Hunting shadows of contraceptives side effects and Sexual negotiation tensions among women at risk for unintended pregnancy in Southwest Nigeria

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Abstract

Objective: This paper explores the views of women at risk for unplanned pregnancy (current contraceptives, preferred choices) and approaches sexual negotiation with their husbands.

Methods: We conducted 4 focus group discussions and 32 in-depth interviews with married women (35-40 years) in two Yoruba communities, Southwest Nigeria.

Results: We found high levels of fear and misconception about contraception. Many women expressed fears about the risks associated with contraceptive use based on misinformation from other women. Some women reported that their partners also had little knowledge about and did not support them in their use of contraception. Sexual conversations and negotiations only took place when there were health challenges associated with contraceptive use. Thus, sexual negotiation was more likely to involve disguised bargaining, excuses, or pleading. Some women who lacked interest in sex described their husband's demand for sex as rape.

Conclusion: To promote sexual health and avoid unintended pregnancy, women need a greater understanding about contraception use and associated risks.

Keywords: Nigerian women, Risk perception, Contraceptives use experiences, Sexual health, Sexual Rights

Introduction

Contraceptive use in sub-Saharan Africa remains low despite the increase in awareness (1, 2). Emerging evidence from different African settings reveals real or perceived risks as a significant contributor to the low or ineffective adoption of modern contraceptives among women of reproductive age (3-7). Studies have suggested the need for contextual understanding of the subjective results of contraceptive use risks as an important step toward meeting the expectations of contraceptive users (8-10). In the same vein is the need to interrogate the influence of perceived risks of contraceptive use for women of reproductive age on quality of marital relations (4, 11). Thus, a contextual understanding of the consequences of contraceptives use, or non-use (3, 4, 12, 13) will provide meaningful contribution to the body of knowledge. As an embodied dimension of marital relations, sexual negotiations can influence responsiveness to modern contraceptive methods, and in the event of dissatisfaction with a method or side effects, such negotiations can influence effective switch between methods.

Existing family planning initiatives in sub-Saharan Africa are somewhat passive in addressing the risks associated with contraceptive use (2, 14, 15). Many efforts have been devoted to addressing the consequences on reproductive behaviour in terms of the number of children and frequency of unintended or unsafe pregnancies (16, 17). However, there is a dearth of studies exploring how real or perceived risks of contraceptive use differ within context and how this might be influencing the quality of marital relations (18), including sexual relations. Yet, effective adoption of modern contraceptives among women of reproductive age remains critical to sexual and reproductive health promotion and could lead to a possible reduction in a number of maternal health challenges (15). Effective contraceptive use also empowers women

by enabling them to contribute more to meeting household expenses, including nutrition improvements.

In recent times, there has emerged a clash of cultures affecting intimate relationships in Nigeria. One such area is the changing social notion of breadwinning and the gradual drift of consensus away from the idea that the man is the sole breadwinner (19, 20). There is emerging evidence that women are becoming breadwinners in many African communities. Value reorientations, socioeconomic and political among other developments, have aggravated the situation (20-22). With the cumulative impact of poor economic growth and development, more emphasis is now on the liberalisation of the Nigerian economy to improve economic performance and social wellbeing (23). This has resulted in the privatisation of public institutions such as schools, electricity generation and distribution, telecommunication, and oil and gas. However, with high unemployment and absence of formal social securities, the immediate ripple effects include an increase in the cost of living and more burden on men and women as they confront difficulties in meeting their obligations as breadwinners. Studies have shown how cultural norms and marital responsibilities keep fueling the trend to assign childrearing responsibilities to women(24, 25). Cultural beliefs around marital responsibilities and expectations among factors could also trigger married women's sensitivity to existing challenges, conformity to marital norms, and strategies of minimising the burden of responsibilities.

Against this backdrop, this paper examines women's views on contraceptive use, their preferred choices of contraceptives, and their approaches to negotiating and protecting their sexual health within marriage.

Gender and Sexual Negotiation in heterosexual relationships within the Yoruba context

Gender and power imbalances in marital relationships can create barriers to attaining optimal sexual health and to reducing maternal health challenges, including the prevention of sexually transmitted infections among couples (26, 27). Some socio-cultural values and practices imposed restrictions in negotiating the use of modern contraceptives among couples (3, 5, 8, 14, 28). Within the Yoruba context, one such cultural value includes the social obligation that the husband is the head and the wife must submit at all times to all his requests (29-31). This includes the cultural assumption and expectation that women are to meet their husbands' sexual and marital obligations (31, 32). Through the socialisation process, males and females are tutored differently on what is required in heterosexual marital relations (32, 33).The situation is similar in a number of African contexts as women of reproductive age struggle to meet marital and other domestic duties (34, 35). Within the Yoruba context, polygyny as a form of marriage exerts differential demands on husbands and wives within the union. By traditional convention, a new wife in a polygynous marriage is junior not only to her husband's other wives, but also to family members born before the date of her marriage (36). The woman is also subordinate in the domestic domain, where her unpaid labour is expected from her husband and other extended family members. For junior wives, sexual submissiveness is one dimension of this subordination, which attracts a high premium. Women are their husbands' property and therefore access should be unrestricted (31). These social arrangements give men greater seniority and control over women, including control over women's sexuality. Both women and men share this world of sexual obligations. While at the individual level, there are possibilities for variation from these

required obligations, existing cultural norms and values exert pressures and shape marital relations.

Thus, in heterosexual relations, the need for couples to meet these obligations is regularly reinforced through various means and measures (29). So, both men and women perceive this aspect of marital relationships as a key to fulfilling social expectations associated with marriage as a social institution. Within this cultural setting, more emphasis is placed on fertility and childrearing than on sexual health promotion. This situation creates an initial hurdle as the women struggle and work toward the status quo. The high premium on fertility comes with socioeconomic challenges that are associated with childbearing and rearing (37, 38). Thus, women are likely to experience challenges in switching from one contraceptive method to another, or in responding to the need for contraceptives. Nevertheless, as co-constructors of their realities, we presume that women in the study setting are likely to develop or adopt measures that could reduce unintended pregnancy. Yet, such efforts could generate tensions and affect contraceptive use and quality of marital relationships (39, 40).

Given the dearth of research on the interaction between perceived risks and quality of marital relationships, it is useful to explore how perceived contraceptive use risks and could trigger or constrain sexual negotiation among women at risk of unintended pregnancy. In this paper, we explore women's views on modern contraceptives, their preferred choice of contraceptives, and approaches in negotiating and protecting their sexual health within marriage. Exploring perceived or real experiences of contraceptive method use represents a way of generating feedback concerning the side effects and the potential need for improvement on a contraceptive method. In this study, we viewed contraceptive risk from the participants' position.

Thus, risk in this study is the individuals' subjective judgment about contraceptive use, including the likelihood and severity of the effect of adopting a modern contraceptive method in marriage. Thus, we raised these research questions: What are the views and risks associated with the use of modern contraceptive methods, and what are the experiences of women who have used at least one method? We probe for prevailing sexual negotiation strategies and how their use might create tensions in the women's marital relations.

Methodology

Research Design

An exploratory research design that consists of focus group discussion and in-depth interviews was used to explore the views of married Yoruba women aged between 35 and 40 years of age in two rural Yoruba communities. Four focus group discussions (FGD) and 12 in-depth interviews were held among married women (32-40 years) in two neighbouring Yoruba communities. Both communities share the same boundary and cultural beliefs. Small private clinics and maternity centres are well located in areas that are accessible within the communities. There are a number of traditional birth attendants providing cheap antenatal services within the communities. The only public hospital serving both communities is located in the local government headquarters, which is about ten kilometres from the two communities. Despite the huge burden of maternal mortality, poor delivery of primary healthcare services remains a major challenge especially in rural areas in Nigeria. This among other factors encourages private establishment of clinics and maternity centres that are sub-standard and profiteering. Members of the communities practice traditional religion alongside Christianity and Islam. The study period was from March to April 2010.

The FGDs and face-to-face interviews focused on experiences with modern contraceptive methods, their preferred choice of contraceptives, and approaches in negotiating and protecting their sexual health within marriage. In-depth interviews allow the researcher to gain insight into people's experience as well as allow participants to speak freely using their own words (41, 42). In different studies, Focus Group Discussions have been used to gain access to various aspects of people's lives (43).

Recruitment and Sampling

All the Participants were purposively recruited through the help of two female informants who are also community health workers. Recruitment of the study participants started by identifying married women of the Yoruba extraction within the age range of 35 to 40 years residing in the study locations. Only women that have at least three living children and are currently living with their husbands were invited for the study. We administered a page questionnaire on the volunteers to determine their eligibility for the FGD. The inclusion criteria include their age (35-40 years), ethnic group (Yoruba), residence within the communities, current marital status and living with a husband, and with at least three children. Each focus group was made up of seven to nine women.

Based on the findings from the FGDs, 32 in-depth interviews were held with women aged 35-40 years, out of which 12 had self-reported experience of unintended pregnancy after 35 years of age. All the FGDs and interviews were conducted in the Yoruba language at locations preferred by the participants. An average of 45 minutes was spent on the interviews, while the average the FGD session lasted 1 hour and 48 minutes.

The interviews explore perceptions of contraceptive risk and relevance, as well as sexual negotiation to prevent future pregnancies. Four experienced female postgraduate students of the department of sociology and anthropology, Obafemi Awolowo University, assisted with the data collection.

Data Analysis

Interviews were tape recorded, transcribed verbatim, and analysed thematically. After coding, the transcriptions were re-read several times to identify patterns of perspectives, which were then extracted by paraphrasing common threads or direct quotes (44).

The themes that emerged were linked to form a comprehensive matrix of the collective perspective of women who are at risk for unintended pregnancy. Specifically, researchers sought to determine these women's perceptions of contraceptive risk perception and of sexual negotiation. Common themes that emerged through this process involved a shared understanding among participants on the dynamics of sexual negotiation and contraceptive use. The emergent themes were organized and structured in relation to the research questions. Salient themes that emerged from the data were noted and triangulated. Direct quotes from the in-depth interviews and FGDs are presented wherever possible, as recommended by Bryman (45).

Ethical consideration

No ethical clearance was obtained from the university's human ethics committee. There was none at the time the study was conducted. However, ethical guidelines were followed as suggested by Edwards and Louw (1997). The participants were briefed on the study objectives, and their informed consent was obtained. Participants were also informed of their rights to withdraw from the discussion at any point, if they were no longer comfortable with the

interviews, and they were free to do so without giving reasons. They were also assured that confidentiality and anonymity would be maintained.

Findings

The average age of the interviewees was 36.4 years, and that of the focus group discussants was 35.9 years. More than half of all the participants had had at least a primary education, while one-thirds attended secondary school as their highest level of education. Both Muslims and Christians were recruited for this study, only among the participants claimed traditional Yoruba religion. A majority of the participants (39) were in monogamous marriages while just a few (23) were in polygamous marriages. Only six had more than five children at the time of the study; 11 had 3 children each, and 15 of them had four children. Among the focus group discussants, 12 of them had at least four children, while seven of them had more than four children. Out of the 32 interviewees, 23 participants reported that their first pregnancy was unintended, and 18 of these had married unwillingly because they were pregnant; only five of these sought antenatal care at a modern health facility. The remaining 13 had their first childbirth with a traditional birth attendant or at church mission homes (faith healers). In this group, five reported that they became pregnant and married a man who was not their choice husband. All the discussants had more than three children at the time of this study and claimed not to be interested in future births. A smaller number of the participants (9) had planned pregnancies. Three participants reported that they were in long-term dating relationships and that they became pregnant so that their partner would marry them.

We identified four interrelated themes, which are discussed in this section under the following subheadings: Contraceptive use and timing of first pregnancy, Contraceptive risk perception, Hurting shadow of contraceptive side effects, and Disguised bargaining in sexual negotiations.

Contraceptive use and timing of first pregnancy

Contraceptive use, timing, and context of first pregnancy event could reveal levels of awareness and acceptability of the usefulness of modern contraceptives prior to marriage. As such, efforts were made to retrospectively elicit information about participants' first pregnancy, whether it was intended or unintended. Some of the participants reported they had their first pregnancy when it was least expected, and they attributed that to inexperience in terms of preventive measures, fear of suggesting condom use to their partners, and radical optimism that unintended pregnancy would not occur despite constant engagement in unprotected sex. The circumstances surrounding the participants' first pregnancy experiences also created mixed options and avenues for unprepared marriage and minimal options for sexual negotiations. However, at the initial stage of entering into an unplanned marriage, there are inherent imbalances that could tarry longer than expected, thereby promoting inequalities and power differentials. It might also fuel social inequalities in the preparation of boys and girls for sexual pleasures and unwillingness or denial of associated responsibilities of unprotected sex.

Some of the participants narrated how their friends who have entered into marriage due to unintended pregnancies are regretful and unhappy. Their explanations rest on the unpreparedness of many young men for marriage due to poor economic conditions and the negative perception of

single mothers. Men are also more socially favoured and have more options to make themselves happy than women. For women, there is the cultural constraint on them to stay in an unhappy marriage while men are free to quit the marriage or marry another wife. This gives men more of an opportunity than women have to become irresponsible to their wives and children. The circumstances surrounding the occurrence of first pregnancy also transcends into other spheres of the women's lives. It affects the quality of marital relations, communication patterns, responsibility sharing, and economic empowerment of the women. Within the study location and in a number of Yoruba communities, unintended pregnancy outside marriage creates challenges for women, especially when it occurs during adolescence or young adulthood. With factors like age of partners and financial independence, it is normative that sexual relationships that result in unintended pregnancy should end up in marriage. However, this could create additional strains and tension for couples in such marriages, as they are unprepared for marriage except for the pregnancy. As one participant explained,

> *When you are less prepared for an important event, chances are there that you will be powerless in taking the best out of it. Some of us are married today because of unplanned pregnancy. It is worse off when a man you don't love impregnates you. Happiness will be far from such woman, and choice making becomes difficult. (*IDI, married woman aged 37)

Given that the majority of the participants come from from low socio-economic backgrounds, empowerment and cultural norms governing marital relations emerged as additional constraints to sexual negotiations and, moreover, to the desirability of a pregnancy. However, with years into marriage and the presence of children, some of the women deny their husbands sex to avoid unintended pregnancy and growing childrearing responsibilities. Some of the participants felt otherwise as there are husbands who will not recognise nor accept their wives' refusal of sex;

thereby reducing the boldness to adopt contraceptives and abilities to negotiate desired family size.

Awareness of the availability of modern contraceptives contributes in a way to the knowledge and possibility of adopting a method. With years into marriage and childbirth experiences at the hospitals, all the participants were aware of at least one modern contraceptive method. Predominant methods mentioned include condoms, injectable, pills, and IUD. In terms of methods preference, findings from the in-depth interviews revealed a preference for injectables and pills. As one participant said,

> *We are familiar with IUD, but it is easier to take an injection or a pill especially when you are doing it without your husband's consent or awareness. It is also quicker and faster to see the results* (FGD with women).

However, the high level of awareness does not translate to high usage. Irregular and low usage of contraceptives emerged as a dominant practice, especially when we raised questions on previous use of contraceptives, circumstances, and desirability of first pregnancy. Participants' responses to the questions showed high consciousness and motivation for the social desirability of fertility within marriage and the fear of stigmatisation for infertility. The presumption that the use of contraceptives among unmarried young people contributes to primary and secondary infertility in marriage also came up as an issue in one of the focus groups. Some of the participants expressed this view as a reality that calls for caution in the drive towards promoting protected sex by way of scaling up contraceptive use among unmarried young people in Nigeria. This may also explain the participants' non-use of contraceptives prior to marriage and thir low or irregular use of contraceptives in marriage. Interestingly, some of the participants admitted that unwillingness to

use a contraceptive contributed in some ways to the situation of some of their peers who had unintended pregnancies as adolescents. Although the focus group discussants described a low level of awareness of modern contraceptives while growing up, the present high level of awareness and the low-use makes the situation complex. In contrast, some of the interviewees describe early exposure to premarital sex as a motivation to consider the use of contraceptives, but socio-cultural practices and beliefs around pregnancy and the side effects of contraceptives account for low or irregular uptake more than low awareness while growing up as adolescents. As one participant explained,

> *My second child was least expected even though I refused to yield to suggestions from the nurses to adopt a contraceptive method immediately after childbirth. I was afraid of the side effects of modern contraceptives, and I believed I could not be pregnant since my first child was still breastfeeding. Unfortunately, I became pregnant. It was a shame for me then. People started laughing at me even though I was married but got pregnant when I still have an infant. It was very challenging for me, but I have learnt my lessons* (IDI, married woman aged 36)

Previous experiences of contraceptive use also account for the way participants view the relevance of and adoption of modern contraceptive. Contraceptive use among the focus group discussants and interviewees was low and irregular. Yet, a slight variation exists in the narratives and opinions of the participants on experiences and perceived side effects associated with contraceptive use. The determination to avoid pregnancy and minimise the psychological effects of economic hardships was cited as the rationale for justifying secret use of contraceptives.

Mixed expectations and Contraceptive risk perception

To understand participants' contraceptive risk perceptions, we focused on participants' perceptions of and experiences with contraceptives. As earlier stated, a high proportion of the participants exhibited high awareness of modern contraceptive methods. However, mixed expectations and fears dominated their perceptions of the usefulness and side effects of contraceptive use. Different opinions were expressed on the perceived relevance of contraceptive use. The feeling that no method is free of error or side effects was expressed in the FGDs and the interviews. This position was attributed to the fallibility of humans and existing imperfections in all creations. Thus, in the absence of absolute risk-free methods, a few of the participants claimed they were no long afraid of using modern contraceptive methods.

However, some of the women were indifferent or undecided. Among those who expressed fear, some claimed they were just sceptical. There were those who expressed the view that contraceptives were dangerous to the womb and could become a serious problem in post-reproductive age-when by physiological factors chances of fertility grow slimmer and difficult. From the various positions expressed and the absence of confirmable facts, quite a number of the participants based their arguments and sources of information on contraceptive side effects the experiences of others, which oftentimes may be unverifiable. There were exceptions, as a few interviewees claimed to have had unsatisfactory experiences in the past with a method of modern contraceptive. In this group, some had switched from one method to another based on professional advice from a nurse. As one participant said,

*In my own experience, I have used two different contraceptives with different experiences. No method is perfect, but initially I was very much concerned with the side effects than the benefits (*IDI, married woman aged, 35*)*

Largely, social fear and disbelief dominated the participants' remarks, especially in the FGDs. Participants frequently mentioned these factors as influential when faced with the option of adopting contraceptives. In response to a question about fears concerning contraception, fear was a common theme, as indicated in the following quotations:

*I can only attribute it to fear because most of the available methods are less expensive, and some take the usefulness of contraceptives for granted (*IDI, married woman aged35).

Many women believe that the use of contraceptive like IUD often cause excessive blood flow during menstruation (FGD with women).

The 'hunting shadows' of contraceptive side effects

Achieving a manageable family size is gradually emerging as an imperative for improved quality of life within the study context. A number of the participants described the increasing burden of sharing household responsibilities with their husbands. This situation requires more rational decisions on issues such as child spacing as women work longer hours to earn a living that could support their households. With more than two children and five years into marriage, fertility was no longer a major concern to some of the women. This feeling was in response to concerns about the increasing burden of sharing the responsibility of breadwinning with their

husbands. Many of the participants have to tend do their children's education and daily upkeep. The participants attributed this development to an emerging shift in childrearing responsibilities and gradual withdrawal of husbands from the social position of a breadwinner.

With this development, breadwinning becomes a shared responsibility between husband and wife. Thus, some of the women were responsible for their children's school fees with little or no support from their husbands. In Nigeria, funding of public schools at the primary and secondary levels is inadequate; this situation is compounded through incessant industrial strikes and disruptions in the academic calendar. This among other factors has stimulated the growth of private schools that are, unfortunately, expensive and beyond the reach of average Nigerians. Despite these shortcomings, a high proportion of the discussants felt comfortable with private schools. The women groaned in FGDs when discussing the growing challenge of meeting their children's needs with little or no support from their husbands. To achieve this desire requires timely access to and effective adoption of contraceptives. However, the indispensability of contraceptives in recent times, along with the chances of experiencing a side effect, created a paradox, as expressed in their discussions. The desire to avoid unintended pregnancy was high as many of the women felt the burden of childrearing and growing household needs. Yet available contraceptives are avoided mainly due to perceived or real risks of side effects. As presented in one of the FGDs,

> *In recent times, the dilemma of making a decision on pregnancy prevention approach is becoming more complex. At hospitals we are encouraged to use contraceptives; we want the benefits and not the side effects. It's just like your own shadow hunting you at the same time (FGD)*

To the participants, the fact that contraceptive use and side effects are hardly separable facilitated a comparison of contraceptives to a hunting shadow. In the opinion of some of the participants, in the social marketing of contraceptives, benefits are often portrayed with an emphasis on the positive outcomes with less or deliberate silence on the potential negative implications. The participants described this position as understandable as the social marketing involves mass canvassing and persuasion. However, the absence or deliberate silence on providing information and solutions to possible side effects was disliked by the participants. They argued that no method created by humans is infallible and, as such, efforts should be made to address both the perceived and real side effects of contraceptive use in its social marketing and supply of contraceptives. Against this backdrop, some participants described the possibility of experiencing contraceptive side effects as a shadow that hunts. The mere existence and awareness of the side effects create a kind of fear on the minds of some women. The availability of modern contraceptives ought to provide succour especially as some of the women want to maintain a manageable family size and reduce the burden of childrearing. In the participants' words,

> *Modern contraceptives have come to stay, but the side effects make it like your own shadow hunting you* (FGD with women).

The overt display of fear as contained in some of the participants' narratives is expected in a cultural setting that provides limited and lopsided information on women's sexual health and accessibility to quality sexual health services. As an alternative, a number of the participants have relied on other women's experiences and grapevine sources that are based scepticisms

around the benefits of using modern contraceptives. By implication, this has created ripple effects and misconceptions around contraceptive use. Some of the participants explained the rationale for such stance:

> *We have to learn from other people's experiences and mistakes. I do not need to experience it first, because the outcomes of life events are less predictable* (IDI, married woman aged 37).

> *We have heard cases of women who started bleeding more than they did during their menstrual periods because of contraceptive. Nobody will tell you that these contraceptives are perfect, we are only being careful with our bodies* (FGD)

Despite the submissions of some of the participants and the indication that diffusion of knowledge and information sharing was lopsided, some of the participants were convinced of engaging in one form of risk or the other through their use of contraceptive. Some of the participants again raised the position that "no method is risk free." Five among the interviewees who had used at least one form of modern contraceptive method described their decisions as risk taking. They based their arguments on the position that the use of some contraceptives like IUDs, injectables, and pills can cause damage to the womb, lead to heavy menstrual flow, and cause infertility or delay in becoming pregnant.

A similar stance of describing contraceptive use as 'risk taking' also emerged in the focus group discussion. Thus, group dynamics in the construction of 'theirs' or 'other women's experiences' as risk taking was vivid in their personal experiences or in the experiences of

‘others’. At this level, quite a number of the women narrated stories of others with few personal examples:

> *I have used Pills and IUD with mixed experiences. I almost aborted the last pregnancy I had because my husband and I have agreed not to give birth again. I visited a private maternity home in a nearby community, but three months later, after I have started with the method I became pregnant and it almost shattered my marriage (FGD participant aged 36).*

> *There are times you use a contraceptive without your husbands’ knowledge. My husband has other wives, and I have had enough children to cope with. He does not really care for us, and I cannot afford any risk of pregnancy. I have some pills that I take (FGD participant aged 37)*

> *Some husbands are indifferent to their wives’ or children’s’ wellbeing. They are just there to have sex with their wives and to avoid unnecessary burdensome women have started using contraceptive even without their husband’s awareness (FGD)*

While some participants supported the use of contraceptive without husband knowledge in conflicting or competitive marriages, a high proportion of the participants also called for caution as they expressed the fear of misconstruing such actions for promiscuity. Even when some men are involved in extramarital relations, a few of the participants still believed that the

use of condoms by their husbands without their knowledge would make them feel safe with their husbands.

Disguised bargaining in sexual negotiation

Sexual negotiations occurred at different degrees based on the quality of marital relations in terms of their preferred means of communication, age gaps between husbands and wives, age of the last child, and the economic and financial situations of the women. A cross-cutting strategy was disguised bargaining. Participants described this strategy as an approach to gaining favour or derived demand from their husbands. Many of the participants confirmed that women adopt the approach as a measure of negotiating for some things in their marriage. They considered the moment of initiating sex as one of the subtle moments of claiming their rights. As one woman said,

> *Some men are selfish it is only in such moments you can have all their attention. Therefore, you use that opportunity to negotiate (*IDI, married woman *aged 36).*

> *Women have this tactics of negotiating sex with their husbands. It is more like give and take, but it should be done with a sense. We cannot just tell our husbands this is what we want and that is final (FGD)*

As a strategy, disguised bargaining revolves around the use of subtle means like pretence and placing demands on their husbands. The strategy revolves around denial and delay in granting their husbands' requests for sex. This practice is associated with the cultural beliefs that women are powerful and could achieve a goal by ignoring sexual advances or denying their husbands the need for sex. Participants were also quick to add that there are instances when the above tactics

may not work. They argued that the use of excuses or pleading might become the next option, especially when their husbands failed to understand their unwillingness to engage in sex at that moment. The participants also argued that some husbands are like rapists; they come when they are interested in sex and care less whether their wives are interested or satisfied. Some of the participants expressed the difficulty in refusing husbands' sexual requests except when they had their menstrual period or ill health.

However, some of the participants argued that this strategy has its limitations and is not a lasting approach to sexual health promotion. One limitation is that it does not ensure cooperative and mutual sexual intercourse, but is only a temporary approach to delaying sexual gratifications that could create rancour and occasional violence in the household. Some of the FGD participants narrated how some women they know have lost their marriages due to disguise and inadequate interest and attention to husbands' sexual demands. Similarly, two of the interviewees narrated experiences of forced sex and occasional physical violence as their husbands could not withstand their disguise at some points.

As stated earlier, the unequal power relations between women and their husbands are commonplace in Yoruba culture, and this became more lucid in the women's narratives on sexual relations. From the participants' position, there are few instances when dialogue on sexual issues in marriage become more vivid, and such occasions revolve around infertility or health challenges. In such occasions, discussion is less confrontational, with a preference for non-verbal means in sexual negotiation.

Discussion of findings

Contraceptive use among women of reproductive age in Nigeria remains low despite the increase in awareness. Perceived risks of usage at both cognitive and experiential levels remain significant to low uptake of modern contraceptives. Thus, an understanding of the dynamics of low demand and non-use of modern contraceptive method among childbearing women within a social context of sexual negotiations in marital relations would enhance the body of knowledge relevant to promoting the effective use of family planning in marital relations. This paper fills the gaps in knowledge by exploring the views of women who are at risk for unplanned pregnancy on current contraceptives, preferred choices, and their approaches in sexual negotiation with their husbands. This paper provides context-based information on subjective risks associated with contraceptives use and the need to address these challenges in existing efforts at scaling up contraceptive uptake among women of reproductive age. It also draws attention to the need to think beyond the mere use of contraceptives or low uptake of contraceptives as a phenomenon unconnected with other issues in marital relations.

The findings showed that a high proportion of women in the study setting are aware of different contraceptives. Notwithstanding, they shared deep reservations about the after effects of contraceptive use. However, with some of their reservations from unverifiable sources, it is suggestive that women in this social category are unexposed to adequate information about the use and possible effects of these contraceptives from health care providers. They largely relied on hearsay and friends' personal experiences. The continuous existence of method-related risks at either the cognitive or experiential level has potential implications for existing efforts aimed at scaling up contraceptive use and the responsive switch from one method to another. This finding

is similar to a recent study in Ghana where a number of women of reproductive age ascribe and maintain misconceptions on contraceptives (4).

Cultural and traditional values that openly support high fertility within marriage would readily promote low use of contraceptives. The fear of infertility either at primary or secondary levels hindered some of the participants from adopting or switching from a contraceptive method to another. Additional information on their contraceptive use experiences and information about the timing and intentionality of the first pregnancy also provided a context for interpreting the possibility of exercising sexual rights in marriage. This finding is consistent with recent studies among women in Cairo (5) and among adults in Ghana (4). Both studies revealed that the attribution of risks to contraceptive use affects both current and potential users of contraceptives. There is a chance that the occurrence of side effects and negative experiences with a contraceptive method will diffuse fast without cautious verifications among social actors within such settings. In this study, even those who agreed that they were using contraceptives also considered it as a risk-taking venture as contraceptive use was viewed as inherently damaging to the woman's womb, and women believe that contraceptives could delay fertility and prolong menstrual flow. Therefore, this undermines the use of contraception among women at risks of unintended pregnancy.

Furthermore, this study revealed that women cannot negotiate safe sexual relations within a hegemonic patriarchal society where men are seen as the sole initiator of sexual advances and their wives are seen as co-operative recipients of every sexual desire. Within this context, cultural practice and beliefs that promote fertility and procreation remain sacrosanct and could endanger the sexual and reproductive health of women. Similarly, in social settings where

polygyny and marital infidelity are normative, safe sex practices and sexual health promotion would be challenging. Within this context of gender and power differentials, married women are socially expected to satisfy their husband's sexual needs and protect their sexual health (7, 29).

Sexual negotiation is a component of marital relations, and both take places within specific socio-cultural contexts. As such, sexual negotiations would be challenging to achieve within social environments where misconceptions and low contraceptive use remain high (4). The situation may be precarious for women at risk for unintended pregnancy as the consequences of mistimed pregnancy at this age are enormous (46).

The findings of this study showed that power relations continue to characterize sexual negotiation among women of reproductive age. Hence, less overt strategies are engaged by women in negotiating sexual relations. These strategies conform to traditional feminine scripts of sexual passivity as the male gender are expected to be the sexual aggressor. Many of the women disclosed that their negotiation was fraught with many cautions and ended up in appeals during periods of ill health and menstruation especially because such women were in competitive relationships with other women in a polygynous marriage or union. This is done in order to win the confidence of the patriarch who should culturally not be turned down when he makes sexual advances to his wife. As a fluid phenomenon, marital relations are prone to tensions with possible health outcomes for heterosexual couples (47). A number of factors influence quality of marital relations- a subjective reality. Marital quality depends on (among other factors) effective communications in marriage, trust and openness, presence of children, and good economic conditions at the household level (47, 48). Facilitating harmonious marital relations requires resolving some other indirect issues that may be generating tensions at the home front.

Given that egalitarian conjugal relations are enhanced by modernization, the findings of this study affirm earlier studies (6) where Yoruba women in Southwestern Nigeria are still restrained by the cultural premium on fertility within marriage and the fear that contraceptive use could cause primary or secondary infertility (29). In a number of African communities, children are perceived as a show of wealth and a storehouse of value in the future for their parents (29, 49). The general tendency is to pay lip service to the sexual health needs of the women as much as reproduction continues.

Ironically, there are policies to scale uptake of contraceptives; however, there is an absence or inadequate attention to issues associated with perceived risks of contraceptive use risks including method-related side effects among users (50). Rather than focusing on the unplanned pregnancy incidents alone and side effects as experienced by current users, there is a need to understand the real or perceived risks of contraceptive use among husbands and the implications of unmet needs on other areas of marital relationships. This has additional benefits in providing insights to the effectiveness and potentiality of women as co-constructors of their sexual and maternal realities. It will also provide an opportunity to understand the implicit pressure of unmet need on women in the face of ongoing family planning initiatives aimed at improving awareness, access, affordability and acceptability in Nigeria. Moreso, inadequate access to information and absence of response to real and perceived side effects from healthcare providers could create set backs in achieving the objectives of these family planning initiatives(51, 52).

As stated earlier, the need to comply with societal norms on fertility in marriage also creates more responsibility and awareness of risks with contraceptive use. However, the incapacitation to negotiate safe sex and convenient contraceptives is often apparent in social

contexts that inhibit and differentiate gender capacity to engage in protected sex through the adoption of relevant and appropriate contraceptive methods. The use of disguise as a sexual negotiation strategy also produced self-deception and additional marital tensions. While disguised bargaining might be a strategy for avoiding unwanted sex and unintended pregnancy, it is not an appropriate health promotion strategy. More holistic measures and focus on sexual health promotion is required to target women and men.

As a relatively heterogeneous group, women at risk for unintended pregnancy could meet at different places like the market, religious settings, or workplaces for comparison of notes and experiences with contraceptives. Through peer interactions like this, users and nonusers may share information that could influence or inhibit the use of contraceptives and obstruct the flow of adequate information from Health Caregivers that could improve the effective use of modern contraceptives. Appropriate and convenient uses of contraceptives are essential to health sexual health and reduction of maternal mortality. Quite a number of maternal mortalities are preventable through effective use and appropriate switching. Where there is inadequate responsiveness to method-related discontinuation, unintended pregnancies and unsafe abortions might become rampant (2, 46). Inappropriate use, indifference or biased disposition and incorrect information possessed by nonusers coupled by the spread of negative experiences by some users with method-related problems may also deter potential users from adopting other methods.

Implications for Policy and Practice

The policy implications of the findings suggest the importance of complementing existing sexual health programmes to capture women and men in its focus, especially in the rural areas of Nigeria where polygynous practices are still customary. Evidence abounds that appropriate adoption of contraceptives helps women to avoid unintended pregnancies and to make informed decisions on the timing and the number of pregnancies (40, 53, 54).

Awareness and non-use of contraceptives create tensions in marital relations. This becomes vivid with structural challenges like cost of living, poverty, high unemployment, and the patriarchal orientation to heterosexual marital responsibilities. Understanding the dynamics of awareness and non-use of contraceptives on sexual negotiation among women at risk of unintended pregnancy has important implications for sexual and maternal health outcomes. Introduction and adoption of mixed contraceptive methods and risks reduction measures are urgently needed in family planning clinics. Healthcare providers need to understand the complexity of cultural values on fertility behaviour and low-utilization of contraceptives among childbearing women. More efforts are also required to help couples to navigate between cognitive and experiential risks associated with certain contraceptives with a view to making an informed decision on contraceptives uptake. An immediate step in this direction could include post-adoption follow-up from community health workers. The follow-up visit could be in the form of provision of information and assistance for women with contraceptive use complications.

There are indications that more investment on empowerment and retraining of health workers and family planning service providers at the local, state, and national levels could lead to quality counselling of women at risk for unplanned pregnancy as well as addressing both

perceived and real side effects of contraceptive use. In the same vein, there is a need to equip family planning providers at the three tiers of healthcare provision with contraceptive options. The availability of different family planning methods will encourage effective and timely switch from one method to another in the event of real side effects. Such options will help women to make alternatives and possibly have a method mix to prevent unwanted pregnancies and sexually transmitted infections. In this direction, holistic sensitisation and concrete efforts aimed at addressing contraceptive side effects are required to build public confidence and improve the perception. The readiness to admit and provide quality responses to the possible side effects of contraceptive use is urgently needed to scale up contraceptive usage in Nigeria.

Conclusions

Low-use or ineffective adoption of modern contraceptives create room for sexual negotiation strategies that may be counterproductive.The findings revealed that perceived risks of contraceptive use could create tensions in marital relations in both objective and subjective ways. However, this influence is fluid, and it differs based on individuality and quality of marital relations. The variability is observable from the narratives and experiences of the women in relation to their strategies of sexual negotiations. Thus, addressing the unintended consequences through sexual health promotion will require acceptable sexual negotiation strategies and effective switches from one contraceptive method to the other in the event of perceived or real risks of use.

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