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ASSESSMENT OF REPRODUCTIVE HEALTH INFORMATION NEEDS AMONG RURAL WOMEN IN AKWA IBOM STATE, NIGERIA

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ABSTRACT
The paper assessed the reproductive health information needs among rural women in Akwa Ibom State, Nigeria. A total sample size of 240 rural women were selected from the rural communities in the state. Data were collected with the use of questionnaire and analysed using descriptive and inferential statistics. The main reproductive health information needs of the women were: Information on Antenatal care (x=3.78), Personal hygiene and nutrition (x=3.77),use of contraception, family planning (x=3.07), prevention and treatment of Malaria (x=2.65), prevention and control of sexually transmitted diseases (x=2.59), and Child delivery (x=2.52). There was a high level of use of reproductive health information in the study area. However, high illiteracy rate (x=2.80), poverty and low socio-economic status (x=2.78), much of the information appears strange to rural dwellers (x=2.76), and lack of power supply to access electronic information from radio, TV and Internet (x=2.74 were the most serious constraints limiting rural women in utilizing reproductive health. Multiple regression estimate showed that religion at p<0.01, education at p<0.01, parity at p<0.01, income at p<0.01, and employment status at p<0.05, were the variables that determined the use of reproductive health information. The study recommended that, Government should repackage reproductive health-care information in appropriate forms suitable for rural communities. Again, reproductive health-care programmes should be expanded and intensified along with culturally appropriate education campaigns and the focus should be on attracting women with little or no education.
Keywords: Reproductive health information needs, rural women, utilization

INTRODUCTION

The development and economic performance of nations around reproductive health depend on how each country protects and promotes the health of women (Onarheim, Iversen and Bloom, 2016). Reproductive health information is a fundamental building block of women's health during her child bearing period. As women are the bedrock of many communities (Mulauzi and Daka (2018); Christian Blind Mission, 2012), improving their health and increasing their income and education, are the best ways to positively impact a community. At such, any program directed towards women will fall short if there is inadequate information on health care. Globally, women are known to be primarily involved and engage in the building of the home and society (Global Volunteer, 2019). In Sub-Saharan Africa, especially Nigeria, women constitute 49.32% of the entire population (World Bank, 2020) and majority of this population (above 60%) live in resource and infrastructure-starved rural and remote

communities (ILO, 2015), engaging in economic activities (such as petty trading, vocational enterprises, handicraft, animal husbandry, farming to agro-processing as well as marketing (Ugwunnadi, 2014), which contribute directly or indirectly to the sustainable development of the society. Again, they are responsible for the provision of learning experiences to the children of the family, care for the sick/older people, maintaining bio-diversity, preserving traditional norms/knowledge and are major contributors to the improvement of the family standard of living (Odeh & Adiza, 2014). However, in Nigeria, their contributions to sustainable development had been marred by the challenges they faced in childbearing period. Reproductive health challenges that occur during child bearing period can be addressed if credible reproductive health information are readily available, accessible and utilized.

The place of information availability and accessibility to an individual determine the level of information needs. Undoubtedly, information needs of people differ significantly depending on what they intend to utilize information for. In this context, information need is the recognition that one's knowledge is inadequate to satisfy a goal and it is considered to be the foundation of information seeking behavior. According to Benard and Chipungahelo (2017), having access to reliable and relevant health information can empower people to make informed health-related decisions and to engage in behaviours that can improve their health. Good health consists of low morbidity and low mortality rates and a reasonably high quality of life. Therefore, women in any given community need information on safe motherhood (comprising prenatal care, safe delivery, post-partum care), family planning, education on physical hygiene and nutrition, abortion and treatment of post abortion, prevention and management of sexually-transmitted infections (STIs), including HIV infection and AIDS (National HIV/AIDS and Reproductive Health Survey, 2003), to help them attain reasonable high quality of life.

Over the past 30 years, substantial investments have been made to enhance access and utilization of reproductive health information in Nigeria. Access to quality reproductive health care services was central to the achievement of the Millennium Development Goals (MDGs), especially MDG 5, which sought among other things, to; reduce the maternal mortality ratio by three quarters between 1990 – 2015 and achieve universal access to reproductive health services by 2015 (Babalola, 2014; WHO, 2009). Even the UN 2030 Agenda for Sustainable Development recognizes that access to relevant health information is important for the economic, political and social well-being of any community (Benard and Chipungahelo, 2017). Although the progress made to reduce maternal death is commendable, Nigeria still accounts for 10 % of global maternal mortality, losing about 58,000 women annually to death from pregnancy-related complications (WHO, 2021; Ifeadike, Ezeama, Nnaji, Emelumadu, Ugwoke & Ofoegbu, 2016). The number of women dying of maternal issues is still unacceptably high as no woman should die while giving life. Apparently, this situation shows a dearth of unmet reproductive health information needs during child bearing period. It reveals that either women tend to be given inadequate information, education and communication during pregnancy and child delivery (CHAMP, 2017; Kasote, 2015; Tsawe and Susuman, 2014; Africa Progress Panel, 2010) or they hardly access and utilize the right information or the information is inappropriate to meet their needs, either in contents (e.g. it does not reflect their reality) or in presentation (ineffective communication due to language barrier). Based on this, the study assessed the reproductive health information needs and utilization among rural women in rural in Akwa Ibom State, Nigeria.

Specific Objectives

1. examine the socioeconomic profile of the rural women in the study area;
2. ascertain reproductive health information needs of rural women;
3. determine the level of utilization of reproductive health information by rural women;
4. ascertain constraints to use of reproductive health information by rural women.

METHODOLOGY

The study area

The study was conducted in Akwa Ibom State, located in the Southern region of Nigeria. The State is made up of 31 Local Government Areas, further divided into three senatorial districts viz; North East, North West and South zones. Each of the districts is made of 10–12 LGAs. The Primary Health Centers situated at the local government headquarters (district) serves as the operational base (OP Base). This is the central facility for PHC activities in the LGA. The reproductive health care services in Akwa Ibom State are provided by public, private for-profit, and non-governmental organizations. The state has a total of 425 public PHC facilities; however, primary care services are also offered by private health facilities. The distribution of the PHC facilities in each zone is 125, 148, and 152 PHCs in Uyo, Ikot Ekpene, and Eket senatorial districts, respectively.

Sample size and sampling techniques

The multi-stage sampling techniques was used in selecting the sample for this study. In the first stage, 3 LGAs (based on prevalence of reproductive health challenges) were purposively selected from Akwa Ibom North West and North East senatorial districts while 4 LGAs were selected from the South, making a total of 10 LGAs. In the second stage, 2 communities (based on availability of public health facilities) were purposely selected from each of the 10 selected Local Government Areas LGAs, giving a total of twenty (20) communities. In the third stage, a random sampling technique was used to select 12 women each from the selected 20 communities, therefore forming a sample size of 240 rural women. The sampled women were those who attended the general meeting called for the purpose of this research.

Analytical Technique

Descriptive statistics such as frequency counts, percentage and means were used to analyse the objectives. The mean rating for each item number was based on a four-point Likert scale and the mean ratings of the items were calculated. The decision rule was determined by a division of the sum of the Likert scales of 4, 3, 2 and 1 by the 4-point scale. The bench mark score was 2.5. Therefore, any mean scores of 2.5 and above were regarded as positive while scores below 2.5 were treated as negative. Analysis of Variance (ANOVA) was employed to test the differences in age range and educational qualification in the acceptability and utilization of health care services among pregnant women in north central zone of Nigeria.

RESULTS AND DISCUSSION

Socioeconomic Characteristics of Rural Women

The result in Table 1 revealed a mean age of 29.5 years. This implied that women were at the period of adulthood which described them as agile, active and productive. A high significant (95.2%) showed that the women were married and had an average of 5.7 children per household. Majority (30.8%) had attended secondary education. This will empower them and also help them to understand the need to use reproductive health information. On employment status, only 46.6% of women were self-employed in the study area. Self-employed shows capacity to pay for services and women control over financial resources. The women earned a

monthly average income of ₦30,500. Having an income empowers women to take active part in decision making about health care in the family. Findings on religion, revealed that 18.3% of women were of orthodox faith, 50% were of Pentecostal faith and 31.7% were of Spiritual faith. Religious practices have been known to shape women's culture, tradition, and values that even when educated, women still tend to uphold and stick on the belief of their religious leaders. Particularly, religion is found to influence the choice of place of delivery by women. In line with this study, Adamu (2011) found that, the impact of religion in determining utilization of Maternal Health Care information lies in the fact that it plays a significant role in shaping beliefs, norms and values, including those that relate to childbirth and health services use.

Table 1: Distribution of Rural Women according to their Socioeconomic Characteristics

Variables	Indices
Age	29.5 years
Marital Status	95.2% (Married)
Number of Children	5.7 (Average children per a woman)
Educational status	30.8% (Secondary school)
Employment status	46.6% (self-employed)
Income Level	₦30,500 (Average income per month)
Religion	50.3% (Pentecostal faith)

Source: Field Survey, 2018

Mean Distribution of Rural Women according to their Reproductive Health Information Needs

Table 2 shows the mean distribution of respondents according to their reproductive health care needs. The reproductive health information mostly needed by rural women in the study area as indicated by a grand mean of (x=2.52) were: Information on Antenatal care (x=3.78), Education on Personal hygiene and nutrition (x=3.77), Information on use of contraception, family planning (x=3.07), Information on prevention and treatment of Malaria (x=2.65), Information on prevention and control of sexually transmitted diseases (x=2.59) and Information on Child delivery (x=2.52).

Table 2: Mean Distribution of Rural Women according to their Reproductive health information needs (n = 240)

Information Needs	**Mostly Needed**	**Often Needed**	**Needed**	**Not Needed**	**Total**	**Mean Score**
Information on Antenatal care	752	156	0	0	908	3.78*
Information on Postnatal care	196	174	316	0	586	2.44
Information on Child delivery	352	90	140	22	604	2.52*
Education on Personal hygiene and nutrition	760	132	12	0	904	3.77*
Information on use of contraception, family planning	376	216	140	4	736	3.07
Information on prevention and treatment of Malaria	192	222	208	14	636	2.65*
Abortion-related information	0	0	108	186	294	1.23
Information on prevention and control of sexually transmitted diseases	280	24	312	6	622	2.59*
Information related to infertility	0	0	0	480	2.00	2.00
Information on Prevention of Cancer of reproductive system	0	0	84	198	282	1.18
Grand mean						**2.52**

Source: Field survey, 2018 (*Significant @ 2.52 and above)

Information such as Postnatal care, infertility, abortion-related and prevention of Cancer of reproductive system showed a mean score rating below x=2.52. Possible explanation is that rural women were not interested in the above information as they were not aware and also that, this information were neither available nor provided by health providers in the study area. This study agrees with Adamu (2011) who postulated that services like cancers of the reproductive system, abortion and treatment of post-abortion complication, voluntary sterilization services and prevention and management of infertility are not mostly provided in Nigerian Primary Health Care.

Utilization of Reproductive Health Information by Rural Women

The distribution of respondents according to their extent of utilization showed a high level of usage of reproductive health information in the study area as indicated by the grand mean score of 2.45. The high level of use however, could be attributed to compulsory visit to health facility to obtain Ante Natal Card which is a criterion used before pregnant women can be attended to during delivering either at home or TBA's place or spiritual houses.

Table 3: Mean score distribution of rural women according to their level of utilization of Reproductive health information (n = 240)

Reproductive Health Information	Mostly Utilized	Often Utilized	Rarely Utilized	Never Utilized	Total	Mean Score
Information on Antenatal care	792	68	16	0	876	3.65*
Information on Child delivery	152	180	160	62	554	2.31
Information on Postnatal care	312	180	132	36	660	2.75*
Information on prevention and treatment of Malaria	384	48	96	80	608	2.53*
Education on Personal hygiene and nutrition	688	150	28	4	870	3.63*
Abortion-related information	0	0	176	152	328	1.36
Information on use of contraception, family planning	224	264	68	62	618	2.58*
Information on prevention and control of sexually transmitted diseases	400	282	24	34	740	3.08*
Information related to infertility	0	0	172	154	326	1.36
Information on Prevention of Cancer of reproductive system	0	0	172	154	326	1.36
Grand Mean					**2.45**	

Source: Field survey, 2018. *means significance @ 2.45 and above

Constraints to utilization of Reproductive health information

The result in Table 4 revealed that, all the variables presented were significant constraints limiting rural women in utilization of reproductive health information. But a grand mean of x=2.63 further indicated that high illiteracy rate (x=2.80), poverty and low socio-economic status (x=2.78), much of the information appears strange to rural dwellers (x=2.76), lack of power supply to access electronic information from radio, TV and Internet (x=2.74), lack of time to seek relevant reproductive Health Information (x=2.67), and unavailability of Reproductive health information resources and facilities (x=2.63), were the most serious constraints limiting rural women in utilizing reproductive health information in the study area.

Table 4: Mean Distribution of Rural Women according to their Constraints in utilization of Reproductive health information (n = 240)

Constraints	Very Serious	Serious	Not Serious	Total	Mean Score
High illiteracy rate	419	254	0	673	2.80*
Health workers hardly organize seminars or workshops on reproductive health information	388	262	8	579	2.41
Lack of power supply to access electronic information from radio, TV and Internet	399	176	4	658	2.74*
Rural women shy away from discussing reproductive health issues	360	262	0	622	2.59
Secrecy and unwillingness to discuss reproductive health information by Health workers	326	284	8	618	2.57
Lack of time to seek relevant reproductive Health Information	386	254	10	640	2.67*
Health workers lack the training to provide reproductive health information	321	242	7	570	2.38
Unavailability of Reproductive health information resources and facilities	466	159	7	632	2.63*
Much of the information appears strange to rural dwellers	490	168	4	662	2.76*
Poverty and low socio-economic status	518	138	10	666	2.78*
Grand Mean					**2.63**

Source: Field survey, 2018 (* significance @ 2.63 and above)

Relationship Between Socio-Economic Characteristics of Rural Women and Extent of Utilization

Table 5 shows result of the multiple regression analysis on the relationship between socio-economic characteristics of rural women and their extent of utilization of reproductive health information in the study area. Linear log form was chosen as the lead equation, since it met the condition cited earlier. Seven variables were estimated in the model but five were statistically significant. They variables were; Religion, education, parity, income and employment. The coefficient 0.100 on religion had a positive relationship with utilization and was statistically significant at 10% level of probability. This implied that religion was directly related to utilization. This is likely due to the fact that religious practices and doctrines are known to shape people's belief, tradition, values and norms that relates to childbirth and health care issues. This study is in line with a study by Machira & Pakmuleni (2017) found that women's affiliation to other religious grouping especially Catholics faith affect their delivery in public facilities. In developing countries, religious affiliation is primarily cultural and traditional practice, and these affect the right of women to use health care information (Singh *et al*., 2012 and Kamal, 2015).

Educational status was positively related to utilization at 1% level of probability. This implies that a unit increase in the level of education will lead to an increase in level of utilization of reproductive health information in the study area. This finding corroborates with study by Lindberg and Maddox-Zinnet (2012), who suggests that mother's education is the most consistent and important determinant of the use of child and maternal health services. Because better educated women can recognize health problems, know where to access health care services, and use the information more effectively to maintain or achieve good health status.

Also, better educated women have the ability to promote their health seeking behaviour and stand a greater chance for better job opportunities.

Parity is negatively significant at 5% level of probability. The negative coefficient implies that, a unit increase in number of children per a woman will decrease the level of utilization of information. This finding is in line with studies by Awusi Anyanwu, and Okeleke (2009) and Assfaw (2010) in Morocco-Tunisia, Nigeria and Ethiopia who respectively found that parity has a strong negative relationship with use of ANC information. Employment status was positively related to utilization at 5% level of probability. This implies that, the more a woman is employed, the higher the likelihood to use reproductive health information in the study area. This finding corroborates with Abor *et al*. (2011) who confirmed that women's involvement in gainful employment empowers women to take part in decision-making in the family and can seek for greater knowledge on pregnancy and childbirth during work other than their households. The coefficient of income level shows a high significant level of 1% which implies that when there is an increased in the level of income of rural women, they will have access and control over social resources (knowledge, power to take decision, prestige) within the family, community and society at large.

Table 5: Multiple Regression Analysis on Relationship between Rural Women Socio-economic Characteristics and their extent of Utilization of Reproductive Health Information

Variables	Linear	Double-Log	Exponential	Semi-Log
Constant	19.495 (11.578)***	4.035 (9.830)***	15.085 (9.830)***	52.702 (16.594)***
Age	0.174 (1.041)	-1.448 (-0.498)	5.834 (1.720)	-3.451 (2.435)
Marital status	-1.057 (-1.262)	-8.571 (-0.349)	0.186 (-1.994)	4.243 (0.321)
Religion	0.199 (0.728)*	2.834 (0.720)	-4.233 (-0.435)	0.233 (0.594)
Education	1.185 (2.420)**	1.547 (3.334)***	3.737 (0.547)**	21.175 (4.999)***
Parity	-2.142 (-5.484)***	-9.281(-2.352)**	0.203 (2.106)*	0.533 (2.105)**
Employment Status	1.328 (3.565)***	1.629 (1.985)**	1.562 (2.594)**	0.623 (1.980)**
Income level	1.577 (9.81)***	0.184 (8.432)***	1.674 (3.724)***	1.930 (0.720)
R Adjusted	**0.895**	**0..690**	**0.753**	**0.820**
R^2	**0.903**	**0.683**	**0.897**	**0.784**
F-Stats	**245.187**	**201.339**	**236.192**	**195.231**

Source: SPSS Version 22.0 Computer Printout (2018)**.** (N/B: Figures in parenthesis () are t-value, *significant at 10%; ** significant at 5% and *** Significant at 1%)

CONCLUSION AND RECOMMENDATIONS

The study found that rural women in the study area needed mostly information on Antenatal care, education on personal hygiene and nutrition, and information on use of contraception/family planning. Despite these generalized information needs, each individual respondent had specific health information needs related to specific individual problems. It was also found that socio-cultural, economic and demographic factors influenced the use of reproductive health information by the rural women. The major challenges limiting the use of reproductive health information were high poverty and illiteracy rate, low socio-economic status, lack of power supply to access electronic information from radio, lack of time to seek relevant reproductive Health Information as well as perceiving much of the information to be strange.

Based on the findings of the study, the following recommendations were made:

i. Government should repackage information in appropriate forms suitable for rural communities, train health information extension workers and post them to rural communities.
ii. Maternal health-care programmes should be expanded and intensified in the study area along with culturally appropriate education campaigns and the focus should be on attracting women with little or no education.
iii. Access to information about maternal services should be made available in the health facilities within rural community to help women make choices about who to see and where to go, as well as decide the type of care they require.
iv. Involvement of community leaders including religious leaders in health programs may enhance in the spread of reproductive health information especially during delivery, postnatal and the seclusion period when the mother and infant are confined to the isolation within their own house and community

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