 23.7 |
| Has never used contraception | 354 | 76.3 |
| Total | 464 | 100.0 |
| **Reasons for not using** | | |
| Fear of side effects | 271 | 76.6 |
| It aids promiscuity | 41 | 11.6 |
| Access is difficult | 26 | 7.3 |
| Husband don't approve | 16 | 4.5 |
| **Ever discussed contraception with your spouse** | **Frequency** | **Percentage** |
| Yes | 176 | 37.9 |
| No | 292 | 62.1 |
| Total | 464 | 100 |
| **Does your spouse approve of FP?** | | |
| **Yes** | 167 | 94.9 |
| No | 9 | 5.1 |
| **Total** | 176 | 100 |

The common misconception agreed upon by women in this study were: it causes bleeding 117 (25.2%), it makes women infertile 150 (32.3%), and it makes women' abdomen fat 188 (40.5%). This is shown in table 3.

**Table 3**

*Attitude (Misconception) to Family Planning*

| Attitudinal Questions | Agree (%) | Disagree (%) | Unsure (%) |
|---|---|---|---|
| FP makes people's abdomen fat (wt. gain) | 188 (40.5) | 96 (20.7) | 180 (38.8) |
| FP makes people infertile | 150 (32.3) | 164 (35.4) | 150 (32.3) |
| FP causes excessive bleeding | 117 (25.2) | 203 (43.8) | 144 (31.0) |
| FP makes people promiscuous | 92 (19.8) | 208 (44.8) | 164 (35.3) |
| FP kills (death) | 20 (4.3) | 18 (3.9) | 426 (91.8) |
| FP causes subsequent abortions | 25 (5.4) | 17 (3.7) | 422 (90.9) |
| I would recommend FP for others | 218 (47.0) | 207 (44.6) | 39 (8.4) |

Table 4 revealed that there was a significant association between spousal communication and ever use of family planning with p value of 0.001.

**Table 4**

*Association between ever use and contraceptive discussion with spouse.*

| Ever use | Spousal Discussion | | Chi square | P value |
|---|---|---|---|---|
| | Yes | No | | |
| Yes | 66 (37.5) | 44 (15.3) | | |
| No | 110 (62.5) | 244 (84.7) | 29.826 | 0.001 |

Table 5 show that women with 0-3, 4-6, 7-9 children, 36.6%, 38.8%, 44.8% of them respectively discussed with their spouse on family planning. This shows that as the number of children increases the tendency to discuss also increases, though this difference is not statistically significant with p value of 0.643. The women with primary education, 26% of them discuss family planning issues with their spouse while 16.7% of those with secondary education did. This different is not significant with p value of 0.182. we couldn't proceed to multivariate analysis since there was no statistically significant association.

**Table 5**

*Association between sociodemographic characteristics and ever use.*

| Variables | Spousal Communication | | Chi square | P value |
|---|---|---|---|---|
| | Yes | No | | |
| Age | | | | |

| | | | | |
|---|---|---|---|---|
| 15 19 | 4 (26.7) | 11 (73.3) | | |
| 20-29 | 59 (39.1) | 92 (60.9) | | |
| 30-39 | 63 (36.0) | 112 (64.0) | | |
| 40-49 | 50 (40.7) | 73 (59.3) | 1.479 | 0.693* |
| Parity | | | | |
| 0-3 | 97 (36.6) | 168 (63.4) | | |
| 4-6 | 66 (38.8) | 104 (61.2) | | |
| 7-9 | 13 (44.8) | 16 (55.2) | 0.842 | 0.643 |
| Educational level | | | | |
| None | 39 (23.4) | 128 (76.6) | | |
| Primary | 57 (26.8) | 156 (73.2) | | |
| Secondary | 14 (16.7) | 70 (83.3) | 3.412 | 0.182 |
| Tertiary | 0 | 0 | | |
| Spouse education | | | | |
| None | 23 (22.8) | 78 (77.2) | | |
| Primary | 52 (24.3) | 162 (75.7) | | |
| Secondary | 32 (22.5) | 110 (77.5) | | |
| Tertiary | 3 (42.9) | 4 (57.1) | 1.440 | 0.696* |
| Occupation | | | | |
| Trader | 48 (22.7) | 163 (77.3) | | |
| Artisan | 45 (26.8) | 123 (73.2) | | |
| Farmer | 9 (23.1) | 30 (76.9) | | |
| Civil servant | 8 (17.4) | 38 (82.6) | 2.011 | 0.570 |

*Fisher's Exact

## DISCUSSION

The mean age of the respondents in this study was like the study conducted in the southern part of the country by Ogbogbodo et al. [1] This is most likely due to the fact that many women get married and bear children around this age group. [1,15] Eight out of ten respondents in this study were illiterate or just with primary education. This may not be farfetched from the reason why the prevalence of ever use of contraceptive is low and much misconceptions like abortion and death that were not so much documented in the previous studies found. Education has been significantly associated with increase in contraceptive prevalence rate. [16] Prevalence of ever use of contraceptive was 23.7% in this study which is far less than what was found 56.2% in another rural community in Lagos State within the same Southwester region. [17]

Contraceptive prevalence rate is still very low and still quite substantial number of women still experience unmet need. Some of the reasons will these persist are because of some perceived misconception by these women of reproductive age group. The following misconceptions were highlighted in this study: weight gain, infertility, bleeding, promiscuity, abortion, and death.

About three out of ten respondents in this study agreed that use of family planning can cause infertility in the women. Similar result was reported by Aniwada et al in Enugu, easter part of the

country. [15] So also, in a study done by Gueye et al in Kenya, Nigeria and Senegal.[5] It has been documented that there is possibility of delay in the normal menstrual cycle for up till a year. [18**]** In some culture and society, women that are infertile are not valued and not worth to be called a woman. This might be why some are saying family planning is associated with infertility. In such society women are not ready to take chance with their fertility at all. **[19]** This misconception can be neutralized by proper education in our communities and adequate training of our health workers.

Four in ten of the respondents in this study agreed that family planning will lead to weight gain in women. This is also corroborated by other studies within and outside the country. [15, 18**]** It has been reported that there is no significant association between weight gain and the use of family planning in a case control study between women using family planning and those not using. Generally, women tend to increase in weigh with pregnancy, breastfeeding and as they get older, because of this people tend to associate family planning with weight gain. [18**]**

Bleeding per vaginal is another misconception that was associated with the use of family planning in the present study. This has been documented in other studies, both qualitative and quantitative study. [18, 20**]** Bleeding was documented equally as a side effect. [14] In most cases most of the perceived misconception were from hearsay from their peers. [20**]** Rural women most likely have their close social network link where the myths and misconception about family planning spread, and they tend to believe these misconceptions from their social network more. [5] Having correct information on the mechanism of the family planning commodities will go a long way in increasing the uptake of family planning. Further research into how these misconceptions is being spread within their social network will help intervention to increase uptake by behavioural change communication. [5]

Promiscuity was another misconception identified in this study. This is equally supported by other studies. [5, 15] Even male partners belief that if their wives are given permission to use family planning, they might be having relationship with other men outside their matrimonial homes without their knowledge. [21] If they allow their wives to use it, it is a sign of weakness on their part and no man wants to be seen as being weak when it comes to his relationship with the wife.

Other misconception found in this study is that family planning can cause abortion and it can lead to death. Other documented misconceptions include headache, backache, birth defect, cancerous growth, reduces sexual urge and its injurious to the uterus. [5, 15] Family planning program should come up with communication initiatives or strategies that will address these social norms.

**Spousal Communication**

Reproductive health is a joint responsibility of the man and the woman, the men's opinion is vital decision making with respect to women's health. This has been supported by many studies. [ 13, 22] To increase acceptance and utilization of modern family planning methods, programmes and intervention should take into cognizant men's participation.

In this present study, about one fifth of the respondents discussed with their spouse on family planning. This is like the result gotten in a rural community in Indian, most likely because this

study was also in a rural community. It has been documented that couples in the rural community discuss less with their spouse on family planning compared with those in the town. [8, 19] Results from other studies shew dissimilarity with our own, Olaniyan et al in Southwestern Nigeria, [23] and Najafi-Sharjabad et al in Malaysia, [9] though the two research were carried out in towns. In the town/city means of livelihood is more expensive so couples need to plan and regulate the number of children and when they would like to have the children. [16, 19]

Couples that discuss family planning had been found to used modern methods of family planning. [24] This study revealed that majority of those that discussed their husbands approved the use of family planning and 38% of them eventually used compared to 15% that used among those that didn't discuss with their husbands. This difference was statistically significant. A similar pattern was documented by Sisay et al in Ethiopia. [25] Some of the factors that hinder communication between spouses on family planning are lack of knowledge on the part of the husband and the influence of the mother-in-law [16, 24]. Family planning majorly is seen as woman issue so program and health workers concentrate on women alone and the men are left out. Behavioural change communication through the mass media can change the narratives [11, 26] Family planning service provider should endeavor to target the couple rather than just the woman because some men may allow their wives to use modern family planning methods if they are educated by health workers rather than their wives due to their ego. [16]

Sometimes engaging the male in meaningful communication by the wife can be difficult because the cultural believe that man is not interested in the discussion or is the man that should decide the number of children since he is the sole prover for the family especially in the rural. [19] The discordant in the number of children desire by the husband and the wife can also be a barrier. [7, 21, 22] Qualitative research should be conducted in the future to understand other misconceptions and barriers to spousal communication.

## Conclusion

Spousal communication enhances acceptability and utilization of modern contraceptives though misconceptions because of cultural believe and social norms are major hindrances in the uptake of the contraceptive commodities.

## Recommendation

Policies should focus on educating couples on need, benefits and misconceptions surrounding family planning. Family planning providers should be involved in pre-marital counselling of both male and female. Social behavioural change communication on media or at the social gathering in the community.

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