International Journal of Sociology of the Family Vol. 45, Nos. 1-2, 2019

PERCEPTION OF FIBROID AMONG CELIBATE-WOMEN IN IBADAN, NIGERIA

CHISAA O. IGBOLEKWU
Landmark University, Nigeria
EZEBUNWA E. NWOKOCHA
University of Ibadan, Ibadan, Nigeria

Uterine fibroid is a major health challenge especially among African women. Studies on fibroid had focused largely on the biomedical aspect of this health condition among non-celibate sexually active women, particularly with regard to its effects on the fecundity status of such women with future fertility intentions. However, little attention has been given to the social issues related to fibroid among Celibate-women (also known as Reverend Sisters). This study, which anchored on the Health Belief Model, examined the perception of fibroid among Celibate-women in the Catholic Ecclesiastical Province of Ibadan, Nigeria, classified in literature among the most vulnerable groups. Data were collected with 370 copies of a questionnaire administered on Celibate-women through a total population sampling technique. Key informant interviews were conducted among 28 purposively selected respondents. Findings reveal that about 90% of the respondents perceived fibroid as treatable, 92% stated that fibroid occurred mainly in sexually inactive women, 41% described it as chronic and 49% perceived it as an acute condition. Celibate-women in the Catholic Ecclesiastical province of Ibadan had diverse perceptions about fibroid which invariably influenced their health seeking behaviour. Introduction

Uterine fibroids are non-cancerous growths that develop in the muscular wall of the uterus. They are more rampant in women of African origin, particularly among those 25years and above. (Sealy, 2012, Godwin, Spices, Worthington-Kirsch, Peterson, Pron, LiS-Myers, 2008, Oguniyi and Fasuba, 1990). Literature has shown that women who are sexually inactive or nulliparous, are more predisposed to the risk of fibroid than sexually active women (Aamir, Manjeet and Janesh, 2014, Ogedengbe, 2003, Aboyeji and Ijaiya, 2002). This study, therefore, examined how Celibate-women who are nulliparous and supposedly sexually inactive perceive their vulnerability to fibroid.

Previous studies have focused largely on fibroid among sexually active non-celibate-women, and mainly undertaken from the biomedical perspective,

especially with regard to its etiology and treatment and/ or management (Elugwaraonu, Okojie, Okhia, Oyadoghan, 2013, Eggart, Huyck, Kavalla and Stewart, 2012). However, negligible attention has been given to the social dimension of this medical condition. Moreover, Celibate-women have been ignored almost totally in the fibroid discourse based on a misleading assumption that neither they nor the society has interest in what becomes of their reproductive system. Thus, a gap exists in the knowledge related reproductive health literature.

This paper argues forcefully that although celibate by choice, these women are not separated from the culture in which they operate. Indeed, in Africa, a high premium is placed on women's fertility potentials and actual reproductive performance; hence, not having a child evokes a sense of deprivation, non-fulfillment and low self-esteem (Nwokocha, 2012; Owumi, Isamah and Okunola, 1996). Hence, even though this category of women is not expected to give birth, they are however naturally still interested in their biological status including those that relate to the reproductive system. Consequently, there is need for research that focuses on the perception of fibroid among this group of demographically understudied women.

Theoretical Framework

The paper is anchored on Health Belief Model which postulates that health seeking behaviour is determined by perceptions of individuals about a disease and the likely strategies or the recommended action to ameliorate its effects upon occurrence (Rosenstock and Becker1988; Hochbaum, 1985). The model focuses on constructs such as perceived susceptibility, perceived seriousness, perceived benefits and perceived barrier among others. With reference to fibroid, the perception of Reverend Sisters about whether or not they are susceptible will define their interest in knowing more about the condition, their attitude towards counseling, and disposition related to avoiding likely predisposing factors among others. Perceived seriousness or severity focuses on an individual's conception or assessment of the extent of the effect of a health condition. This construct portends implications which impinge on attitude and behavior towards seeking health related actions targeted at ameliorating a negative health condition that has already occurred.

In the context of this paper, much emphasis will not be placed on analyzing perceived seriousness given that the present paper is only focusing on the perception of Celibates about the condition, and not on whether or not they have experienced and/or experiencing it in order to be able to discuss how severe they perceive the condition. Put differently, only people that have

experienced a negative health condition can adequately speak to the issue of perceived severity, as this is not meant to embed in assumptions. With regard to perceived benefits, the construct examines how Reverend Sisters view health seeking for fibroid in terms of patterns, pathways and timing which are critical to effective diagnosis, treatment and management. To be sure, it is only when an action is conceived as likely able to bolster efficacy that the acting individual would embrace such an approach.

With regard to perceived barriers, the model supposes that adequate understanding of the likely inhibitions against seeking medical solution to a health condition, in this case fibroid, should derive from empathizing with the individual experiencing the condition. The implication is that such limitations are different among individuals considering contextual and cultural differences. Reverend Sisters constitute a special group with rules and regulations guiding attitude and behavior different from expectations in conventional society. As such, factors that may discourage or undermine early detection and treatment of fibroid may likely outweigh those reported by other women or their non-celibate counterparts. For instance, due to the oat of celibacy taken by these women which forbids them from marriage, coitus and childbearing fibroid may not be conceived as a priority over other demands simply because conception is forbidden. Yet, it has been reported that fibroid may constitute a medical emergency (Igbolekwu 2017).

Method

We chose the Catholic Ecclesiastical province of Ibadan for the research based on the fact that it is the province in South-western Nigeria, with the highest population of Celibate-women. The province comprises 21 congregations with a total of 375 Celibate-women residing in these congregations at the time of this study.

The study employed a combination of qualitative and quantitative data collection techniques. A total of 375 copies of a questionnaire were administered on the Celibate-women, while 21 Key Informant Interviews (KII) were conducted among the Mother Superiors of each of the congregations. In addition, 5 case studies were undertaken on selected Celibate-women. Field work commenced with KIIs which provided preliminary insight that necessitated design of the questionnaire schedule. A sample questionnaire was designed and pre-tested in locations other than those selected for the research. The questionnaire consisted of 30 closed and open-ended items addressing perceptions of fibroid among the study population.

Field assistants, who were mainly females, were trained in a one-day workshop. Total population sampling technique was employed considering the population of the congregations was just moderate. Thus, the instrument was administered on each Celibate-woman present in the Catholic ecclesiastical province of Ibadan as at the period of the study. Each KII aimed to ascertain the Celibates' perception about the causes of fibroid, severity of fibroid, possibility of treatment, sexuality, cultural beliefs about fibroid, among other issues. Five case studies were undertaken. Two of the cases were those whose fibroid condition was complicated and posed serious threat to their health, another two had the fibroid condition successfully treated and one who was living with fibroid at the time of data collection.

The consent of both respondents and participants was sought prior to their participation in the study. The right to withdraw at any point or to withhold any information perceived by participants as impinging on their privacy was adhered to. Similarly, their confidentiality was guaranteed to the extent that information volunteered in the course of data collection could not be traced to any of the research subjects. Additionally, ethical approval was obtained from University of Ibadan Ethical Review Committee before fieldwork was commenced. Qualitative data were content analyzed. However, quantitative data were edited to eliminate inconsistency that could undermine validity and reliability of information. Data were finally analyzed using the Statistical Package for Social Sciences (SPSS). Descriptive and Inferential statistics were used in analysing data and presented in simple percentages and Chi-square.

Results

Table 1 shows the socio-demographic profile of the respondents indicating their age distribution, which ranged from 22 to 55 years with the mean age of 39.3 ± 9.6years. The majority of respondents (81%) were below 41 years. This shows that a large number of the Celibate-women studied were within the reproductive age. The distribution of the respondents according to their level of education reveals that 81 percent had post-secondary education, about 15 percent had secondary education, and 4 percent had primary education. This result indicates that all the respondents had some level of formal education.

Table 1: Distribution of Respondents by Socio-demographic Characteristics

Characteristics	Categories	Frequency	Percent
Age – group	≤ 25 years	26	6.9
	26 - 30 years	62	16.5
	31 – 35 years	105	28.0
	36 – 40 years	110	29.3
	41years and above	72	19.3
	Total	375	100.0
Education	Primary	15	4.0
	Secondary	55	14.8
	Post - secondary	301	81.2
	Total	371	100.0
Ethnicity	Hausa	14	3.8
	Igbo	209	56.8
	Yoruba	126	34.2
	Other	19	5.2
	Total	368	100.0
Duration of celibacy (profession)	< 10 years	114	33.8
	10-20 years	115	34.1
	21-31 years	84	25.0
	31+ years	24	7.1
	Total	337	100.0
Occupational Status	Student	74	19.9
	Medical Personnel	181	48.8
	Teachers	108	29.1
	unemployed	8	2.2
	Total	371	100.0
Monthly Income	<10 000	11	4.3
	10 000 – 19 999	28	10.9
	20 000 – 29 999	84	32.7
	30 000 – 39 999	97	37.7
	40 000 – 49 999	24	9.3
	50000 and above	13	5.1
	Total	257	100.0

Although the study was conducted in the South-west, Nigeria inhabited mostly by the Yoruba, most of the celibate women that participated in the study were of Igbo extraction. The majority of the respondents were also

employed and earned income. The data equally show that the majority of the respondents who were gainfully employed earned between ₦30, 000 and ₦30, 999 (slightly over $100) monthly.

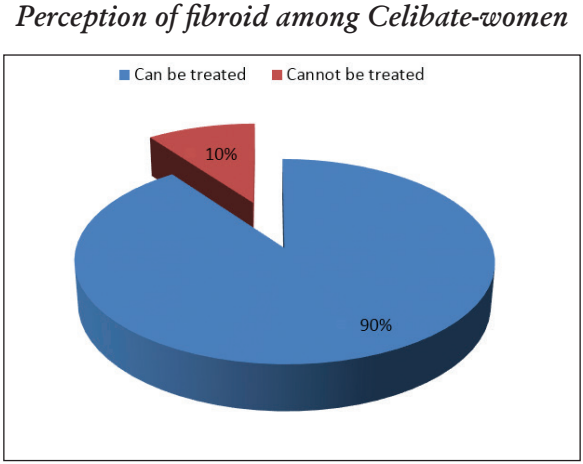

Figure 1: Showing percentage distribution of respondents by description of fibroid

Figure 1 indicates that a very large majority (90%) of the respondents were of the opinion that fibroid can be treated, especially when diagnosed on time. While only 10 percent stated that the fibroid condition cannot be treated. However, some of the respondents were of the view that fibroid could become very complicated if it is not detected early. This is further buttressed in what this respondent said:

> *…fibroid is easy to treat especially when it is diagnosed on time, but if ignored it can cause damages in the body system and become complicated. (KII/Ekiti Diocese/ 2016).*

If the above perception is correct, it would imply that although fibroid conditions may not always be classified as emergency in hospitals and by the patients, there is still need for early diagnoses and regular check-ups given that delays could result in severe complications, especially when the symptoms involve heavy bleeding.

On the perception of the causes of fibroid, some Celibate-women enumerated the following including hormonal imbalances, genetics (hereditary), sexual inactiveness, null parity, early onset of menstruation, stress, poor dietary control, not giving birth and when there is no fertilized egg to develop in the womb. For instance, a respondent stated that:

Fibroid is a growth, although the cause may not be known for now, however, there are predisposing factors, including that the womb of a Celibate which is supposed to nurture pregnancy is denied its natural role; so when what should be normal for the uterus is not forth coming, the uterus compensates itself by inducing growth of tissues which results to fibroid. It grows up to fill the vacuum the baby could have filled. Although this may not be scientifically proven, it is the general belief among people. (KII/Osun Diocese/2016)

The statement above shows that some celibates saw celibacy and by extension their nulliparous condition as one of the major predisposing factors to the development of fibroid. This was also corroborated by a Matron engaged in Key Informant Interview:

It is the abnormal joining of tissues, anything can lead to fibroid growth, it could be toxins, food, it could also be because we are humans. For married women when there is pregnancy, the fibroid grows with the baby but when the baby is eventually delivered, it reduces the blood supply to the uterus and this causes both the uterus and the fibroid to shrink and most of the time degenerates. For people that are not married like Reverend Sisters, since there is no baby to grow inside the uterus, the fibroid continues to grow and does not shrink, which often leads to surgical intervention (KII/Oyo Dioceses/ 2016).

Yet another respondent also said:

I have been through a lot of health challenges because of this fibroid. It is common among us, just because we do not give birth; that is the only difference between us and any other woman. (Case study (celibate-woman living with fibroid)/ Oyo Dioceses/ 2016)

The above responses indicate diverse speculations about the causes of fibroid, however one major risk factor the Celibates pointed out was their non-involvement in sexual activity. One of the respondents expressed a different view insisting that it is not common among Celibate-women just because they do not procreate:

It is correct that a lot of Celibate-women come down with fibroid. Some people say we have it because we do not give birth, in as much as this may be true, but being a medical personnel, I do not believe it because it is not scientifically proven. Furthermore, we have seen women who were diagnosed of fibroid, get pregnant and give birth to children. I feel that Celibates who have fibroid do so because of the same reasons that predispose married women to fibroid. For instance, if a Celibate-woman takes a lot of red meat, indulges in reckless life style and has a family history of fibroid, she may be predisposed to the condition (KII/ Hospital Administrator/Osun Dioceses /2016).

This implies that factors other than nullparity could also predispose a Celibate-woman to the risk of fibroid. On their perception about hereditary as a predisposing factor of fibroid, a respondent stated that:

> *For me fibroid is not hereditary, I have four biological sisters and none of them has fibroid except me, I feel it may be because we do not get involved in childbearing (Case study/ Osun Diocese/2016)*

Although heredity has been identified by previous studies as one of the risk factors of fibroid, some of the respondents perceived fibroid as mainly explainable by null-parity. Another respondent however added:

> *I believe fibroid could also be hereditary; women either married or unmarried could have fibroid, especially when it runs in a family. That is what I was taught in school and I think it is true (KII/Osun Diocese/ 2016).*

The implication of such diverse and inconsistent views about the etiology of the medical condition is that undertaking vigorous awareness related to fibroid has become particularly necessary both to bolster behavior modification at individual level and intervention at community level. Table 2 indicates that 93 percent of the respondents stated that fibroid can manifest in a virgin. They maintained that fibroid develops in the uterus and therefore not actually related to whether an individual is a virgin or not given that the condition of the external genitalia does not define fibroid status among women.

Table 2 further shows that about 41 percent of the respondents perceived fibroid as a chronic condition, 49 percent perceived the condition as acute and 11 percent described it as both acute and chronic that needed to be given adequate medical attention. Approximately 84 percent believed that fibroid could lead to death.

Table 2: Percentage distribution of respondents by perceptions about fibroid

Perceptions	Response	Frequency	Percent
Fibroid and virginity	Fibroid can manifest in a virgin	323	92.8
	Fibroid cannot manifest in a virgin	25	7.2
	Total	348	**100.0**
Description of fibroid	Chronic	149	41.4
	Acute	180	48.8
	Both 1& 2	40	10.8
	Total	**369**	**100.0**
Critical stage of fibroid	Fibroid can lead to death	303	83.7
	Fibroid cannot lead to death	59	16.3
	Total	**362**	**100.0**

Effect of culture on perception	Cultural beliefs affect perception of fibroid	64	17.2
	Cultural belief does not affect perception of fibroid	209	82.8
	Total	**373**	**100.0**
Perception about where fibroid can be found	Only in sexually active women	16	4.7
	Among non-sexually active women	322	95.3
	Total	**338**	**100.0**

The reasons adduced included late presentation, diagnoses and poor management, which could degenerate into cancer, excessive pain and loss of blood, among others. Additionally, as Table 2 shows, that the rest 16 percent that opined that fibroid does not ordinarily lead to death maintained that it is rather the complications arising from fibroid related surgery that usually lead to deaths. This was further buttressed by a respondent who stated:

> *Fibroid is harmless, I have lived with it for ten years now, it is not giving me problems; the Doctors said it will shrink when I reach menopause. I think that complications from the surgery is usually responsible for related deaths rather than the fibroid condition itself (kII/48 years old Mother Superior/ Kwara Dioceses/2016)*

This view clearly suggests that while some fibroid conditions could be acute and could result in loss of lives, some could be asymptomatic. The above narrative represents the opinion of an individual which cannot be generalized to the study population. Another respondent also said:

> *I do not think fibroid can kill especially if diagnosed and treated on time, rather the post-surgical complications and other factors such as anemia, infection, denial for fear of surgery and so on could lead to death or life threatening damages to some sensitive organs. For instance, I know of a Celibate-woman whose fibroid was growing toward the heart, it resulted to her having difficulty in breathing, high blood pressure and oedema of the legs all because she was afraid and kept it to herself. Eventually, she was operated upon and has since regained her health. (KII/Celibate Matron/ Oyo Diocese/2016)*

This suggests that the fear of surgery and post-surgical complications could be an impediment to early diagnoses and timely medical attention, thereby predisposing such women to morbidity. The extent to which the further health consequences alluded to by the respondent is medically correct is beyond the scope of this paper. Furthermore, 82.8 percent of respondents stated that their

cultural beliefs did not affect their perception of fibroid while 95.3 percent noted that fibroid is experienced among non-sexually active woman. However, a handful of the population (17.2% and 4.7%) linked fibroid to cultural beliefs and sexuality respectively.

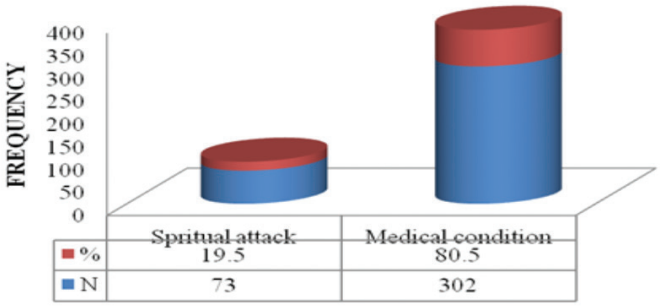

Figure 2: Showing percentage distribution of respondents by other causes of fibroid

Figure 2 indicates that 80.5 percent also perceived fibroid as a medical condition, while 19.5 percent saw it as a spiritual attack. This shows that the majority of Celibate-women in the study area described fibroid as a medical condition, rather than spiritual attack. This could have been influenced by the high literacy level among the Celibates studied on one hand and strong belief in the efficacy of prayer to neutralize spiritual attacks.

Table 3 reveals the different perceptions that some of the congregations studied had about the fibroid condition. While 39.6 percent of the Franciscan Sisters of Immaculate Conception perceived fibroid as a medical condition, 45.8 percent stated that fibroid was hereditary in nature and about 15 percent perceived it as caused by spiritual attack. Data also indicate that just a few of the congregations (7.8%) perceived fibroid as a spiritual attack, while the majority of congregations (64.5%) perceived fibroid as a medical condition, followed by those that perceived it as hereditary (27.7%).

Table 3: Percentage distribution of respondents by perception of causes of fibroid according to Congregations

Congregation	Perception			Total	Chi-square	df	p-value
	Spiritual attack	Medical condition	Hereditary				
Franciscan Sisters of Immaculate conception	7(14.6)	19(39.6)	22(45.8)	48(100)			
Daughters of the Holy Spirit	9 (14.1)	27(42.1)	28(43.8)	64(100)			
Sisters of St Michael De Archangel	3(8.8)	18(52.9)	13(38.3)	34(100)			
Poor and Handmaid of Jesus	1(3.4)	28(96.6)	0	29(100)			
Immaculate Heart of Mary	0	15(65.2)	8(34.8)	23(100)			
Daughters of Mary Mother of Mercy	1(5.6)	16(88.9)	1(5.6)	18(34.8)			
Dominican Sisters	0	16(100)	0	16(100)	482.622	20	.000
Medical Missionaries of Mercy	0	12(100)	0	12(100)			
Eucharistic Heart of Jesus	1(5.9)	16(94.1)	0	17(100)			
Sisters of our Lady of Apostle	0	6(5.0)	6(50.0)	12(100)			
Daughters of Divine Love	0	9(100)	0	9(100)			
TOTAL	22(7.8)	182(64.5)	78(27.7)	282(100)			

As Table 3 further shows Celibate-women that belong to Poor and Handmaid of Jesus (PHJ) Congregation were more likely to perceive fibroid as a medical condition than those that belong to other congregations (χ^2 = 482.622 df=20, p <0.05). This implies that there is a significant relationship between respondents' congregation and their perception.

Discussion and Conclusion

The majority of Celibate-women studied fall within the age range considered by previous studies *as* more vulnerable to fibroid condition *(*Elugwaraonu *et. al.* 2013; Ogedengbe 2003). This shows that they were very mature and competent to speak on the subject matter. Similarly, the dominance of the Igbo celibate in the population studied despite the location of the study in the South West Nigeria largely corroborates the observation of Agulana, (1998) that eighty-five percent of people of South-east, Nigeria, are predominantly Roman Catholics with most families eager to have at least a member as Celibate-woman or man.

Furthermore, the observation that the majority of the Celibates were employed could be attributed to the fact that most of the congregations in the Catholic Ecclesiastical Province of Ibadan owned and operated either schools or hospitals. Further probing also revealed that the so called unemployed were not entirely so considering spiritual duties allocated to them, which could not formerly be classified under any formal job category.

The income earned by some of these Celibates is barely enough to take care of their material needs even though they live a communal life. Irrespective of the type of job and the amount earned, Celibate-women are not allowed to open and/or operate bank account. The incomes are put together in the congregation's 'common purse' (which could be a bank account) and disbursed to members according to their personal needs by the Mother Superior of various congregations. It is also through these funds that other expenses, like food, clothing, shelter, health and repairs among other issues are funded.

A large majority of the respondents perceived fibroid as a condition that can be treated; they also stated that it requires timely medical intervention, as its consequences could become life-threatening if not detected early and for a long period of time. However, the study reveals that several cases of fibroid among these Celibates were left unchecked for a long period of time which resulted in complications. This could have been borne out of fear of surgery expressed by many of the Celibates who had fibroid. Hence, the observations of Jegede, (2002) that the adoption of both preventive and curative methods on any form of ill-health is dependent on individuals' perception of the health condition. For instance, although some of these Celibates perceived their fibroid condition as serious, they were reluctant to present themselves for prompt medical interventions.

These findings also contradict the construct on perceived seriousness, which speaks to an individual's belief about the seriousness or severity of the disease, while the perception of seriousness is often based on medical information, knowledge or experience; it may also result from beliefs a person has about the difficulties a disease would cause or that it would have on his or her life in general (Haralambos and Holborn, 2008). The contradictions to this construct are also reflected in the observation that although some Celibates perceived their fibroid condition as serious, their health seeking behaviour was influenced by the fear of surgery and other post-surgical complications.

This study also observed that majority of the respondents perceived their null parity as the major cause of fibroid. Indeed, null parity has consistently been identified as a major risk factor for fibroid by previous studies (Aamir *et. al.*, 2014; Parker 2013; Laughlin, 2012; Adache, 2010; Aiyeyemi *et. al.,* 2008;

Ogedengbe, 2003). A few of the respondents, however, maintained that the etiology of fibroid is still not clear and were not inclined to accept the commonly held notion that the condition results from sexual inactivity. As a result, further medical investigations have become peculiarly imperative to specifically identify the major cause of fibroid among women generally and isolated groups in particular.

Additionally, although family history (heredity) has also been implicated as a strong predisposing factor to uterine fibroid (Adegbesan-Omilabu *et. al.* 2014; Andrea *et. al.*2013), the majority of the respondents did not share this view. The argument was that had it been inherited, biological sisters of someone with the condition should experience also same. Thus, as has been reported, uterine fibroid could develop in any woman irrespective of her sexual behaviour (Laughlin, 2012). This position counteracts the findings of Ikechebelu *et. al*, (2012) and Akinyemi, *et. al.* (2004) that identified heredity not only as a factor but that 40 percent of first-degree female relatives of women with fibroid will develop fibroid.

Furthermore, data on whether fibroid is normally acute and/or chronic revealed very little perceptual disparities among the respondents. This lack of clear distinction also suffices in literature which indicates that fibroid could either be symptomatic or asymptomatic depending on the biological make-up of the individual experiencing the condition, as well as the location of the fibroid in the uterus (Sabry, *et. al.* 2012; Sealy, 2012). As Okolo (2008) observed, the majority of women with uterine fibroid are asymptomatic and require little or less clinical attention. We however contend that each fibroid condition should be examined as peculiar which may indicate either severity and may constitute an emergency on one hand or merely chronic but without showing signs of threat to life, on the other.

Although the majority of respondents viewed fibroid as responsible for deaths, a few insisted that mortality arising from the condition usually results from post-surgical complications rather than the fibroid as a condition. Haney (2000) had noted that regardless of their generally benign neoplastic character, uterine fibroids are responsible for significant morbidity in a large segment of the female population. Indeed, whether or not fibroid or the complications ascribed to it drive mortality among women, it is important to note that this medical condition constitutes a major threat to life and should be so perceived. The belief among some of the Celibates that fibroid will shrink as they advance in age largely agrees with the observation of Aiyeyemi *et. al.* (2008) that fibroids occur and increase in size during the reproductive years but regresses during menopause. However, this study found out that some of these Reverend

Sisters develop fibroid as early as age 27, hence having to wait for it to shrink at menopause may constitute a barrier to timely medical intervention.

The overwhelming perception of fibroid as a medical condition rather than a spiritual attack among the population of study contradicts the findings of Adegbesan-Omilabu *et. al.* (2014) and Kwame-Aryee and Seffah (1999) that over two-thirds of women perceived fibroid as a spiritual issue and invariably sought solution from spiritual homes. Perhaps, Reverend Sisters by their calling, firm belief in the efficacy of prayers and high literacy status have divergent disposition to the spiritual explanation of fibroid unlike the general population.

Studies on fibroid are numerous and enjoy interdisciplinary focus probably because it constitutes social, biological, psychological and economic issue. Literature is replete with data on the aetiology, treatment, and management of this medical condition especially among sexually active women at the expense of Celibate-women. This study has bridged that gap by examining Reverend Sisters in the Ibadan Catholic Ecclesiastical Province, which also brought to fore the social dimension of the condition and the need to engage in further academic inquiry into the condition probably among other groups that are yet to attract adequate scholarly attention.

Comprehensive understanding of fibroid among all categories of women is essential to foist appropriate policies that could modify attitude and behavior. This will go a long way to bolstering informed safety measures and that way minimize the incidence of fibroid in society generally especially in the context of a characteristically poor medical system that is sustained by weak governance structure and state-insensitivity.

References

Aamir, T. K.; Manjeet, S; Janesh, K.G. 2014. Uterine fibroids: current perspectives. *International Journal of Woman's Health. Vol 6. p.95-114.*

Aboyeji, A.P.; Ijaiya, M.A. 2002. Uterine Fibroids. A ten-year clinical review at University of Ilorin Teaching Hospital, Ilorin, Nigerian. *Nigeria Journal of Medicine; Vol.*11, p.16- 19.

Adache, C. 2010. Factors responsible for uterine fibroid among women of reproductive age in Osun State. A project submitted to the department of Nursing Sciencies, Ladoke Akintola University Ogbomoso.

Adegbesan-Omilabu, M. A.; Okunade, M. A.; Gbadegesin, A. 2014. Knowledge of perception of, and attitude towards uterine fibroids among Women with fibroids in Lagos, Nigeria. *Scientifica. Vol. 2014. p. 5.*

Agulana, B.C. 1998. *The Mbaiseness of Mbaise.* Owerri1-0 publishers.

Aiyeyemi, A.; Jimoh, A. A.G.; Balogun, O.R. 2008. Management of uterine fibroid

at the University of Ilorin Teaching Hospital, A 5-year review, *Nigeria Journal of Health Sciences Vol.10. p.16-19*.

Akinyemi, B.O.; Adewoye B.R.; Fakoya, T. A. 2004. Uterine fibroid: A review. *Nigeria Journal of Medicine. Vol.*13. p.318 – 329.

Andrea, C.; Jacopo, D.G; Piergiorgio, S; Nina, M; Stefano, R. 2013. Uterine Fibroids: Pathogenesis and interaction with Endometrial and Endomyomerial junction *Obstetrics and Gynaecology International Vol.34 p.11- 22*.

Eggart, K.L.; Huyck, P.; Somasundaram, R.; Kavalla, E.A.; Stewart, A.T. 2012.Genome-Wide linkage and association analyses implicate FASN in predisposition to uterine leiomyomata.' *American Journal of Human Genetics,Vol, 91. p. 621-628*

Elugwaraonu, O.; Okojie, A.I.O.; Okhia, O.; Oyadoghan, G.P. 2013. The incidence of Uterine Fibroid among reproductive age women; a five-year review of cases at 1st, Irrua, Edo**,** Nigeria**.** *Journal home. Vol. 2. p. 3*.

Haney, A. F. 2000. Clinical decision making regarding leiomyomata: what we need in the next millennium. *Environmental Health Perspective. Vol. 108 p. 835-839*.

Haralambos and Holborn. 2008. *Sociology, themes and perspectives*, Seventh Edition.Hamper Collins publishers, hammersmith London.

Hochbaum, G.M. 1985. *Publication in Medical Screening Programmes: a socio-psychological Study.* Public Health service publication No572 Washington DC: government printing office.

Igbolekwu, C. 2017. Perception of Fibroid and Coping Strategies among Celibate-women in the Catholic Ecclesiastical Province of Ibadan, Nigeria. *Unpublished Thesis*, Ibadan: University of Ibadan, Nigeria

Ikechebelu, J.I.; Ezeama, C.O.; Obiechina, N.J.; Ezeama, N.N. 2012. Clinical Presentation of Uterine Fibroids in Nnewi, Nigeria: A 5-year Review. *Annals of Medical and Health Science Research, Vol. 22. p.114–118*.

Jegede, S.A. 2002. The Yoruba cultural construction of health and illness. *Nordic Journal of African Studies. Vol. 11 p. 322-335*.

Kwame-Aryee, R. A.; Seffah, J. D. 1999. Uterine fibroid, in Handbook of Gynaecology, *Practical Guide for Student and Practitoner. Vol. 5, p.135*.

Laughlin, S.K. 2012, 'Pregnancy-related fibroid reduction'.*Fertility Sterility Elsevier International. Vol. 94. p. 2421-2423*.

Nwokocha, E.E. 2012. Widowers' account of maternal mortality among women of low Socio-economic Status in Nigeria. *African Journal of Reproductive Health. Vol.16. p. 3*.

Ogedengbe, O.K. 2003.*Uterine fibroids in Contemporary Obstetrics and Gynaecology for Developing Countries.* Intec Printers Limited, Ibadan, Nigeria, 1st edition, Eds., pp. *Vol. 42. p.* 202- 213.

Ogunniyi, S.O. and Fausaba, O. 1990.The Management of Infertility.*Obstetrics Vol. 33. p. 41- 47*

Okolo, S. 2008. Incidence, etiology and epidemiology of uterine fibroids. *Best and Practice Research ClinicalObstetrics Gynaecology.Vol. 22 p. 571-588*.

Owumi, B.S.; Isamah, A.N.; Okunola, R. A. 1996. Socio-cultural and economic determinants of value of children in Kaduna, Lagos and Enugu States. *A publication of PRF NISERISBN Vol. 97. p.181-215*.

Parker, W.H. 2013. Etiology, Symptoms and Diagnosis of Uterian Leiomyomas. *Elsevier Inc. Vol. 87. p.725-736*.

Rogan-Gibson.J.2001. Perception of threat, benefits and barriers to breast self-examination amongst young asymptomatic women. *British Journal of Heath Psychology. Vol. 6. p. 361-372*

Rosenstock, I.M.; Stretcher, V.J.; Becker, M. 1988. Social Learning Theory and the Health Belief Model. *Health Education Quarterly. Vol. 15 p. 175-183*.

Sabry, M.; Al-Hendy, A. 2012. Innovative oral treatments of uterine leiomyoma. *Obstetrics Gynaecology International. Vol. 943635. p.1155-1635*.

Sealy, P. 2012. Fibroids: a silent health problem affecting women in Trinidad and Tobago. *Journal of the Department of Behavioural Sciences. Vol. 2. p 1*.