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Knowledge and Attitude to Sexual and Reproductive Health Rights among Reproductive-Age Women (RAW) in Malete, Kwara State

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Abstract

Sexual and reproductive health rights are essential human rights which are indisputable globally and therefore should be well known and embraced by all individuals. This study was purposely carried out to assess the knowledge and attitude to sexual and reproductive health rights among reproductive-age women (RAW) in Malete, Kwara State. A descriptive cross-sectional study of survey type was employed for the study. The sample for the study was drawn from the 5467 RAW in the study area using a multi-stage sampling technique. Sample size of 360 was determined with the aid of the Research Advisor application. Researcher-developed structured questionnaire which was validated by experts in related fields and tested for reliability using split-half technique was adopted for data collection. Frequency counts and percentages were used to analyse the data collected. This study showed that the knowledge of RAW about sexual and reproductive health rights was very low (17

Index terms— knowledge, attitude, sexual and reproductive health rights, reproductive-age women, malete.

Introduction cross all cultures, sexual and reproductive health is basically fundamental to individuals, families and their social, spiritual and psychological wellbeing. This could actually be related to the fact that sexual and reproductive health is strongly perceived to be very important throughout the life course of every individual. According World Health Organisation (WHO) (2015) sexual health is fundamental to the physical and emotional health and well-being of individuals, couples and families, and ultimately to the social and economic development of communities and countries. **??**ercer (2014) submitted that sexual health is essentially important at every stage of live because sexual health is no longer restricted solely to sexually transmitted infections (STIs) or prevention of unplanned/unintended of pregnancy but it is increasingly recognised a additionally encompassing elements of broader reproductive health, sexual function and non-volitional sex.

Sexual and reproductive health is a state of complete physical, emotional, mental, and social wellbeing in all matters relating to sexuality and reproductive system, its functions and processes (United Nations Population Fund, 2016). It indicates 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 if, when and how often to do so. Cartwright (2008) described sexual and reproductive health as enjoyment of sexual relation without exploitation, oppression or abuse; safe pregnancy and childbirth, and avoidance of unintended pregnancies; and absence and avoidance of STIs, including HIV. This simply means the ability to have informed, consensual, safe, respectful and pleasurable sexual relationships and healthy reproductive life. Sexuality is a central aspect of humanity and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction (United Nations, 1994).

However, Glasier, Gulmezoglu, Schmid, Moreno and Van Look (2006) opined that improving sexual and reproductive health remains an issue of public health importance worldwide. For this reason, attainment and sustainability of sexual and reproductive health entails that the sexual and reproductive health rights of all individuals must be respected, protected, and satisfied. In 2002, a WHO-convened international technical

consultation on sexual health submitted that sexual and reproductive health rights include the right of all individuals, free of coercion, discrimination and violence, to: the highest attainable standard of sexual health, including access to sexual and reproductive health care services; seek, receive, and impart information related to sexuality; sexuality education; respect for bodily integrity; choose their partner; decide whether or not to be sexually active; consensual sexual relations; consensual marriage; decide whether or not, and when, to have children; and pursue a satisfying, safe and pleasurable sexual life.

Worku and Gebresilassie (2008) defined sexually transmitted infections (STIs) as forms of reproductive tract infections which are caused by organisms that are passed through sexual activity with an infected partner. United Nations Population Fund (UNFPA) (2008) stated that an estimated 340 million new cases of four common sexually transmitted bacterial and protozoal infections are acquired annually and if other STIs are added, the estimates for new infections rise to more than one billion which means that slightly more than one infection among seven adults of reproductive age. Glasier et al.(2006)reported that sexually transmitted infections, excluding HIV/AIDS, are the second most important cause of loss of health in women, especially young women, and are a substantial cause of morbidity in men. Similarly, after pregnancyrelated causes, sexually transmitted infections are the second most important cause of healthy life lost in women.

Most often, people perceive sexual and reproductive health services as services related mainly to family planning and treatment of STIs/reproductive tract infections. In an attempt to correct this perception, WHO (2004a) identified the five core components of sexual and reproductive health care which are: improvement of antenatal, perinatal, postpartum, and newborn care; provision of high-quality services for family planning, including infertility services; elimination of unsafe abortions; prevention and treatment of sexually transmitted infections, including HIV, reproductive tract infections cervical cancer, and other gynaecological morbidities; and promotion of healthy sexuality. According to WHO (2010) the ability of individuals to achieve sexual health and wellbeing depends on them having: access to comprehensive information about sexuality; knowledge about the risks they face and their vulnerability to the adverse consequences of sexual activity; access to good quality sexual health care; and an environment that affirms and promotes sexual health.

WHO (2016) opined that promotion of family planning by ensuring access to preferred contraceptive methods for women and couples is essential to securing well-being and autonomy of women, while supporting the health and development f communities. Taylor (2014) contended that family planning gives women the option to wait until they are financially able to take good care for a child and gives them time to pursue educational and employment goals without worrying about the financial implications of unintended/unwanted pregnancy. Collumbien, Gerressu and Cleland (2004) submitted that family planning could prevent up to onethird of all maternal deaths by allowing women to delay motherhood, space births, avoid unintended pregnancies and unsafely performed abortions, and stop childbearing when they have reached their desired family size.

Furthermore, the use of family planning in preventing unwanted/unplanned pregnancies has been found to be a significantly strategy in saving public expenditures. According to Amaral et al. (2007) the unintended pregnancies prevented by California's family planning demonstration project would have incurred US$1.1 billion in public expenses within two years, which is significantly more than the US$403.8 million expended on the project. Stover, Dougherty and Hamilton (2006) found a potential savings of almost US$25 for every dollar spent on family planning at HIV/AIDS care and treatment facilities. Population Reference Bureau (2009) reported that babies born less than two years after their next oldest brother or sister are twice as likely to die in the first year as those born after an interval of three years. In addition, WHO (2007) argued that experts now recommend that after a live birth, women should wait at least two years before trying to become pregnant again in order to reduce infant health risks/deaths.

Sexual behaviour as contended by Mercer et al. (**??**013) is a key component of well-being which is often influenced by social norms, attitudes and health. According to Gebhard (2017) sexual behaviour is any activity (solitary, between two persons or in a group) that involves sexual arousal. Omeje, Ekwueme, Ugwu (2013) submitted that sexual behaviour means all sexual actions and responses demonstrated to seek sexual pleasure. Sexual behaviour has also been described as a broad spectrum of behaviours, ranging from the solitary (such as masturbation, and autoerotic stimulation) to partnered sex (intercourse, oral sex, nonpenetrative sex), through which humans display their sexuality (sexual behaviour, n.d).According to Eyo (2004) sexual behaviour refers to the total action of individuals in handling their sexual impulses, which actually implies the notion of expressing it as a male or female and how to live with it.

In addition, it has been established through various literature that sexual behaviour could be categorized as healthy and risky sexual behaviour. Omeje et al. (2013) argued that healthy sexual behaviour is any sexual behaviour that is planned or intended, done with caution and respect such as the one acted out between life partners or married couples. Centres for Disease Control and Prevention (2010) argued explained that risky sexual behaviour is generally described as behaviour (such as early sexual debut, having multiple sexual partners, having sex while under the influence of alcohol or drug) that increases one's susceptibility of contracting STIs/HIV and experiencing unplanned pregnancies.

Sexual and reproductive health rights are essential human rights which are indisputable globally and therefore should be well known and embraced by all individuals, especially the RAW. RAW, in the context of this study, are described as a group of women between the age of 15 -49 years regardless of their marital status. This study was particularly targeted at the group in order to find out their knowledge and attitude to sexual and reproductive

health rights. However, to the best knowledge of the researcher, no study has been conducted among RAW in Malete, Kwara State investigating their knowledge and attitude to sexual and reproductive health rights. Upon this premise, the researcher was prompted to investigate the knowledge and attitude of RAW to sexual and reproductive health rights so as to make practical and relevant recommendations based on the findings of the study.

1 II.

2 Statement of the Problem

The researcher's experience revealed that women in the study area are often regarded as third parties in issues that are strongly connected to their sexual and reproductive health care because of the unequal power relation between women and men which reduces their power of decision making over their sexual and reproductive health. Similarly, the researcher's informal conversation with some female members of the community showed that their sexual and reproductive health rights concerning child birth and spacing, consensual sex life among others are usually violated probably due to their inadequate knowledge about these rights. Hence, the researcher conducted this study to actually investigate the knowledge and attitude to sexual and reproductive health rights among RAW in Malete, Kwara State.

3 III.

4 Objectives of the Study

The general objective of the study was to assess the knowledge and attitude to sexual and reproductive health rights among reproductive-age women (RAW) in Malete, Kwara State. The specific the objectives were to: IV.

5 Research Questions

In order to guide the conduct of this study, the following corresponding research questions were raised and answered:

6 Methodology

A descriptive cross-sectional study of the survey type was employed to assess the knowledge and attitude to sexual and reproductive health rights among RAW in Malete, Kwara State. The study population comprised all the RAW in the study area, estimated to be 5467. The sample size of 359 (approximated to 360) was determined with the aid Research Advisor application. The sample for the study was then selected using a multi-stage sampling technique. At the first stage, cluster sampling technique was used to divide Malete community in to 18 clusters based on proximity and each of the clusters comprised a group of households. At the second stage, simple random sampling technique was adopted in choosing 20 RAW within each cluster using random numbers. At the third stage, systematic random sampling technique was employed to select a starting point (first household) within each cluster by spinning a bottle (grid method). Lastly, purposive sampling technique was used to choose the index person from the clusters.

Data used for this study was gathered through the use of researchers-developed questionnaire tagged "Questionnaire on Knowledge and Attitude to Sexual and Reproductive Health Rights among RAW (QKASRHRRAW)". The research instrument was subjected to content and face validity by giving it to three (3) jurors in related fields. The corrections, modifications and suggestions raised by them were used to adequately improve the original draft of the questionnaire. During the second look, the jurors adjudged the instrument valid. The instrument's reliability was established with the use of split-half method and a reliability coefficient of 0.71 was obtained, showing that the measuring instrument was very reliable.

The data obtained were collated, coded and analysed using frequency counts and percentages. In order to answer the three (3) research questions on the knowledge of RAW about sexual and reproductive health rights, STIs and benefits of family planning, percentage score statements 80percent and above specified Very High (VH); 79 per cent -60 per cent indicated High (H); 59 per cent -40 per cent classified as Moderate (M); 39 per cent -20 per cent considered Low (L); and less than 20 per cent signified Very Low (VL) knowledge. In answering the fourth research question which is on the attitude of RAW to the identified sexual behaviours, the Likert scale Strongly Agree (SA) and Agree (A) were merged and tagged "Positive Attitude" indicating healthy sexual behaviour while that of Disagree (D) and Strongly Disagree (SD) were also merged and tagged "Negative Attitude" indicating risky sexual behaviour. It is shown through table 4 that RAW in Malete, Kwara State showed negative attitude to the described sexual behaviours because the average total score of the negative attitude (85.2%) was higher than that of the positive attitude (14.2%). This simply implies that all the sexual behaviour identified in the table were risky sexual behaviours.

7 VI.

8 Results

9 Research

10 VII.

11 Discussion

The conduct of this study was guided by four research questions which focused on the knowledge of sexual and reproductive health rights, knowledge of STIs/HIV, knowledge of the benefits of family planning and attitude to sexual behaviour among RAW in Malete, Kwara State. The findings of the study revealed that the knowledge of RAW about sexual and reproductive health rights was very low (17%). This assertion is corroborated by that of Igbokwe (2011) which reported low level of knowledge of sexual and reproductive health rights among childbearing mothers in Nsukka Local Government Area of Enugu State. However, it is apparently credible to contend that this low knowledge level of sexual and reproductive health rights is a major factor contributing to the sexual and reproductive ill health prevalent among women aged 15-44 in low income communities as submitted by Wiklund (2015).

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The results of the study also indicated that the knowledge of STIs/HIV among RAW in Malete, Kwara State was moderate (56%). The knowledge of these respondents is obviously better than the low STIs knowledge reported by Mmbaga, Leyna, Mnyika and Klepp (2008) and Samkange-Zeeb, Spallek, and Zeeb (2011) in Tanzania and Europe respectively. In addition, the study asserted that the knowledge of RAW about the benefits of family planning was low (35%). This is in line with the finding of Mutombo, Bakibinga, Mukiira and Kamande (2014) that women in rural Western Kenya have low level of knowledge about benefits of family planning.

Furthermore, this study showed that RAW in Malete showed negative attitude to sexual behaviours like socializing with opposite sex, premarital sex, extramarital sex/affairs, homosexuality, having physical intimacy with the opposite sex etc. Although this submission negates that of Twenge, Sherman and Wells (2015) which reported positive attitude towards most of these identified sexual behaviours among the Americans. However, the researcher agrees with the finding of this study because in most African communities, especially in areas like the study area, good sexual values are often embraced and promoted as they are seen as societal pride and dignity.

14 VIII.

15 Conclusion

Based on the findings of this study, the following conclusions were drawn: 1. The knowledge of RAW about sexual and reproductive health rights was very low. 2. Reproductive-age women in Malete, Kwara State were moderately knowledgeable about STIs/HIV. 3. Knowledge of RAW about the benefits of family planning was low. 4. The attitude of RAW was negative to sexual behaviours like socializing with opposite sex, premarital sex, extramarital affairs, homosexuality, anal sex, having physical intimacy with the opposite sex and having baby out of wedlock; all of these behaviours were, therefore, tagged risky sexual behaviours.

IX.

16 Recommendation

The following recommendations were given in accordance with the findings of this study: 1. There is need to increase the knowledge of RAW in Malete on sexual and reproductive health rightsthrough intensive awareness and advocacy campaigns by the health care providers and community leaders. 2. Providing the study population with clear and effective health information on the benefits of family planning to children, parents, families and the country at large.

3. Integration of sexual and reproductive health information to antenatal and postpartum services. 4. Commencement of the teaching of sexual and reproductive health education to females from childhood.

[1] [2]

[1]Knowledge and Attitude to Sexual and Reproductive Health Rights among Reproductive-Age Women (RAW) in Malete, Kwara State

[2]

V.

Figure 1:

1

(n=360)

Figure 2: Table 1 :

1

Research Question 2:

Figure 3: Table 1

2

(n = 360)

Figure 4: Table 2 :

3

S/N	Items Description	Frequency	Percentage (%)	Decision
1.	Family planning reduces the risk of maternal mortality and morbidity resulting from repeated pregnancies	126	35.00	Low
2.	Birth timing in relation to the mother's age helps in avoiding a number of congenital anomalies which are associated with advancing maternal age	101	28.05	Low
3.	Proper child spacing helps in improving and maintaining the health of mothers	165	45.83	Moderate
4.	A child is likely to receive full share of care and love from his parents when the family size is moderate and births are properly spaced	162	45.00	Moderate
5.	Limiting the family size enhances child growth and development	134	37.22	Low
6.	Family planning is an essential strategy of insuring survival of all children in the family	104	28.89	Low
7.	Household resources are economically managed when intervals between pregnancies/births are properly regulated	90	25.00	Low
	Average Total		35.00	Low

Figure 5: Table 3 :

3

Figure 6: Table 3

4

S/N	Item Description	SA	A	Positive attitude (%)	D	SD	Negat attitu (%)
1. There is nothing bad in engaging in homosexuality		4 (1.11%)	10 (2.78%)	3.89	88 (24.44%)	258 (71.67%)	96.11
2. It is acceptable to have baby out of wedlock		9 (2.50%)	28 (7.77%)	10.27	174 (48.33%)	149 (41.40%)	89.73
3. It is appropriate to socialize with the opposite sex		42 (11.67%)	66 (18.33%)	30	94 (26.11%)	158 (43.89%)	70
4. It is all right to have baby out of wedlock		59 (16.4%)	37 (10.27%)	26.67	135 (37.50%)	129 (35.83%)	73.33
5. There is nothing bad in having anal sex		33 (9.17%)	42 (11.67%)	20.84	138 (38.33%)	147 (40.83)	79.16
6. It is acceptable to have physical intimacy (e.g. hugging) with the opposite sex		12 (3.335)	26 (7.22)	10.55	121 (33.61%)	201 (55.83%)	89.44
7. There is no problem in practising extramarital affair		0	5 (1.39%)	1.39	69 (19.17%)	286 (79.44%)	98.61
Average Total				14.80			85.20

Figure 7: Table 4 :

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