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RESEARCH ARTICLE

REPRODUCTIVE HEALTH RIGHT AMONG WOMEN ATTENDING ANTENATAL CLINIC IN STATE SPECIALIST HOSPITAL, MAIDUGURI, BORNO STATE, NIGERIA.

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ABSTRACT

This study was conducted on the knowledge, attitude and practice of reproductive health right among women attending antenatal clinic in state specialist hospital Maiduguri, Borno state with the aim of ascertaining the level of knowledge, attitude, practice and factors affecting the practice of reproductive health right. Furthermore, descriptive survey was adopted for the study where self-constructed questionnaires were distributed to 171 respondents on a face to face basis who were recruited using convenience non-probability sampling technique. The data collected from the 165 returned questionnaires was analyzed using the IBM SPSS version 20 and presented in tables. The results revealed a low level of knowledge, neutral attitude and a very low level of practice of reproductive health right. More so, religion culture, low level of education, poor socio-economic status, ignorance and fear were the factors hindering the practice of reproductive health right among women. Therefore, hospital policies and guidelines are needed to promote and maintain respondents' knowledge, attitude and practice of reproductive health right.

INTRODUCTION

While motherhood is a thing of joy, it is also a source of sadness to many households as many women lose their life giving birth in Nigeria. Every single day, Nigeria loses about 2,300 under-five year olds and 145 women of childbearing age (Oluwakemi, 2013). Women's reproductive health is part of their general health and therefore is considered one of their human rights (Dixon-Mueller, 2013). The World Health Organization (WHO) confirms that reproductive rights rest on the recognition with good knowledge of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence (WHO, 2014).

The International Conference on Population and Development (ICPD) held in Cairo in 1994 defined reproductive health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. And reproductive health right (RHR), is a right of a citizen to have good knowledge and able to make informed decision of reproductive health. The concept is centered on human needs and development throughout the entire life cycle, "from the womb to the tomb" (Federal Ministry of Health [FMOH], 2001).

Reproductive health implies a state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are: the rights of men and women to be informed, have access to safe, effective, affordable and acceptable methods of family planning including methods for regulation of fertility, which are not against the law; and the right of access to appropriate health care services to enable women to have a safe

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pregnancy and childbirth and provide couples with the best chance of having a healthy infant (ICPD, 2013). Reproductive rights embrace the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as other methods of their choice for regulation of fertility which are not against the law, the right to appropriate healthcare services which will enable women go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. Reproductive health is thus a constellation of methods, techniques and services that contribute to reproductive health and wellbeing by preventing and solving reproductive health problem (Gbadamosi, & Olaide, 2007).

Every single day, Nigeria loses about 2,300 under-five year olds and 145 women of childbearing age. This makes the country the second largest contributor to the under–five and maternal mortality rate in the world. What is more devastating is that these deaths could have been prevented by basic investment in primary healthcare and infrastructure by the government. The high rate of maternal mortality is a source of grave concern and the need to improve maternal health cannot be over emphasized (Atsenuwa, 2004; and Oluwakemi, 2013).
Reproductive health rights are rights of all people, regardless of age, gender and other characteristics (whether young or old, women, men or transgender, heterosexual, gay, lesbian or bisexual, HIV positive or negative), to make choices regarding their own sexuality and reproduction, providing these respect, the rights of others to bodily integrity. That is, people have the right to make choices regarding their own sexuality and reproduction, provided that they respect the right of others. Reproductive health rights were first officially recognized at the International Conference on Population and Development (ICPD) in Cairo in 1994 (Griffin, 2006; and Tallis, 2012). The Program of Action of ICPD recognized that meeting the reproductive health (RH) needs is a vital requirement for human and social development. Protecting and promoting the reproductive rights of the women and empowering them to make informed choices is a key to their wellbeing (Lane, 2014). As one of the countries that approved the historic Programme of Action that emanated from the ICPD, Nigeria committed herself to the implementation of the Reproductive Health concept and the achievement of the ICPD targets in the interest of the health and development of her citizenry (Nwoso, 2001).

Reproductive healthcare covers a wide range of services. These services are defined in the ICPD Programme of Action (PoA) as including family planning counseling, information, education, communication and services, education and services for antenatal care, safe delivery and post-natal care, and infant and women's health care; prevention and treatment of infertility; prevention and treatment of infections, sexually transmitted diseases, including HIV/AIDS; breast cancer and cancers of the reproductive system, and other reproductive health conditions; and active discouragement of harmful traditional practices, such as female genital mutilation (FMOH, 2001).

Thus the essential elements of a comprehensive reproductive health package are; comprehensive sexuality education, access to contraception, safe abortion, where not against the law, maternity care, and diagnosis and treatment of sexually transmitted infections (STIs), including HIV, diagnosis and treatment of breast and cervical cancers and other cancers that affect the reproductive system. This package of services enables girls and women to decide whether and when to get pregnant, to decide whether to carry a pregnancy to term, and to experience pregnancy and childbirth safely with functional and accessible referral (International Women's Health Coalition [IWHC], 2008).

This article focuses on reproductive health as a human rights issue and discusses the knowledge, attitude and practice (KAP) of the right of women attending antenatal care, SSHM, to reproductive health. This paper will also looks at the right of women to reproductive information, education and services, with safe motherhood, choice of fertility, contraception, protection against rape, sexually transmitted disease and female genital mutilation. Every single day, Nigeria loses about 2,300 under-five year olds and 145 women of childbearing age. This makes the country second largest contributor to the under–five and maternal mortality rate in the world. What is more devastating is that these deaths could have been prevented by basic investment in primary healthcare and infrastructure by the government. The high rate of maternal mortality is a source of grave concern and the need to improve maternal health cannot be over emphasized (Atsenuwa, 2004; Oluwakemi, 2013).

Nigeria ranks amongst countries with the highest rate of maternal mortality and morbidity and in spite of the global recognition of the right to health as a human right, Nigeria is yet to embrace the concept as there is no specific legislation on the right to health in Nigeria (Oluwakemi, 2013).

Despite considerable efforts to reduce the maternal mortality ratio (MMR) by three quarters from 1990 to 2015 in order to meet the fifth Millennium Development Goal, an unacceptable number of pregnant women continue to die in many developing countries, including Nigeria. It is suggested that pregnancy-related mortality is due to delays in seeking required medical help, seeking a medical facility in time, and receiving adequate care which are channelled to poor attitude and practice to reproductive health, inappropriate knowledge to their reproductive health right (Gilles, Bukola, Maria, & Rebecca, 2013).

It's pertinent to undergo a form of this study that could test the KAP of RHR among women attending antenatal clinic (ANC), SSHM because during my antenatal care experience in SSHM at my undergraduate years, and at course of my participation in antenatal counselling, significant numbers of antenatal clients sympathetically expressed needs for liberty at discussing with their husbands freely regarding the decision of time and number of pregnancy. Moreover, academic discourse on reproductive health rights is a relatively novel phenomenon in Nigeria.

Objectives of the Study

1. To determine the knowledge of reproductive health right (RHR) among women attending ante – natal care (ANC) at State Specialist Hospital, Maiduguri (SSHM).
2. To identify the attitude of the women toward RHR.

3. To determine the practice of RHR among women attending ANC, SSHM.
4. To identify factors mitigating against the practice of RHR among women attending ANC, SSHM.

Research Questions

1. Do women attending ANC at SSHM know about RHR?
2. What is the attitude of women attending ANC, SSHM towards RHR?
3. How do the women attending ANC at SSHM, practice RHR?
4. What are the factors mitigating against the practice of RHR?

Non-experimental cross-sectional descriptive survey was used for this study. This method is considered apt for the study because it does not involve manipulation of participants experience and it is effective in seeking views from people about their experiences.

Method

Setting of the Study

The setting of the study is State Specialist Hospital Maiduguri, Borno State. The hospital is a general hospital owned by the Borno State Ministry of Health. It was established in 1928 and located along Shehu Laminu way, Maiduguri M. C. Borno state of Nigeria.
The total man power is 967.
Bed capacity = 500
Wards = 16
Nurses = 322.

Target Population

The target population of the study were women aged 15 to 45 attending antenatal care at State Specialist Hospital Maiduguri, Borno State. This population is chosen because they are at the age of child bearing and are the best to give report of satisfaction with the services. The monthly statistics of ante-natal care, University of Maiduguri Teaching Hospital, Borno State register shows an average number of 300 clients per week receiving ANC services.

Sample and Sampling Technique

Convenience non-probability sampling technique was used to get women attending antenatal clinic in state specialist hospital. In order to find the sample size the sample size, the researcher to use the Yaro Yamane formula:

$n = \frac{N}{1+N(e)}$2=formula
n= require sample size
N= total population of the study
Therefore, N=300
e= alpha level or margin of error at 5% (standard of value of 0.5)
Substituting the formula therefore:

$n = \frac{300}{1+300\ (0.05^2)}$

$n = \frac{300}{1\ +300(0.0025)}$

$n = \frac{300}{1+0.75}$

$n = \frac{300}{1.75}$

n = 171 approx.

The sample size of this research was 171 respondents selected from the target population which are women (15-45 years) of reproductive age attending antenatal clinic in State Specialist Hospital Maiduguri.

Instrument for Data Collection

The instrument for data collection was a self-developed questionnaire. The questionnaire involved four (4) sections, section A consist of demographic variables of the respondents, section B consist of respondents knowledge on reproductive health right, section C consist of respondents attitude towards reproductive right, section D consist of practice of reproductive health right while section E was on factors mitigating the practice of reproductive health right.

Close-ended questions were used to generate demographic data in section A while the questions used to solicit information in section B,C, D and section E were graded on likert scale 4 (strongly agree (SA) = 4, Agree (A) = 3, disagree (D) = 2, and strongly disagree (SD) = 1).

Validity And Reliability of the Instrument

The adopted instrument was submitted to the project supervisor who critically assessed the relevance of the content, clarity of the statement and logical accuracy of the instrument. Corrections made was effected and used to modify the final instrument before data collection

Reliability was done using test-re-test, the questionnaire was administered to 17 respondents (i.e. 10% of the sample size) twice at an interval of one week in a pilot study after they had been validated and the data collected at both intervals will be compared to see if they met the expected reliability rate. The test-re-test method involves administering one test to the same group of people on two different occasions and the two scores obtained, used to compute a correlation co-efficient, which is interpreted as an estimate of reliability. The formula for calculating reliability by Pearson is given below.

$$r = \frac{N\sum XY - \sum X\sum Y}{\sqrt{N\sum X^2 - (\sum X)^2}\ \sqrt{N\sum Y^2 - (\sum Y)^2}}$$

Where X refers to the frequency figure on variable X, Y is a frequency figure on variable Y and N is the number of subjects measured on both variables. The result gave high correlation coefficient of 0.91 indicates high reliability of measuring instrument

Procedure for data Collection

Ethical clearance was shown to staffs on duty who introduced the researcher to the staff on duty. Then informed consent was solicited, there after the self-structured questionnaire in a simple language was distributed to research respondents on face to face basis. With the aid of trained research assistant, copies of the questionnaire were collected immediately after completion.

METHODS OF DATA ANALYSIS

The information obtained was analysed electronically in line with the research objectives with the aid of SPSS software (taking account of both descriptive and inferential statistics) of version 20, manufactured by IBM. Results were further organised and tabulated with the aid of pencil, pen, ruler, calculator and computer system.

Ethical Consideration

Introductory letter from the H.O.D of nursing department, university of Maiduguri attached with proposal letter which contains relevant information about the nature of study was written to the CMD via the ethical review committees of state specialist hospital Maiduguri for approval. Informed consent was obtained from the respondents and assured of anonymity and confidentiality and their wishes and rights were respected throughout the period of data collection including the right to withdraw from the study at any time they wish. Respondents were treated with respect, dignity and their rights and welfare were protected. All the findings of this study were used with high level of confidentiality.

Data analysis and findings

This chapter presents and analyzes the data collected on knowledge, attitude and practice of reproductive health rights among women attending antenatal care in State Specialist Hospital Maiduguri (SSHM). One hundred and seventy one (171) questionnaires were distributed but only one hundred and sixty five (165) were retrieved making a 96.5% return rate.

Data analyzed were presented in tables. The first section (A) of the analysis consists of the socio-demographic characteristics of the respondents, section B; assessment of knowledge of RHR among women attending ANC, section C; evaluation of attitude towards RHR among women attending ANC, while section D contained the determination of practice of RHR among women attending ANC. Section E contained factors mitigating against the practice of RHR.

RESULTS

Table 1 Demographic characteristics of the respondents

Serial No	Variables	Categories	Freq.	Perc. (%)
1	Age	≤18 yrs	11	6.7
		19-25 yrs	42	25.5
		26-30 yrs	69	41.8
		31-40 yrs	30	18.2
		41 years and above	13	7.9
		Total	**165**	**100.0**
2	Marital status	Single	13	7.9
		Married	103	62.4
		Divorced	20	12.1
		Widowed	23	13.9
		Cohabiting	6	3.6
		Total	**165**	**100.0**
3	Level of education	No formal education	21	12.7
		Primary	33	20.0
		Secondary	52	31.5
		Tertiary	59	35.8
		Total	**165**	**100.0**
4	Current occupation	Employed	27	16.4
		Unemployed	24	14.5
		Business woman	64	38.8
		House wife	40	24.2
		Student	10	6.1
		Total	**165**	**100.0**
5	Ethnic group	Fulani	21	12.7
		Hausa	21	12.7
		Kanuri	57	34.5
		Shuwa	34	20.6
		Others	32	19.4
		Total	**165**	**100.0**
6	Religion	Christianity	26	15.8
		Islam	125	75.8
		Traditionalist	12	7.3
		Others	2	1.2
		Total	**165**	**100.0**

As shown in the demographic characteristics **table 1** above, majority of the women attending ANC, (41.8%) were at the age range of 26-30 years whereas the least group (6.7%) of age attending ANC, were ≤18 years of age. A majority of them (62.4%) were married while 6.7% of the population reported cohabiting. Majority of the respondents (35.8%) attended tertiary education while the least population (12.7%) do not have formal education. The respondents were majorly (38.8%) business women, 24.2% were pure time house wife, whereas, the minimal number (6.1%) of the reported being a student. Amongst the identified ethnic groups on the list, Kanuri (34.5%) recorded the highest population of the respondents and 75.8% of the total respondents were of Islamic religion.

Table 2 Response of respondents' knowledge regarding RHR

S/N	Variables	Categories	Freq.	Perc. (%)
1	If respondent have heard of the existence of reproductive health right	Yes	100	60.5
		No	65	39.4
		Total	165	100.0
2	If the respondent is acknowledged that she is entitled to RHR	Yes	114	69.1
		No	51	30.9
		Total	165	100.0
3	The decision of the number and spacing of children should be made by …….	Husband	32	19.4
		Wife	44	26.7
		Couples	76	46.1
		Parents	13	7.9
		Total	165	100.0
4	The decision of when and when not to marry for a mature lady should be made by …….	Parents	82	49.7
		Fiancé	48	29.1
		The respondent	34	20.6
		Uncles and relatives	1	0.6
		Total	165	100.0
5	If it's right for a married woman to raise and freely discuss family planning	Yes	133	80.6
		No	32	19.4
		Total	165	100.0
6	……. is expected to exercise the right of whether to bear children	Husband	70	42.4
		Wife	21	12.7
		Couples	62	37.6
		Parents	12	7.3
		Total	165	100.0
7	If it's rightful for a family woman to sorts for family planning information on her own	Yes	129	78.2
		No	36	21.8
		Total	165	100.0

The mean percentage of the correctly answered questions by the respondents as computed from **table 2** above was 56.1% and that of the incorrectly answered questions was identified to be 43.9%. Comparing the percentages with McDonald's standard of learning outcome measured criteria;

Level of knowledge/practice		Composite percent of scores
Very low	.....	<60%
Low	.....	60%-69.99%
Moderate	.....	70%-79.99%
High	.....	80%-89.99%
Very high	.....	90%-100%

56.1% showed a very low knowledge of women attending ANC, SSHM regarding RHR.

Table 3 Response of respondents' attitude toward RHR

S/N	Variables	Categories	Freq.	Perc. (%)
1	Women should exercise the right of when to get married.	Strongly agree	120	72.7
		Agree	25	15.2
		Disagree	14	8.5
		Strongly disagree	6	3.6
		Total	165	100.0
2	Women should assess the information of family planning at any point of her wish.	Strongly agree	74	44.8
		Agree	39	23.6
		Disagree	39	23.6
		Strongly disagree	13	7.9
		Total	165	100.0
3	The decision of when to have sex should be reserved for husband/male partner.	Strongly agree	79	47.9
		Agree	39	23.6
		Disagree	16	9.7
		Strongly disagree	31	18.8
		Total	165	100.0
4	The decision of the number and spacing of children should be reserved for husband.	Strongly agree	74	44.8
		Agree	41	24.8
		Disagree	24	14.5
		Strongly disagree	26	15.8
		Total	165	100.0
5	It not good for a married woman to seek for family planning services.	Strongly agree	49	29.7
		Agree	33	20.0
		Disagree	23	13.9
		Strongly disagree	60	36.4
		Total	165	100.0
6	Women reproductive health right should not be promoted in Nigeria because it's against our religious practices	Strongly agree	44	26.7
		Agree	52	31.5
		Disagree	24	14.5
		Strongly disagree	45	27.3
		Total	165	100.0
7	The decision of where to give birth should be made by the husband.	Strongly agree	65	39.4
		Agree	36	21.8
		Disagree	33	20.0
		Strongly disagree	31	18.8
		Total	165	100.0
8	Married women reserve the right to pursue a satisfying, safe and pleasurable sexual life	Strongly agree	104	63.0
		Agree	36	21.8
		Disagree	20	12.1
		Strongly disagree	5	3.0
		Total	165	100.0

Table 3 above put forth the mean percentages of both positive and negative attitude toward RHR as 66.3% and 33.7% respectively. And in comparing with score percentage of each level as developed to be;

Level of attitude		Score
Negative	.....	<64.99%
Neutral	.....	65%-74.99%
Positive	.....	>75%

The shown result of 66.3% indicated that women attending ANC, SSHM harboured neutral attitude towards RHR, they are neither against the right nor for it in totality; meaning, their attitude toward RHR is being regulated by the system they operate within.

Table 4 Response of respondents' practice of RHR

S/N	Variables	Categories	Freq.	Perc. (%)
1	I firmly reserve my right to freedom from domestic and sexual violence against unplanned sex with my husband	Always	97	58.8
		Sometimes	58	35.2
		Never	10	6.1
		Total	165	100.0
2	When do you have access to information of family planning at any point of her wish?	Always	70	42.4
		Sometimes	60	36.4
		Never	35	21.2
		Total	165	100.0
3	I decide with my husband and agree on when to have sex.	Always	83	50.3
		Sometimes	44	26.7
		Never	38	23.0
		Total	165	100.0
4	I plan with my husband and decide on the number and spacing of our children.	Always	74	44.8
		Sometimes	48	29.1
		Never	43	26.1
		Total	165	100.0
5	My husband and parents don't interfere when I wish to seek for family planning services	Always	56	33.9
		Sometimes	49	29.7
		Never	60	36.4
		Total	165	100.0
6	I have the freewill to discuss and agree with my husband on when and whether to bear children	Always	100	60.6
		Sometimes	53	32.1
		Never	12	7.3
		Total	165	100.0
7	I exercise my right to confidentiality in reproductive health care services and the right to autonomous reproductive choices.	Always	77	46.7
		Sometimes	61	37.0
		Never	27	16.4
		Total	165	99
8	I strictly practice my right to adequate nutrition especially when I'm pregnant to ensure positive pregnancy outcome	Always	89	53.9
		Sometimes	59	35.8
		Never	17	10.3
		Total	165	100.0
9	I do pursue a satisfying, safe and pleasurable sexual life	Always	114	69.1
		Sometimes	42	25.5
		Never	9	5.5
		Total	165	100.0

Table 4 showed that 51.2% of women attending ANC, SSHM do practice their RHR while 48.8% of the respondents do not actually practice their RHR. By referring this percentage of practice to McDonald's standard of learning outcome measured criteria below;

Level of knowledge/practice		Composite percent of scores
Very low	.....	<60%
Low	.....	60%-69.99%
Moderate	.....	70%-79.99%
High	.....	80%-89.99%
Very high	.....	90%-100%

Unfortunately, 51.2% on the list of McDonald indicated a very low practice of RHR among women attending ANC, SSHM.

Table 5 Factors mitigating against the practice of RHR

S/N	Variables	Categories	Freq.	Perc. (%)
1	Religion	Strongly agree	120	72.7
		Agree	25	15.2
		Disagree	14	8.5
		Strongly disagree	6	3.6
		Total	165	100.0
2	Culture	Strongly agree	125	75.8
		Agree	25	15.2
		Disagree	9	5.5
		Strongly disagree	6	3.5
		Total	165	100.0
3	Level of education	Strongly agree	100	60.6
		Agree	49	29.7
		Disagree	6	3.6

		Strongly disagree	10	6.1
		Total	165	100.0
4	Low information	Strongly agree	74	44.8
		Agree	41	24.8
		Disagree	24	14.5
		Strongly disagree	26	15.8
		Total	165	100.0
5	Parents	Strongly agree	49	29.7
		Agree	33	20.0
		Disagree	23	13.9
		Strongly disagree	60	36.4
		Total	165	100.0
6	Socio-economic status	Strongly agree	65	39.4
		Agree	36	21.8
		Disagree	33	20.0
		Strongly disagree	31	18.8
		Total	165	100.0
7	Ignorance	Strongly agree	75	45.5
		Agree	36	21.8
		Disagree	23	13.9
		Strongly disagree	31	18.8
		Total	165	100.0
8	Fear	Strongly agree	104	63.0
		Agree	39	23.6
		Disagree	17	10.3
		Strongly disagree	5	3.1
		Total	165	100.0

Table 5 revealed that 120(72.2%) strongly agreed that religion is a factor, culture 125 (75.8%), level of education 100 (60.6%), low information 74 (44.8%), socio-economic status 65 (39.4%), ignorance 75 (45.5%), fear 104 (63.0%) while on parents 60 (36,4%) strongly disagree.

DISCUSSION OF MAJOR FINDINGS

The findings are discussed in four parts: (1) respondents' knowledge (2) respondents' attitude (3) respondents' practice (4) factors mitigating against the practice of RHR.

Research Question One: Respondents' knowledge

The findings showed that the women who participated in this study had a very low level of overall knowledge of reproductive health right (RHR). Their formal education background may be a factor related to this very low level of knowledge. Only 35.8% of the total respondents attended tertiary institution. The lack of opportunity to advance in western educational program might preclude the respondents from remembering, understanding, and applying suitable knowledge of reproductive health right. The findings of this study is in agreement with the review of Cornaro (2013), whose study was conducted on assessment of knowledge of RHR, had revealed results that 2052 women, girls and men had attended rural educational/awareness session on reproductive health. 1246 women have undergone breast checks, 918 pap smears were performed, contraceptives were prescribed as required, and 162 were referred to clinic to create awareness indicating a hallmark of good knowledge and practice of RHR, and to empower rural girls and women on reproductive health/ RHR, in combination with the provision of health care services. Meaning access of women to advance knowledge either on the subject matter or other formal education program may have positive influence on their level of remembering and knowing of RHR.

Research Question Two: Respondents' attitude

Results revealed that majority of the respondents indicated neutral level of attitude (66.3%) toward RHR as referenced to McDonald's standard of learning outcome measured criteria. This finding proved that the majority of the respondents were neither completely against nor supporting the adoption of RHR and from their registered interest of neutral attitude toward RHR, a little adjustment of influencing factors in the system in which the women operate could either further promotes positive attitude or negative attitude toward RHR.

Research Question Three: Respondents' Practice

It was revealed from the result of the study that the practice of the respondent of RHR was on a very low level. A possible reason for explaining this very low level of practice may be due to certain factors. Firstly, the hallmark of the reported very low level of knowledge regarding reproductive health right. Secondly, only 16.4% of the total respondents were gainfully employed as against 24.2% of full time house wife; both socioeconomic status and demographic development have significant positive effects on practice level of RHR. This is similar to a study conducted by Pillai &Rashmi (2011) on RHR in developing countries which suggests that both economic and demographic development have significant positive effects on knowledge and practice level of gender equality. The level of social development plays a prominent role in promoting reproductive right. It was found that RHR channels influence of social structural factor and gender equality of reproductive health, 67% of the respondents showed adequate knowledge and good practice of reproductive health right.

Research question four: factors mitigating against practice of RHR

The study revealed several factors that hinder the practice of RHR among women in SSH, the chief factors are religion, culture, low level of education, socio-economic status, ignorance and fear. This is in line with a study conducted on RHR by WHO (2013) which states that the factors hindering the practice of RHR are poor access, or because of social barriers such as the need for parental or spousal consent making the awareness and practice of reproductive right strangulated for women.

CONCLUSION

A non-experimental cross-sectional descriptive study was conducted to assess the knowledge, attitude, and practice of RHR of women attending ANC, SSHM together with factors hindering practice. In addition, the relationships between the respondents' age and attitude, educational qualification and practice were also examined. The study was carried out from January 2018 to April 2018 in antenatal care clinic, SSHM, Borno State. The participants were all women attending ANC, SSHM.

Strength and Limitation

This assessment of the current situation of knowledge, attitude and practice of reproductive health rights among women attending antenatal care in ANC, SSHM could provide baseline data for the further study of reproductive health right. There are some limitations to this study. The main limitation was using a

self-report questionnaire to examine respondents' practice. The responses might not reflect actual RHR practices. Another limitation was the generalizability of the findings because this study was conducted in one state specialist hospital. The findings may not be generalized to other specialist hospitals or to hospitals at other levels.

Implication for Nursing Practice

Despite the above limitations, it is recommended that women attending ANC, SSHM needed good information on RHR in order to improve their practice. More so, SSHM ANC nurses have a pivotal role to play in this regard because this context is channelled down to proper health education. Although the attitude level was neutral and the practice very low, the knowledge level was equally very low. These findings indicated that knowledge is and important factors in relation to practice of RHR.

Recommendations

The following recommendations are put forward to improve knowledge, attitude, and practice of RHR among women attending ANC, SSHM:

- Hospital policies and guideline are needed to promote and maintain respondents' KAP of RHR.
- The results of this study should be shared with stake holders such as nurse administrators, nurse teachers, nurse researchers, nurse clinicians, hospital administrators and the public. This should make the problem of RHR of women a public concern.

Suggestion for Further Studies

- Further interventions studies should be initiated to assess the knowledge, attitude, and practice of RHR among other groups of women.
- Another study should be carried out on the same topic but using focused group discussion as the instrument for data collection.

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