

**ASSESSMENT OF CHILD BEARING DECISIONS OF WOMEN IN ANIOCHA-NORTH
LOCAL GOVERNMENT, DELTA STATE**

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ENUGU CAMPUS**

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TITLE PAGE

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ANIOCHA-NORTH LOCAL GOVERNMENT, DELTA STATE**

BY

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**Msc DISSERTATION
TO THE DEPARTMENT OF NURSING SCIENCES, FACULTY OF HEALTH
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DECEMBER, 2015

APPROVAL

This dissertation has been approved for the award of Master Of Science Degree In Nursing in the Department of Nursing Sciences, Faculty of Health Sciences and Technology, University of Nigeria, Enugu Campus.

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CERTIFICATION PAGE

I, Njoku Linda C. PG/MSc/12/64488 certify that this original work is mine except as specified in the acknowledgement and references. Neither the dissertation nor the original work contained therein has been submitted to this University or any other institutions for the award of M.Sc in Nursing.

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DEDICATION

I dedicate this work to all the members of Odikpo's family in Onicha-Olona, Aniocha-North L.G.A of Delta State.

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The researcher is grateful to God Almighty for his mercy, grace and loving kindness throughout the course of this project. I sincerely thank my project supervisor, Professor C. B. Okafor for her unalloyed support, motherly kindness, direction and scrutiny of this project. Indeed, you are the best. This work would be incomplete without mentioning my parents Mr and Mrs. Venansius Njoku for their unalloyed support, and my siblings Chinasa, Onyebuchi, Cynthia, Kyna, Akachi, Eberechi, and Chimezuru. I couldn't have done this without your support. Many thanks also to Dr A.C. Nwaneri (Head of Department), for believing in me, Mrs Ihudiebube for standing with me and understanding my inadequacies, Dr (Mrs.) Chinweuba, Dr Nwonu, Dr (Mrs.) N.P. Ogbonnaya and Dr (Mrs.) Ehiemere I. O. for your wonderful motherly encouragement, Dr (Mrs.) Okpala, Dr (Mrs) P. Iheanacho, Mr JustinIngu Justine, entire staff of this noble department. My unreserved gratitude goes to my dear friends Ogbogu Chinenye, Anyanwu Vivian and Mokezie Chinyere for their encouragement all the way. My profound gratitude goes to my research assistants Miss Precious, Miss Florence, Mr Emmanuel Okwechime and Mr. ElvisBakpa. This work was possible because you were part of it. May God richly bless you, Amen.

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Abstract

This study was designed to obtain information on the childbearing decisions of women in Aniocha-North L.G.A of Delta State. The specific objectives of the study was to: (i) identify the pattern of childbearing among women in Aniocha –North Local Government Area, Delta State, (ii) identify the extent of women’s participation in child-bearing decisions in Aniocha –North Local Government Area, Delta state and (iii) determine the factors that influence women’s child-bearing decisions in Aniocha –North Local Government Area, Delta State. The descriptive survey research design was used for the study. Using power analysis, a sample of 387 participants were enlisted in the study. The Questionnaire was the only tool used for data collection. The data were analyzed using IBM/ SPSS version 20. Major findings revealed that: A good number of the respondents have low literacy level in the communities hence about 137(35.4%) had no formal education while 98(25.3%) had primary education with 236(61%) having farm work or petty trade as their major economic activities. The mean value of the number of living children is 4.68. Age at first birth showed that on the average the women make their sexual debut at 16 years old. The mean values for these statements When to become pregnant, Number of children, when to have sexual intercourse and child spacing period were 2.93, 2.93, 2.93 and 2.96 respectively while the mean value of where to receive ANC and where to deliver which read 3.15 and 3.14 respectively. Majority of the women are not involved in decision of when and how to use family planning hence the mean value is 1.84. Apart from the cultural factors that have some impact on the women’s childbearing decisions, socio-economic, biological and religious factors have little or no influence on Aniocha-North’s women’s childbearing decisions. Therefore midwives have a role to play by health educating women on the need for their involvement in decision making with regards to their fertility and also the need for family planning as an effective way to reduce their family size, unsafe abortion, maternal mortality and achieve their MDG 4 & 5 target.

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CHAPTER ONE

INTRODUCTION

Background to the study

The ability of women to take decisions in childbearing issues such as family size, when to have a baby, choice of spacing period and the use of family planning services may not only enhance their bargaining power in family matters but will also reduce their vulnerability to sexually transmitted infections (STIs) (Tavory & Swidler, 2009). Fertility and its decisions in the family is influenced by ideas and changes that occur in the life of the individual associated with such characteristics as education and income levels. Thus as women climb the educational ladder and men are faced with economic challenges of life, coupled with the pressure from the family to provide and satisfy their physiological needs, women are faced with the need to make choices with respect to the number of children they should give birth to and the size of their families (Weeks, 2010) and many others.

In developed and industrialized societies, the trend towards smaller family sizes has emerged due to the spread of formal education, medical and health advancements and the enhanced status of women (Miller, 2010). Education, for example, is a very powerful indicator of involvement in fertility decision making among women globally (United Nation, 2005). It has been widely recognized as a key concept in understanding fertility behaviour (Miller, 2010). This is in line with Weeks (2010), who asserted that women who delay marriage are more likely to stay in school and then upon attaining higher education, are also more likely to find suitable employments, they are able to compete effectively with their male counterparts in family building and lower parities than their less educated female counterparts that give birth to larger number of children.

In as much as women have ben empowered through education and economic employment to be assertive in family life decisions gender inequality, is a universal phenomenon which largely confronts women. It has been observed that in no society do men and women receive the same

rewards. The UN World Conference held in Mexico City, Copenhagen and Nairobi in 1975, 1980 and 1985 respectively for the advancement of women underscored the peculiar problems facing women (Pietila, 2007). Globally, women do not enjoy equality with men in terms of political, legal, social and economic rights. It has been observed that in every country, jobs that were predominantly done by women were the least well-paid and had the lowest status (Marger, 2008). The 1995 World Bank report acknowledged the same fact that gender inequality also manifests itself in childbearing decision-making hence gender inequality in decision-making constitutes the major concern in this study.

Childbearing decision of women is a global concern because of the social and environmental impacts of population growth and maternal mortality (Ronsmans & Graham, 2006). Furthermore, Marger, (2008) admitted the gender differences in childbearing decision making and attributed to power relation and traditional gender roles. This view was supported by Vaessen, (2004) who argued that women lack control over decision-making in reproductive health especially with regards to their childbearing. They commented that women are often pressured by husbands and relatives to have large families and maintained that society had not recognized and made use of women's knowledge and capabilities. In most developing societies, most women have no option than to succumb to the dictates of their spouses, friends and kinsmen with no control allowed over their childbearing decisions (May, 2014).

Of great concern is the high value traditionally placed on children, which has sustained the high fertility rate in Aniocha Local Government Area and made it resistant to the forces that brought about decline in fertility in the developed countries. The cultural and national traits of women of some geo- political regions of the world do influence their childbearing decisions to the extent that the childbearing preferences of these women even in the developed nations reflect what obtains in their home regions as revealed by Woollett, Matwala and Hadlow (UN, 2009).

Human reproductive behaviour which is the result of a complex interplay of economic, social, cultural, religious and biological factors influence the childbearing decisions of women in the developing world (Caldwell, 2009). Childbearing decisions within the traditional family system are based on factors such as children as old age security for parents, prestige attached to large family size, labour force for agricultural practices, as security against high infant mortality and the social benefits of having children and grandchildren. Children are, therefore, cherished as sources of labour in the agrarian and traditional societies. This has led many women into having many children as a result of many child births which have effects on the mother, children in such families and the nation at large. The effects include: maternal, neonatal and child mortality and morbidity; over population, social ills, poverty and lack of community development hence the family is the building block of the community. The low status accorded to women made them desire for larger family sizes. They felt secure in the number of children they had, as a woman's value and status were linked to her reproductive efficiency and this also give them support in the event of unexpected vicissitudes of life such as widowhood, divorce and physical incapacitation.

How applicable are these global gender inequalities with respect to child bearing decision-making of women in the 21st century Nigeria especially in Aniocha-North Local Government, Delta state. This is what the researcher seeks to investigate.

Statement of Problem

More than half a million women, nearly all of them in developing world die each year in pregnancy or childbirth, amounting to one death every minute (Ronsmans & Graham, 2006). Another million suffer serious, and sometimes permanent pregnancy – related injuries such as – vesico vaginal fistula etc. Much of this suffering and death could be prevented through appropriate maternal and child health services including ANC, labour and delivery services as well as family planning services.

In Nigeria traditional attitudes towards gender relations have affected the power of decision-making both within and outside the household. Buor, (2004) observed that women, especially in traditional families were subservient to the man in marital relationship, so the man assumes a key position in decision making which is evidenced in the area of childbearing. Some of the result of such subservient role in decision making include; a situation where a pregnant woman's life is in danger on presenting to the hospital required immediate surgical intervention but will refuse to give her consent until the husband comes. This was observed severally by the researcher and most times when the husband comes, he might decide to take the woman out of the hospital putting the woman's life in great danger and many others scenario that the researcher personally observed in Aniocha – North LGA hence the women cannot solely make decision on their own even on issues that affect their health during childbearing which sometimes result to maternal death due to delay in decision making. It was suggested that traditional attitudes towards gender relations might reduce effective communication between couples and restrain a wife's freedom to make childbearing decisions (May, 2014). The effect of the inferior role of women in decision-making is that they have traditionally been suppressed in taking decision even on matters that affect them such as childbirth.

The National Population commission (2014) reported that Delta State in Nigeria demographic and health demographic and survey (NHDS, 2013) recorded a total fertility rate of 5.7 and there existed fertility differentials between the rural and urban communities of the state of 7.0 and 4.7 respectively. The researcher also observed a similar trend in the childbearing pattern of women in Aniocha North LGA which was recorded to be 5 based on the findings from the research study. Women's non involvement in their childbearing decisions affects their health and could lead to high frequency of childbirth among women which could result in serious health risk like; maternal, neonatal and child mortality and morbidity; over population, social ills, poverty, lack of community development hence the family is the building block of the community, economic stagnation, marital

burden and inability of families to educate most of their children resulting in high illiteracy rate in the rural communities of the State. Consequently the question that comes to mind are: Is the large family size the choice of the woman or women have no role in decision making with regards to controlling their fertility? If family planning is women's rights do these rights apply in family decisions? To what extent do women exercise reproductive right by participating in issues that directly affect their well beings? Do women have any control over decision-making issues that relate their child bearing?

To answer these questions and many others the study seeks to assess the child bearing decision of women in Aniocha –North Local Government Area, Delta State. Hence the need for this study cannot be overemphasized, especially in an environment with high fertility and low contraceptive use.

Purpose of the study

The purpose of this study was to assess the child bearing decisions made by women in Aniocha –North Local Government Area of Delta State.

The specific objectives of the study include;

The objectives of the study were to:

1. Identify the pattern of childbearing among women in Aniocha –North Local Government Area, Delta State.
2. Identify the extent of women's participation in child-bearing decisions in Aniocha –North Local Government Area, Delta State
3. Determine the factors that influence women's child-bearing decisions in Aniocha –North Local Government Area, Delta State.

Research Questions

The research was guided by the following questions as:

1. What is the pattern of child-bearing among women in Aniocha –North Local Government Area, Delta State?
2. To what extent do women in Aniocha –North Local Government Area, Delta State participate in child-bearing decision making?
3. What are the factors that influenced decisions made by women during childbearing in Aniocha –North Local Government Area, Delta State?

Significance of the study

The study is to help in finding the reasons for women's participation or not in child-bearing decisions of their families that, to some extent, inform the pattern of childbirth which results in fertility differentials in Aniocha –North Local Government Area, Delta State. This will help address the issues related to women's empowerment and their reproductive autonomy in Aniocha –North Local Government Area, Delta State.

Findings from this study will add to the existing literature on pattern of childbearing and how decisions about childbearing are taken in Aniocha-North local government, Delta State Nigeria. The result of the study will also assist planners and administrators of the town to adopt strategic plans that will help raise the level of consciousness of the women in the town with regard to their child bearing. The study will also serve as the source of information to students and the basis of further research into women's reproductive decisions.

Scope of the study

The study was delimited to the birth patterns and childbearing decisions of women in Aniocha –North Local Government Area, Delta State, the factors that influence women's childbearing

decisions and the extent to which they have the autonomy to participate in the childbearing decisions of their families.

This study is delimited to all women within the age of 15 and 49 years who will be present in the area during the period of the study and will be willing to participate in the study.

Operational definition of terms

Factors that influence women's childbearing decisions; These refer to the social (eg; education, age at marriage, residence ,availability of social amenities), cultural (men as sole decision maker , children as source of labour in agrarian society , influence of extended family,), religious(the commandment to increase and multiply, unacceptability of contraceptives due to religious groups), biological(infertility and its treatment options), economic (level of income, poverty) influences affecting the choices of women in Aniocha –North Local Government Area, Delta State on childbearing issues.

Child bearing decisions ; This refers to choices a woman in Aniocha-North makes on when to becomes pregnant, the number of children she intends to have, the interval between births, and the family planning services she intends to use, gender mix of children ,where to receive ANC and where to have her delivery etc.

Extent of women's participation in childbearing decisions: This refers to how far a woman in Aniocha –North Local Government Area, Delta State take part/get involved in choosing when to pregnant, the number of children to have, the interval between births, and the family planning services to use, gender mix of children gender mix of children ,where to receive ANC and where to have her delivery etc.

Pattern of childbearing; This refers to the number of pregnancies/children a woman in Aniocha – North Local Government Area have had, interval between birth, number of miscarriages, age at first birth etc

CHAPTER TWO

LITERATURE REVIEW

This chapter dealt with the review of conceptual, theoretical and empirical literature on child bearing decisions of women. For the purpose of this study, it was discussed under the following sub headings; Conceptual Review; Concept of decision making; Child bearing decision making; Patterns of child-bearing in the developed and developing nations; Factors identified as influencing child-bearing decisions of women in the developed and developing world, Women's participation in their child-bearing decisions and, Women's perceptions as to what constitutes an ideal family size, The theory underpinning the study, Empirical literature review and Summary of literature review.

Concept of Decision making

Decision making is the process of identifying and choosing alternatives based on the values and preferences of the decision maker. Making a decision implies that there are alternative choices to be considered, and in such a case we want not only to identify as many of these alternatives as possible but to choose the one that best fits with our goals, objectives, desires, values, and so on (LeyvaLópez, 2003). According to Ekárt and Németh, (2005), decision making should start with the identification of the decision maker(s) and stakeholder(s) in the decision, reducing the possible disagreement about problem definition, requirements, goals and criteria. Then, a general decision making process can be divided into the following steps:

Step 1. Define the problem

This process must, as a minimum, identify root causes, limiting assumptions, system and organizational boundaries and interfaces, and any stakeholder issues. The goal is to express the issue in a clear, one-sentence *problem statement* that describes both the initial conditions and the desired conditions. Of course, the one-sentence limit is often exceeded in the practice in case of complex decision problems. The problem statement must however be a concise and unambiguous *written*

material agreed by all decision makers and stakeholders. Even if it can be sometimes a long iterative process to come to such an agreement, it is a crucial and necessary point before proceeding to the next step.

Step 2. Determine requirements

Requirements are conditions that any acceptable solution to the problem *must* meet. Requirements spell out what the solution to the problem *must* do. In mathematical form, these requirements are the constraints describing the set of the feasible (admissible) solutions of the decision problem. It is very important that even if subjective or judgmental evaluations may occur in the following steps. The requirements must be stated in exact quantitative form, that is for any possible solution it has to be decided unambiguously whether it meets the requirements or not. We can prevent the ensuing debates by putting down the requirements and how to check them in a written material.

Step 3. Establish goals

Goals are broad statements of intent and desirable programmatic values.... Goals go beyond the minimum essential *must haves* (i.e. requirements) to *wants* and *desires*. In mathematical form, the goals are objectives contrary to the requirements that are constraints. The goals may be conflicting but this is a natural concomitant of practical decision situations.

Step 4. Identify alternatives

Alternatives offer different approaches for changing the initial condition into the desired condition. Be it an existing one or only constructed in mind, any alternative must meet the requirements. If the number of the possible alternatives is finite, we can check one by one if it meets the requirements. The infeasible ones must be deleted (screened out) from the further consideration, and we obtain the explicit list of the alternatives. If the number of the possible alternatives is infinite, the set of alternatives is considered as the set of the solutions fulfilling the constraints in the mathematical form of the requirements.

Step 5. Define criteria

Decision criteria, which will discriminate among alternatives, must be based on the goals. It is necessary to define discriminating criteria as objective measures of the goals to measure how well each alternative achieves the goals.. Since the goals will be represented in the form of criteria, every goal must generate at least one criterion but complex goals may be represented only by several criteria. It can be helpful to group together criteria into a series of sets that relate to separate and distinguishable components of the overall objective for the decision. This is particularly helpful if the emerging decision structure contains a relatively large number of criteria. Grouping criteria can help the process of checking whether the set of criteria selected is appropriate to the problem, can ease the process of calculating criteria weights in some methods, and can facilitate the emergence of higher level views of the issues. It is a usual way to arrange the groups of criteria, subcriteria, and sub-subcriteria in a tree-structure (Ekárt & Németh, 2005). Such criteria should be:

- able to discriminate among the alternatives and to support the comparison of the performance of the alternatives,
- complete to include all goals,
- operational and meaningful,
- non-redundant,
- few in number.

Step 6. Select a decision making tool

There are several tools for solving a decision problem. The selection of an appropriate tool is not an easy task and depends on the concrete decision problem, as well as on the objectives of the decision makers. Sometimes the simpler the method, the better but complex decision problems may require complex methods, as well.

Step 7. Evaluate alternatives against criteria

Every correct method for decision making needs, as input data, the evaluation of the alternatives against the criteria. Depending on the criterion, the assessment may be objective (factual), with respect to some commonly shared and understood scale of measurement (e.g. money) or can be subjective (judgmental), reflecting the subjective assessment of the evaluator. After the evaluations the selected decision making tool can be applied to rank the alternatives or to choose a subset of the most promising alternatives.

Step 8. Validate solutions against problem statement

The alternatives selected by the applied decision making tools have always to be validated against the requirements and goals of the decision problem. It may happen that the decision making tool was misapplied. In complex problems the selected alternatives may also call the attention of the decision makers and stakeholders that further goals or requirements should be added to the decision model.

Concept of child bearing decision making

In nearly every situation in life, one has choices about the action one takes. Many of the choices have such negative consequences that they are quickly eliminated and thus it appears as if there are no choices (Ekárt & Németh, 2005).

Childbearing decision making is a process of making choices on the basis of preferences with regards to when a couple want to get married, have children, number of children to have, the interval between births, fertility control services they will wish to adopt when they have completed their family, gender mix of children, where to seek for maternal and child health services when the woman is pregnant (Pender, Mardagh, Person, 2010). It can also be regarded as the ability to make choices with respect to the number of children a couple should give birth to and the size of their families (Weeks, 2010).

Childbearing decisions are often thought to be an important part of couples' discussions before marriage. Ideally child bearing decision making is a rational process based on the premise that human beings are agent with free will. Their choices need to be respected hence they become aware of their personal values. Rational decision making is based on accurate information which involve active rather than passive approach in decision making. Child bearing decisions active approach involves individual's projective planning , assessment of the situation, consideration of options, examination of risks, benefits and consequences of various options(Debra, 2014). Many women found themselves with unintended pregnancy because they were passive and made no decisions which was as a result of certain factors like: psychological factors- which is a serious factors as most child bearing decisions are made based on emotional feelings rather than logical and rational process, socio-cultural factors which Pender, Mardaugh, & Person (2010) asserted that child bearing decisions making often reflects ones social and cultural background. The decision regarding children involve husband, relatives and most times entire extended family. Other factors include; competence to make choices which involves cognitive skills and abstractive thinking, readiness for decision, freedom to make choices before the recognition of decision point and implementation of choices (May, 2014).

Women are the most affected in child bearing decision making hence most women report experiencing undesirable pressure from others regarding childbearing after they have been married for few years (Pender,Mardaugh,&Person, 2010). This is remarkable in most African countries hence families need to be allowed to make informed decision with regards to their childbearing based on accurate information as free will individuals involved in family building

Patterns of child-bearing in the developed nations

Fertility is a choice by parents involving a life-cycle claim on their resources, from which they may receive satisfaction as consumers and benefit as producers from children's labour and care giving

support. In addition, fertility may be the source of externalities that affect members of society other than the decision-making parents, in which case society may view fertility as a legitimate issue for social policy (Philipov, 2012).

Fertility preferences show variations that linger around two children per woman across the industrialized / developed nations of the world. The average expected number of children ranges between 2.0 and 2.5 (United Nation, 2009). The UN report indicated that in some Northern and Western European countries, the total fertility rates hover between 1.0 and 2.0 children per woman. In Western Europe, total fertility range from 1.3 children per woman in Austria to 1.9 children per woman in France. In Northern Europe, this varies from 1.5 in Sweden to 2.1 in Iceland.

The former German Democratic Republic had a total fertility rate of 0.9 for several years. In most of these developed nations, and as in their developing counterparts, marriage remains the primary framework of child-bearing. With the interest in raising one's social and economic status, delayed marriages had become the norm in the developed nations of the world (Weeks, 2010). It has been revealed that age at marriage and age at first birth were close to each other. Although most women of the developed nations delay marriage in order to pursue social and economic objectives, a greater number of them also either delay birth for the same reasons or space their births so as to reach their life goals- academic, vocational or occupational. These, to the experts, had been some of the major reasons for the low fertility rate in the developed world. (Vaessen in UN, 2009).

These notwithstanding, the cultural and national traits of citizens of some geo- political regions of the world do influence their fertility decisions to the extent that the fertility preferences of these ethnic minorities even in the developed nations reflect what pertains in their home regions. In their own view, Woollett, Matwala ,Hadow, & UN, (2009) revealed that in the highly developed western European nation of the United Kingdom (UK), women of Asian origins and descent constitute a large ethnic minority in the UK. Although there is some evidence that Asian family size is larger

than average for the UK, little is known about Asian women's attitudes to reproductive decisions of families, use of contraception, and methods of contraception. Responses from their interviews revealed that reproductive decisions were often explained using economic models, in terms of the costs and benefits of having children. Such models assume that attitudes operate in irrational ways to influence decisions about family size or the use of a contraceptive method and that people who want fewer children or to delay starting their family are considered to use contraceptives or to use them more effectively than those who want a larger family or do not want to delay having children (Woollett, Matwala, & Hadlow, 2009).

Patterns of child-bearing in the developing nations

The patterns and trends of fertility which are mostly geographically classified, place most Latin American, Caribbean-Pacific, South-east Asian and Sub-Saharan African nations on the higher plane of the demographic transition trend. A report released by the United Nations Population Division revealed that between 1995 and 2000, 49 countries with a total population of 770 million, most of which could be located in the developing world, have fertility levels of 5 children or more per woman (UN, 2009). A release by the Guttmacher Institute revealed that Latin America had a mean total fertility rate of 4.3 ranging from 3.3 to 5.1 children per woman; with Bolivia in the higher side of the fertility divide (UN, 2009). The South-east Asian region reported a TFR around 2.1 in the more developed countries of the region to 4.1 in the most populous regions of Indonesia and Polynesia. The Sub-Saharan African region however, has a slightly higher TFR in relation to her Latin American counterparts. The World Population Data Sheet places the region within the 3.9 to 5.5 children per woman range with East and West/ Middle Africa falling within the fertility ranges of 5.1 to 7.0 and 5.1 to 7.5 children per woman respectively (Population Reference Bureau, 2000).

The National Population commission (2014) reported that Delta State in Nigeria demographic and health demographic and survey (NHDS)-2013, recorded a fertility rate of 5.7 and there existed

fertility differentials between the rural and urban community of the state of 7.0 and 4.7 respectively. The survey revealed that higher frequency of birth among women results in serious health risks, economic stagnation and poverty, marital burden and inabilities of the families to educate most of their children, resulting in higher illiteracy rate in the rural communities of the state. A number of factors are responsible for these variations in fertility within the country and in the African region on one hand and between the geographical regions of the world on the other. These factors include; social, economic, cultural, biological, and religious.

Factors that influence women's child-bearing decisions in the developed world

The fertility decisions of the female sex in the developed as well as the developing world have been influenced and determined by various factors. (Philipov, 2012) identified these as the supply of children, the demand of children and the material and non- material costs of fertility. To the researchers, the supply of children is determined by natural fertility and the rate of child survival. The former is considered to be a product of post-partum abstinence or the beginning of sexual intercourse exposure, and the rates of marital disruption. He explained that the survival rates of children on the other hand, depend on such factors as mother's age and parity, the parents' (male and female) socio-economic status, their educational and income levels and the adequacy and availability of good drinking water, quality healthcare, nutrition and residential environment, among others.

In the developed world where scientific innovations, technology, good and quality healthcare and nutrition coupled with quality and higher education abound, the decisions of women to give birth, when to give birth and the number of children to give birth to depend to some extent, on the cost of child birth, care and the education of the children from their toddlerhood to adulthood when they become independent to cater for themselves. The economic costs of child birth and care are therefore felt by both men and women. Education has been identified as the main economic cost of child birth and care in the developed world .Caldwell, in UN 2009 explained that in both the developed and the

developing economies, the growing recognition of the importance of the education of children and their costs are held to be the most important factor swinging the flow of wealth away from parents and an important pre-condition for the fertility transition. Since educated parents aspire to have educated children, the cost becomes a major deterrent to high fertility (UN, 2009).

The importance of a mother's education for child's survival through pathways other than enhanced socio-economic status was brought into focus by Caldwell, (2009). Miller, (2010) argues that the education of women plays an important role in determining child survival, even after the control of a number of other factors such as the socio-economic characteristics of the husband including his own educational level and occupation. Some of these socio-economic factors was identified by (Hopkins in UN, 2009) as the health, occupational and residential status of the husband and status in life. This implies that not only is the educational level of the woman one of the decisive factors in the woman's child-birth decision- making process but also the educational level, the health and residential status and the career prospects of the husband.

Some countries with low fertility rate are Sweden, The Netherland, Finland and Austria, among others. A study conducted by the UN revealed that the Total Fertility Rate in the United States of America which stood at 2.1 is supported by a combination of independent and other socio-economic variables (UN, 2003).

The study also revealed that in the Hispanic societies of the US however, cultural factors resulted in higher fertility differentials between 2.0 and 3.1. To the UN publication, while child birth is being postponed in the urban American communities due to the pursuit of educational and career objectives, the Hispanic rural communities allow increasing fertility to reflect their socio-economic environment and activities that promote higher demand for children. This has been corroborated by a UN data on the fertility situation in Western Europe, ranging from 1.3 children per woman in Austria to 1.9 children per woman in France.

In these and other Western European states and other well- established market economies, couples postpone, space and limit child-bearing to enable them to plan and prepare for their children and have a stable and secure future for their families. By this, the demand for children had been influenced by the life goals and socio-economic status of both the husband and the wife with little or no interference from their kinsmen and friends. In the middle- income and highly developing nations such as Argentina, Brazil, Mexico and Indonesia, families and kinsmen have great influence on the fertility decisions of the spouses. This is also similar to what pertains in the developing world, especially in Sub-Saharan Africa.

Factors influencing women's child-bearing decisions in the developing world

Human reproductive behaviour which is the result of complex interplay of numerous factors such as economic, social, cultural, religious and biological influence the reproductive decisions of women and their families in the developing world. These had led to high fertility rates in most developing nations and a rising Total Fertility Rate (Kisambira in UN, 2007)

Economic factors

In the developing nations, economic factors had been identified as the most dominant that influence women's child-bearing decisions especially in the rural communities. It has been found that fertility is higher among the low income groups. In their study of the fertility differentials in Latin America (Gabriel & Villarreal in UN, 2009) saw that there is a higher fertility rate among the destitute poor in Honduras and Bolivia respectively. With this poor socio-economic background, children from these poor households have less chance of acquiring educational and nutritional profile that will secure them productive employment. With a higher level of marital instabilities in the region, most of these single mothers therefore enter the labour market at earlier ages. This shows that a number of Latin American and Caribbean countries, daughters of single mothers have a higher probability of becoming pregnant teenagers.

Social factors

Education, especially women's education has received considerable attention from researchers and scholars with respect to the concept of fertility in demographic literature. Writing on the situation in Bangladesh, Miller,(2010) reiterated the role education plays in women's child-bearing decisions as influencing their supply of children, their ages at marriage, family size, duration of lactation and post-partum care as well as education and welfare of their children, among others. In corroboration with Miller's view, Weeks (2010) postulated that the educated females are more conscious and courteous of their family size, quality of life and the functioning of their human bodies, placing a higher premium on their families' living standard, their personal health and the health of their children. To Weeks, the educated women show a more positive attitude toward fertility regulation programmes than their illiterate counterparts.

Age at marriage which also influences the time of first birth is also another social factor that influences the reproductive decisions and fertility levels of women which also determines the number of children they should give birth to during their reproductive years. Thus, many women in the rural communities of the developing world who marry at an early age either consciously or unconsciously have many children.

Linked to these fertility decisions is the issue of residence, rural or urban which (UN, 2007) reveals that rural women in most cases have no role models, little or nothing to compete for and no struggle for the use of land, accommodation and other facilities as compared to their urban counterparts who have to compete for schools, health facilities, land, water, accommodation and other socio-economic facilities at higher cost (Weeks, 2010).

Cultural factors

The cultural traditions of people in most developing nations especially in Nigeria, play a major role in the reproductive decisions that couples make especially, women. UN, (2003) found that close to

60% of the Nigerian men in his study said that they themselves are the sole decision makers in the area of child birth and family size. 40% to 50% of the female respondents also agreed that men do make the child birth decisions.

In patriarchal African societies, the fertility of women and men alike has long been highly valued with preference for large families, the care of children being the responsibility of all adults in the extended family, placing children in the care of others, marriage for women at young age and the polygamous marriage system (May, 2014). The demand for children and large family sizes thus, become the sole goal for many patriarchal African societies. Another aspect of the cultural tradition that influences the child- birth decisions of women is the extended family system. May, (2014) explained that the extended family has a great influence on the nuclear family members in the child-bearing decision making process. May also saw childbearing decisions to be more of a group effort than we realized. This influence is so great among the Deltan communities where the survival of the patrilineage depends on its female members that a barren woman is seen as a disgrace and despair. Childless couple is scorned and despised, nicknaming the woman who fails to get pregnant as 'Aga' (Infertile). In pre-modern Nigerian societies, women were seen as bearers of children and farmers. Within the traditional sphere, child-bearing ability of women was explained as the means by which the lineage ancestors were allowed to be reborn. Barrenness was therefore considered the greatest misfortune. It was confirmed that by this traditional view of procreation, about 60% of women in Nigeria's rural communities preferred to have families of five (5) or more children (Avatim, 2009).

Cultural beliefs in Nigeria detract women from their ability to negotiate sexual relations, determine the number of children they want to and should have and the method to apply in that regard, resulting in the high fertility levels in the rural corridors of the country (Avatim, 2009). Children in the Nigerian cultural setting was seen as social insurance benefits of the aging parents, social prestige and source of labour in the agrarian societies where food and cash crop farming, fishing and

animal rearing are the dominant economic activities. This makes the rural and uneducated women baby production machines, responding to the dictates of their spouses, friends and kinsmen so as to benefit from the tenth child reward (Bleek in Stephenson, 2006). Thus to (Oppong & Abu, 2007), there is a strong traditional norm of high fertility as children are the *raison d'être* of marriage which also results in higher fertility in the rural communities where sex preferences dominate their decisions, than the urban communities of the nation.

The women's place in the childbearing decision- making, her participation and concern are not the issue to be thought of by the spouse and his kinsmen. Most rural women still see themselves as toads under furrows that needed to be assisted to identify their potentialities so as to come out of the socio-cultural doldrums they find themselves in with respect to child-bearing decisions: when to marry, when to give birth, how to space their births and sizes of the family May, (2014). Factors that had led to these gender inequalities especially in the rural communities of the country therefore, need to be investigated.

Religious factors

Human reproduction, the Godly ordained process by which numbers are added to the human population through birth, had been with us from the Garden of Eden when the Supreme Being commissioned Adam to „be fruitful and become many and fill the Earth....“ Gen.1: 26-28. The womb of the woman thus, serves as the receptacle that carries the foetus which through birth becomes the baby that adds to the human population every other day of the year. The emphasis placed on human reproduction is so great that in the Nepalese traditional/ Islamic religious societies, the birth of sons is seen as both social and economic advantages with the adage ‘May your progeny fill the hills and mountains’ (Philipov and Berghammer, 2007). Conversely, religious beliefs and practices do prevent some persons from accepting or practicing fertility regulation techniques as a means of making reproductive decisions. Thus, the concept of family planning and artificial

contraception, reproductive health decisions and any form that follows the policies, tenets and decisions of the Programme of Action of the Cairo Conference (ICPD) 1994, were opposed by the Holy See, The Papacy of the Catholic Church (McIntosh & Finkle, 2005).

Biological factors

Marital relationships can be strained when children are not forthcoming, forgetting the scientific findings that the male could also be the cause. Writing under the caption, 'Gamete Source, Manipulation and Disposition' Tournaye reported that 51.2% of couples are infertile because of the male factor with 39% of these men present with abnormal semen analysis for idiopathic reasons. The second largest category (23%) is men present with varicocele. The medical experts further stated that within that major block of 51.2% is another 12% suffering from male accessory gland infections. To address this biological anomaly so as to satisfy the societal demand for children, couples who inherit these reproductive imbalances seek medical and scientific assistance in the forms of Artificial Insemination, Gamete Intra-fallopian Transfer, Intra-cytoplasmic Sperm Injection, In-vitro Fertilization and Zygote Intra-fallopian Transfer to enable them mother / father children as their natural inalienable rights (Westoff and Freyka, 2007)

Women's participation in their child-bearing decisions

Participation in child-birth decisions is one of the inalienable fundamental human rights of the individual. This is practiced based on the level of socio-economic and political autonomy that the individual possesses. In the Sub-Saharan African communities, the level of participation varies from urban to rural communities. In the urban African communities where the level of education is on an appreciable higher level, access to education, information and other means of communication enables married couple to participate effectively in family planning and child birth decisions of their families.

Education was identified as the main source of woman autonomy, enabling her to gain control over her resources, make reproductive decisions, and expose her to the outside world and promoting husband- wife closeness (Miller, 2010). It also encourages greater intimacy between spouses to enable them to discuss some culturally forbidden subjects as sexual behaviour, contraception and the number of children to give birth to. Thus whether in the urban or rural communities, women with an appreciable or higher education tend to make positive reproductive decisions with respect to when to marry, give birth, space or limit birth. This becomes more appropriate when both couples are better educated.

In the rural communities of most Nigeria communities where education is very low, women with no education tend to become “toads under furrows” that have to abide by the dictates of either their dominant male spouses or their patriarchal kinsmen or both in issues pertaining to their child- birth decisions. Women are seen as having very little or no role in their families’ reproductive decisions, and that women who indulge in strenuous work tend to have more children. They are seen to be on the supply side of the fertility divide where preference is given to sons and their formal education to the disadvantage of daughters. Besides all the domestic chores on their shoulders, most rural women have to cope with pregnancies and continuous child births along with trading and farming activities. As the carriers and nurturers of the children of today and the future generation, the role played by women in the child- birth decisions should be given adequate support by society, whether rural or urban, to promote the development of the society. There is the need to encourage their effective participation in child-bearing decisions, taking their health needs into consideration.

Women’s perception as to what constitutes an ideal family size

The concept of an ideal family size is a measure of the desire among the members of a community as to the number of children a family should give birth to at a given time and a given context. It is a collective average of the number of children the family perceives to be what it can adequately cater

for with the available resources at its disposal according to the particular circumstances in which the household finds itself within any given time (UN, 2009). The concept of an ideal family size could be classified into four, namely, desired family size, preferred family size, expected family size and wanted family size.

The desired family size

The desired family size refers to the response provided by any member of the community especially the women with respect to the number of children they want to have in all, including those that she already has. It was noted that family size preferences are represented by a combination of the desire for a total number of children and also by the desire for additional children (Asikpata in Philipov, 2012). It is also simply the measure of the additional children. The concept of the desired family size as one gets married or had just got married may vary with time, taking into consideration the issue of child survival, family and cultural background and the status of the couple concerned.

The preferred family size

The family size preferences can take various forms. Within the context of a particular family, parents may desire at least one child of each sex, or approximately equal number of particular sons and daughters. Yet some couples may continue to bear children beyond their desired family size in order to achieve a favourable distribution of sons and daughters. The preferred family size was seen as the number of children respondents would like to have in the absence of any constraining factors, including unfavourable demographic or child-bearing experiences or socio-economic conditions and circumstances (Philipov, 2012).

The expected family size

This concept, which has gained much acceptance in the developed societies, is normally derived from interviews with couples about the number of children they prefer.

Some couples who might have fertility impairments and accordingly will have fewer children than they would prefer, may expect to have still more (Cadwell, 2009). These group of individuals might be having two (2) children at the moment, but may wish or expect to have additional two (2) or more based on their child sex preferences which they have not been able to satisfy.

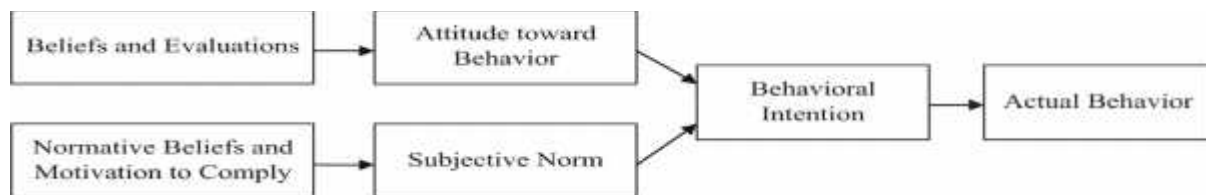
The wanted family size

In trying to differentiate between the concept of Desired and the Wanted Family Size based on an individual's single and successive decision-making perspective (Philipov, 2012). Considering an individual's single-decision perspective, family preferences are often represented by the desire for a total number of children. However from the successive- decisions perspective, they are represented by the additional children. One school of thought believes that family size preferences are fixed at the time of marriage and retained as a goal throughout the fertility career. Another school of thought however argues that the actual child-bearing experiences, coupled with other variance circumstances, will lead to a continuous revision of the family size preferences, either to limit birth or add to the number of children the couple have, as the woman advances in her fertility career (Pullum in UN, 2009). The ideal family concept therefore, helps in shaping the fertility of the society. It also helps in initiating family planning programmes that target individuals who will wish to freely implement their preferences by achieving their desired family size goals so as to avoid unwanted pregnancies.

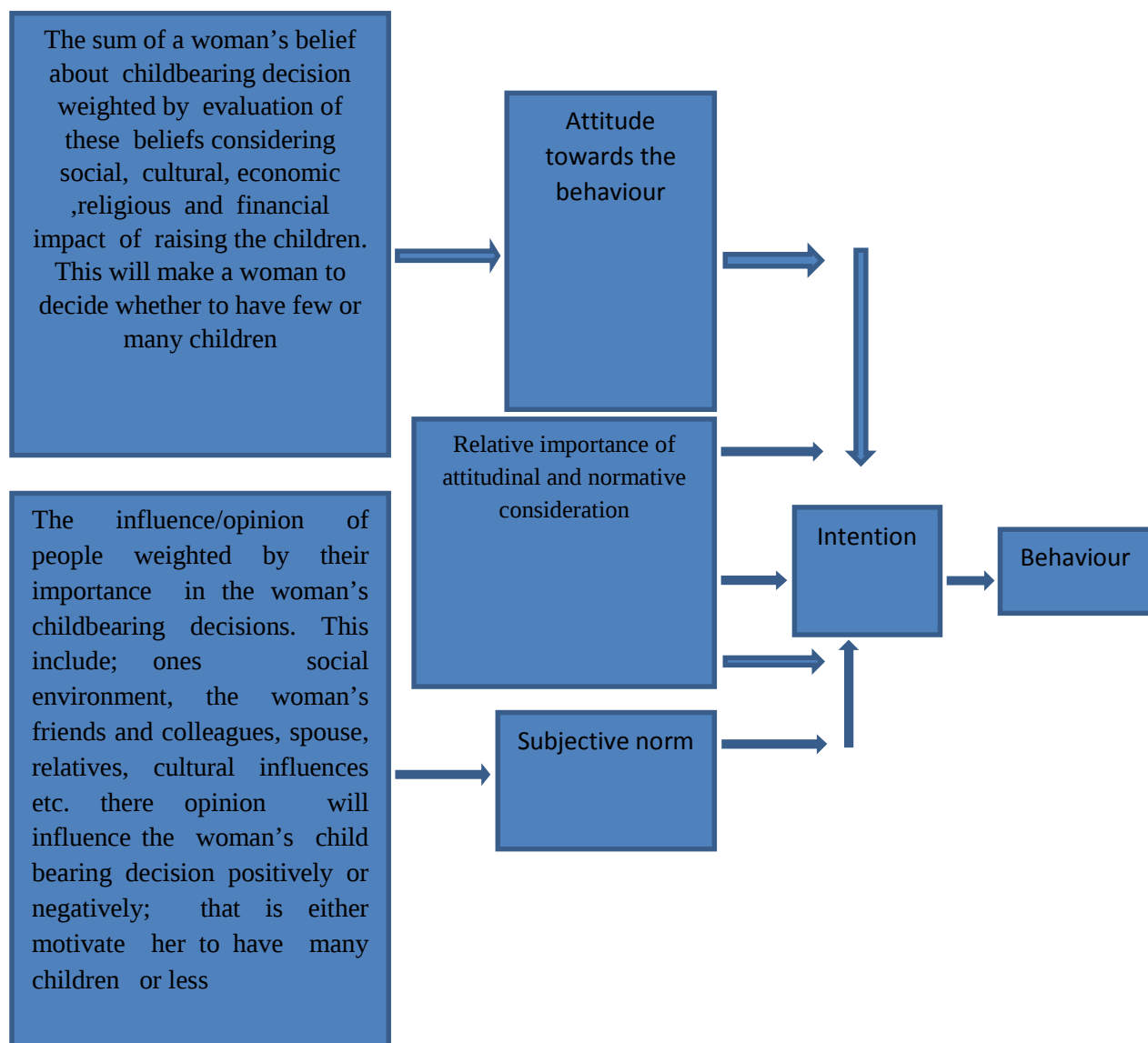
Theoretical review

The theory that relates to this study is;

- Theory of reasoned action



Diagram;



The theory of reasoned action (TRA) was proposed by Ajzen & Fishbein between 1975 and 1980.

The components of TRA are three general constructs;

- A Behavioral intention (B1)
- B Attitude (A)
- C subjective norm (SN)

The theory of reasoned action suggests that a person's behavioral intention depends on the person's attitude about the behavior and the subjective norms, the $B1 = A + SN$ if a person intends to exhibit a behaviour then it is likely that a person will do it.

Behavioral intention measures a person's relative strength of intention to exhibit (perform) a behaviour. Attitude consists of belief about the consequences of performing the behavior multiplied by his/her evaluation of these consequences (Ajzen & Fishbein, 1975)

Subjective norm is seen as a combination of perceived expectation from relevant individuals or groups along with intention to comply with these expectations. In other words the individual's perception that most people who are important to him or her think he should or should not exhibit a behaviour in question (Ajzen & Fishbein, 1975).

To put the definition into simple terms, a person's voluntary behavior is predicted by his attitude toward that behaviour and how he thinks other people will view him if he exhibits that behaviour.

A person's attitude combined with subjective behaviour forms his behavioural intention. Fishbein and Ajzen suggested that attitude and norms are not weighed equally in predicting behavior. Indeed depending on the individual and the situation, these factors might have very different effects on behavioral intention. Thus a weight is associated with each of these factors

in the predictive formula of the theory. For example an individual might be the type that cares little for what others think, in this case the subjective norms would carry little weight in predicting his behaviour.

Application of theory of reasoned action to the study

Billari, Philipov, & Testa, (2009) defined each of the three components as follows and uses example on child bearing decisions to illustrate the theory .

Attitude: The sum of belief about a particular decision weighted by evaluation of these beliefs . For example, a woman may have belief that having too many children is good for her and her well being although she might be health conscious or uncomfortable with something's as regards to social, cultural, economic and financial impact of raising the children. This will make her to decide whether to have few or many children.

Subjective Norms: looks at the influence of people weighted by their importance in ones social environment on his behavioural intention. The belief of people weighted by the importance of one's attribute to each of their opinion will influence ones behavioral intention.

A woman might have some friends that have many children and constantly encourage her to be like them . Bearing too many children is a kind of prestige to a woman and most women behave as if they are even competing on the number of children to bear. The woman might have a spouse that is not educated, a farmer who believe that children are sources of wealth and labour for his agricultural business, this will affect the woman's choice or women's decision as regards to child bearing.

Cultural influences will not be left untouched because in many part of the rural communities , having many children is seen as favour from the fore-fathers and God's blessing hence most

cultures support a Woman having too many children to prove she is a woman and she is blessed like others . This is subjective norms and will influence the woman's child bearing decision positively or negatively; that is either motivate her to have many children or less.

Behavioral intention; this is a function of both attitude and subjective norms towards a woman's decision which have been found to predict actual decision. A women's attitude and decision as regards childbearing, each with their own weight will lead the woman to either have too many children or not to which will then lead to his or her actual decision as regards child bearing.

Empirical review

Childbearing decisions of women is an interesting area that require more research work. In the developed countries research studies on childbearing decision of women are fairly available. Tough, Tofflemire, Benzies, Fraser-Lee, Newburn, Cook (2013) studied factors influencing childbirth decision and knowledge of women and non-parenting men in Canada. The objectives of the study were; 1) To determine the factors influencing the timing of childbearing for non-parenting men and women, 2) to determine knowledge among non-parenting men and women about maternal age-related reproductive risks, the consequences of low birth weight and multiple birth, and issues related to infertility, and 3) to determine characteristics associated with limited knowledge of these reproductive risk. The method used was an age-stratified random sample of individuals, aged 20-45 years and without children, completed a computer-assisted telephone interview from two urban regions of Alberta, Canada (1006 women and 500 men). The results showed Factors that influenced timing of childbearing for both men and women included: financial security (85.8%) and partner suitability to parent (80.2%). Over 70% of men and women recognized the direct relationship between older maternal age and conception difficulties. Less than half knew that advanced maternal age increased the risk of stillbirth, caesarean delivery, multiple birth and preterm delivery. The

researchers concluded that poor understanding of the links between childbearing after age 35, pregnancy complications and increased risk of adverse infant outcomes limits adults' ability to make informed decisions about timing of childbearing. The researchers recommended health education and awareness creation as means of letting people know the impact of age on maternal and child outcome

In California Katz, (2006) studied Childbearing decisions and family size among women with rheumatoid arthritis with the Arthritis Research Group and the Rosalind Russell Arthritis Center, University of California-San Francisco. The objective of the study include: To estimate childbearing trends relative to age and stage of family development and to report on childbearing decisions among women with rheumatoid arthritis (RA). The method used was Information about childbearing history and decisions was collected through structured telephone interviews with an existing cohort of married women with RA ($n = 411$), and was examined according to women's age at RA diagnosis and when RA was diagnosed relative to when children were born. Result showed that: Almost all women (91.2%) reported at least 1 pregnancy; the majority (85.4%) reported at least 1 live birth. The odds of any pregnancy or a live birth were not significantly different according to age at diagnosis; however, women diagnosed at age $< \text{or } = 18$ had fewer pregnancies and fewer children. Similarly, women diagnosed with RA prior to the birth of their first child had the fewest pregnancies and children. Few women (8%) reported being advised to limit family size, although approximately 20% reported that RA had affected their childbearing decisions. Being advised to limit family size was associated with fewer pregnancies and fewer children ($P < 0.0001$). Consideration of RA in childbearing decisions was more common among women diagnosed with RA at an early age. Women who reported that RA affected childbearing decisions were not less likely to have any pregnancy or any children, but had significantly fewer pregnancies and children. He concluded that: Lower birth rates among women with RA may at least in part reflect choices by

women to limit family sizes. Future research into the link between RA and fertility should take women's childbearing choices into account.

Linzi, Williamson, Karen, Lawson, Pamela & Roger, (2014) researched on Informed Reproductive Decision-Making: The Impact of Providing Fertility Information on Fertility Knowledge and Intentions to Delay Childbearing at Department of Psychology, University of Saskatchewan, Saskatoon SK .The Objective of the study was : To examine the impact of providing fertility information on personal levels of fertility knowledge and intentions to delay childbearing. The Methods: Participants (n = 69 young childless women) were randomly assigned to either an experimental (fertility-related) or control (alcohol-related) informational intervention group. Subsequent to the exposure to information, participants completed a questionnaire measuring fertility knowledge and intentions for reproduction. We predicted that the provision of fertility-related information would result in greater fertility knowledge and less intention to delay childbearing among young childless women. Results showed that: The young women exposed to the brief fertility information intervention were significantly more likely to respond correctly to questions testing their fertility knowledge, and reported less intention to delay childbearing than the young women in the control group. Conclusively, this study provided evidence that providing fertility related information contributes to greater reproductive knowledge and may affect childbearing intentions. The researchers recommended future research is warranted to examine the influence of fertility information on reproductive decision-making within a theoretical framework in order to ensure that subsequent information interventions maximize their effectiveness.

In Africa Philip, (2012) investigated factors influencing pattern of child bearing among women in Birim City of Ghana. A mixed approach was adopted, namely a combination of research instrument of questionnaire and interview schedule. Whereas the questionnaire was used to collect data from

one hundred (100) women from target population, the interview were used to collect data from (10) practicing TBAS from the target population.

At the end of the study, they concluded that the factors that influence child bearing pattern of women include poverty, husband's demand, pressure from in laws, pressure from family members, pressure from peers or friends, lack of suitable role model in the community, cultural influences, religious influences, as old age security and children as source of labour . The researcher made the following recommendations based on the findings of the study; To check high incidence of adolescent pregnancy and birth in the rural Communities of the Municipality, the development of population and family life education as part of the syllabus at the Basic and Higher Education Schools.

Another study was conducted by Nkrumah, (2011) on the power of women in reproductive health decision making as a reproductive right and empowerment drive. The main purpose of the study was to examine the socio-economic profile of women, nature of reproductive health decision and factors which influence women's reproductive health decision making. The study adopted a quantitative case approach method. An interview guide was used as an instrument to gather information from 180 respondents from 180 household purposefully selected. The findings from the study revealed that respondents participated in child bearing, antenatal and family planning decision – making. The study also revealed that reproductive health decision was jointly taken on by husband and the wife. It further, established women power and control over issues that affect their lives and thus affirming women's autonomy and right in reproductive health decision. The researcher recommended the Ministry of Health to ensure effective counselling through availability of space for private conversation and adequate trained personnel to increase access to health services and thereby boosting women confidence and bargaining power. Also empowering Metropolitan, Municipal and District Assemblies through planning authorities to ensure grass root promotion of reproductive health.

Weeks, (2010) study on education and marriage in rural and urban areas shows that education may actually delay marriage may shorten the period of childbearing. If post-primary educational opportunities are available only in urban areas .A stronger correlate between education and delayed age at marriage existed in urban rather than rural areas .Differences in the perceived costs and benefits of children also account for urban-rural fertility differentials. Some of benefits relevant to childbearing decisions are strongly influenced by the community context in which a woman reside, where children work, large families are seen as advantage. In many rural communities, children begin with such simple task as scaring away birds and as they grow so do their work responsibilities, both at home and in the field grow. In fact, a large family may be fundamental family's strategy to raise its income above bare subsistence, as Java and Nepal where larger families actually have more disposal income than smaller families, partially because the children's will help their parents to put their energies into the most product tasks.

Summary of Review of Relevant Literature

The literature of this study focused on five sub-heading, namely; patterns of child bearing in the developed and developing nations, factors identified as influencing child – bearing decision of women in the developed world, women's participation in their child – bearing decisions and women perception as to what constitute ideal family size. The theoretical framework, empirical review and summary of the review was also considered.

Pattern of child bearing in the developed and developing world, factors that influence the child bearing decision of women in the developed and developing world ,extent of women's participation in their childbearing decisions and women's perception as to what constitute an ideal family size were discussed.

Empirical literature review was done from the developed to the developing countries. In developed countries, literature reviewed that only 1 study was related to childbearing decisions and family size

of women (Katz, 2006), the remainder of the 2 studies were narrowed down to pattern, and informed reproductive decision making (Linzi , Williamson, Karen, Lawson, Pamela ,Roger, 2014). In the developing countries, the three studies reviewed were all from Ghana and not on childbearing decisions of women (Weeks,2010, Philipov,2012 & Nkrumah, 2011).

In Nigeria, there is paucity of literatures on the childbearing decisions of women. The few literatures available were limited to women's empowerment in reproductive decisions and fertility trends. Generally most of the studies were zeroed down to pattern of childbearing, education and marriage of women, factors influencing decisions and knowledge of women and non-parenting men which are just an aspect of childbearing decisions. This study holistically assessed the childbearing decisions of women. In Nigeria however, nothing has been done on childbearing decisions of women, particularly in South Southern Nigeria where Aniocha North LGA of Delta State is located. The child bearing decisions of interest will identify the pattern, extent of women's participation and factors that influenced the decisions made by women. This then underscores the need for identifying the child bearing decision of women in Aniocha –North Local Government Area, Delta State. This present study is community based and will fill the gap in knowledge which previous studies have created

CHAPTER THREE

RESEARCH METHODS

This chapter discussed the method for the study under the following headings; the research design for the study, area of study, study population, sample size, sampling procedure, instrument for data collection, validity and reliability of the instrument, ethical consideration, procedure for data collection and method of data analysis.

Research design

The design used for this study was the descriptive research survey design which involves describing the behaviour of subjects without influencing it in anyway (Polit & Becker, 2006). The research design was considered appropriate as the researcher is concerned with the Assessment of childbearing decisions of women in Aniocha –North Local Government Area, Delta State. It involved orderly collection of data, analysis, interpretation and reporting of pertinent information about the current situation.

Area of Study

The study was conducted in Aniocha-North local Government Area of Delta State. Delta state is located between longitude 5A⁰00 and 6A⁰45e and latitude 5A⁰00 and 6A⁰30⁰N. It has total land area of 16,842sqkm. The states that share boundary with Delta state are Edo to the North, Ondo to the North west, Anambra to the east and Bayelsa and Rivers to the South East. On its Southern flank is 160km of coastline of Bight of Benin.(Canback Global Income Distribution Database, 2008).

Aniocha-North Local Government Area has its headquater in Issele-uku. It has an area of 406km² and population of 104,711 at 2006 census report. It is made up seventeen communities. The communities used for the study include; Onicha-Olona, Ezi,Issle-Mkpitime, Issele-Uku, Onicha-Uku, and Onicha-Ugbo. The main economic activity in the area is agriculture (farming). They are

Ibo and their common language is Ibo. The researcher observed women of the area have high parity rate.

Population for the study

The target population consists of the women of child bearing age (15 to 49) years in Aniocha – North Local Government Area who are residents of the communities that constitute the Local Government Area. The total projected population of females in Aniocha –North Local Government Area is 53,131 (National Population Commission Asaba, Delta State 2013). The population of females from the six selected communities is 17,036 and 22% amounted to 3753 according to WHO,(2012) i.e women of childbearing age.

Sample for the Study

The sample for the study was determined using power analysis. The formular for calculating sample size by Creative Research System, (2012) is as follows;

$$N = Z^2 P(1-P)/d^2 \text{ (Creative Research System, 2012)}$$

where n=minimum sample size required

$$Z = 1.96 \text{ (at 95\% confidence interval)}$$

P=proportion or a best guess about the value of the proportion of interest. In this study , there is no information on the proportion of interest on child bearing decisions of women. Therefore the 50% usually used for unknown proportion is used. it is expressed in decimal. that is 0.5

$$d = \text{error margin i.e } 0.05$$

Applying this formular ; a sample of 348 women were selected and 10% attrition rate brought the sample size to 387.(see Appendix D)

Sampling procedure

This involved a multi- stage sampling procedure.

Aniocha-North Local Government Area was selected for the study based on the researchers knowledge about the population.

In the first stage, the 17 communities that constitute Aniocha-North L.G.A were listed. Simple random sampling with replacement was used to select six communities which represent approximately 40% of the entire women population. Six communities was selected because the population for the study geographically are widely dispersed. This was also to also enable the researcher to manage available resources and time.

In the second stage, stratified sampling method was used to select women of child bearing age ,and because the population of women from each community was known a proportional stratified sampling method was used to select the representative sample size. In the quarters (Ogbe's) the population was also known therefore, the researcher also used proportionate sampling design to select a representative sample of childbearing women from each quarter using the following formula;

$$NS = N_s \times n/N$$

Where NS=sample size from the community

N_s =population size of the community

n=sample size for the study

N=total population

To reach each of these subjects from each quarter, the third stage in the process was non probability sampling procedure (Convenience sampling) which was used to collect data from eligible women in the selected communities until the sample size is reached.

Inclusion Criteria

- Women between the ages of 15-49 who reside in the selected communities during the study period
- Women who are married
- Women who consented to participate in the study

Instrument for Data Collection

Data was collected using interviewer administered questionnaire constructed by the researcher according to the objectives of the study on assessment of childbearing decisions of women. The researcher designed closed ended and open ended structured questionnaire (Appendix A). The questionnaire has 4 parts; participants demographic characteristics, pattern of child-bearing among women, factors influencing child bearing decision among women in Aniocha-North Local Government Area and extent of women participation in child-bearing decision.

Validity of Instrument

Face and content validation of instrument was done by the project supervisor. Her inputs was used to modify the instrument for pilot test. The researcher designed tool was also sent to various experts for their expert opinion and construct validation. The experts reached include; maternal and child health educator, family planning specialist and expert in the field of measurement and evaluation. The validators critiqued the items of the questionnaire regarding clarity, suitability, scope, validity of constructs and coverage of study variables in line with the topic and objectives. Items not found to be valid were either eliminated or modified to agree with the validators observations.

Reliability of Instrument

To establish reliability of the instrument, a pilot test was conducted using thirty women of childbearing age in Obomkpa in Aniocha-Local Government, who have similar characteristics with the actual population of the study. The data generated was tested for reliability using split half reliability technique. Pearson Product Moment Correlation formula was applied to obtain the reliability coefficient. A reliability coefficient of $r=0.97$ was obtained. The instrument was considered reliable for the study.

Ethical Consideration

Ethical clearance certificate was obtained from the Delta State Ministry of Health Research Ethics Committee. Written administrative permit was sought for and obtained from the chairman of Aniocha-North local government and the heads of the six communities that was used for the study.

Informed consent was obtained from the respondents who met the inclusion criteria and assurance was also given to them that the information gotten from the study would be purely for research purpose and will be handled confidentially.

Procedure for Data Collection

The researcher trained four trained nurses as assistants to administer the questionnaire. The research assistants who understand the people's local language were trained to understand the objectives of the study and how to administer the instrument to the respondents. They were instructed to understand the project being carried out. The letter of introduction, the authority letter and ethical clearance was made available to the research assistants. These documents were presented to the respondents to gain their acceptance and co-operation. The researcher reached the eligible women by visiting their house by house in each quarter based on the required number from each village. Upon signing the informed consent, the questions in the questionnaire were administered to the respondents who met the inclusion criteria and those that could not read the English version had the

questions interpreted in ibo language to the selected respondents and their responses were recorded into the questionnaire. Data collection was done from 9am to 5pm each day excluding Sundays. A total of five (5) weeks was used for data collection. Each selected and consenting respondent had only one opportunity to participate in the study. This one opportunity was controlled by a form of identification on the certificate of informed consent. Completed questionnaires were collected the same day. Data were collected until the sample size from each quarter attained.

Method of Data Analysis

Quantitative data were collected and analyzed using IBM/SPSS version 20. Results were presented in tabular forms. Each of the facets of the responses in section A and B of the instrument was presented in their respective categories as tables including frequencies & percentages. The responses for each item in the research questions on section C were rated on a four point likert type scale as follows:

SM= solely mine	4	points
SH= shared by husband	3	Points
RD=relatives decide	2	points
NI = Not involved	1	point

Also section D was rated on four point scale as follows;

Highly	4	points
Quite a bit	3	Points
Not so much	2	points
Not at all	1	point

Means and standard deviation were used in answering the research questions in C and D for discussion, explanation, general description and summary of the data.

CHAPTER FOUR

PRESENTATION OF RESULTS

This chapter discusses the results of the data collected. Results are presented in accordance with the research questions. The questionnaires were administered to 387 women who gave their consents between October and November, 2015. After data collection, the questionnaires were sorted, perused and none had an error. Hence the study analysis was done based on 387 (100%) respondents that their questionnaires were correctly filled.

Table 1: Demographic profile of childbearing women in Aniocha-North L.G.A. n=387

Socio demographic	Frequency (percentages %)
Age category	
15-25	51(13.2)
26-35	122(31.5)
35-49	214(55.3)
Marital status	
Married	267(69.0)
Not married	15(3.9)
Divorced	30(7.8)
Widowed	52(13.4)
Cohabiting	23(5.9)
Community	
Ezi	35(9.0)
Onicha Olona	59(15.0)
Onicha Uku	22(6.0)
Onicha Ugbo	70(18.0)
Issele Uku	165(42.0)
Isselle Mkpitime	36(10.0)
Educational level	
No formal	137(35.4)
Primary	98(25.3)
Secondary	88(22.7)
Tertiary	64(16.5)
Occupation	
Full time housewife	90(23.3)
Farmer/ petty trader	236(61.0)
Public servant	58(15.0)
Others	3(0.8)
Religion	
Christianity	346(89.4)
Islamic	5(1.3)
Traditional	33(8.5)
Others	3(0.8)

Table 1; The demographic profile of respondents indicated that a good number of the respondents were between the ages of 26-35 (31.5%) and 36-49(55.3%).The table also revealed that many of the respondents 69.0% (138) were married and of Christian religion 346(89.4%). About 137(35.4%) had no formal education while 98(25.3%) had primary education with 236(61%) having farm work or petty trade as their major economic activities. A few respondents were, however, either house wives 90(23.3%) and public servant 58(15.0%).

Table 2: Objective one: To determine the pattern of child bearing among women in Aniocha- North LGA

Child bearing pattern	Frequency n=387	Percentage
No of pregnancy		
None	27	7.0
1-5	221	57.1
6-10	124	32.0
11 and above	15	3.9
Mean(SD)	4.68(2.95)	
No of miscarriages		
None	298	82.8
1-3	48	13.3
4-7	14	3.9
Mean (SD)	1.69(0.94)	
Number of children delivered		
None	11	3.1
1-5	219	60.8
6-10	118	32.8
11 and above	12	3.3
Number of children alive		
1-5	239	68.5
6-10	105	30.1
11 and above	5	1.4
Age at first birth		
13-17	137	45.7
18-22	84	28.0
23-27	58	19.3
28 and above	21	7.0
Mean(SD)	16.18(4.19)	
Child bearing Interval		
		24.3
Not sure	94	23.5
One year	91	30.0
Two years	116	15.5
Three years	60	4.7
Four years	18	0.5
Five years	2	1.6
Six years	6	

The result in the table shows that many (221) of the women had between 1-5 children. They represent 57.1%, this was followed by those who have had between 6-10 children. They were 124 and the number represents 32% of the respondents. The mean value is 4.68. Also the result shows a lower pattern and frequency of miscarriages as the number that have no miscarriages were 298 accounting for 82.8% of the respondent. A total of 249 women have children that are alive. Age at first birth and it showed that an average women starts sexual debut at 16 years old hence the mean value is 16.18 and the age with highest frequency is 13-17 years.

Table 3: Objective Two: Identify the extent of women's participation in child-bearing decisions in Aniocha –North Local Government Area, Delta State

Participation in child bearing issues	Not involved F(%)	Relatives decide F(%)	Shared by husband F(%)	Solely mine F(%)	Mean(SD) F(%)
When to become pregnant		4(1.0)		43(11.1)	2.93(0.68)
Number of children	33(8.5)	12(3.1)	307(79.3)	50(12.9)	2.93(0.70)
Where to receive ANC	32(8.3)	8(2.1)	293(75.7)	107(27.6)	3.15(0.70)
Where to deliver	21(5.4)	1(0.3)	251(64.9)	93(24.0)	3.14(0.64)
Sex combination of children	18(4.7)	2(0.5)	275(71.1)	32(8.3)	2.78(0.80)
When to have sexual intercourse	58(15.0)	3(0.8)	295(76.2)	33(8.5)	2.93(0.62)
Child spacing period	28(7.2)	5(1.3)	323(83.5)	56(14.5)	2.60(1.03)
To use family planning	102(26.4)	1(0.3)	224(57.9)	52(13.4)	1.84(1.17)
	250(64.6)		84(21.7)		

For objective two, the researcher assigned weights to the scale of 1,2,3 and 4 to Not involved, Relatives decide, Shared by husband and solely mine respectively. From the foregoing, the cut off points is 2.5. Here the means values for these statements When to become pregnant, Number of children, when to have sexual intercourse and child spacing period were 2.93, 2.93, 2.93 and 2.96 respectively. Also it shows that the mean values for where to receive ANC and where to deliver was 3.15 and 3.14 respectively. The mean value in decision of when and how to use family planning is 1.84.

Table 4: Determine the factors that influence women’s child-bearing decisions in Aniocha – North Local Government Area, Delta State.

3a; Socio-economic factors that influenced the decisions made by women on child bearing matters

Socio economic factors	Not at all F(%)	Not so much F(%)	Quite a bit F(%)	Highly F(%)	Mean(SD)
Level of education	226(58.4)	66(17.1)	25(6.5)	70(18.1)	1.84(1.16)
Employment status	245(63.3)	49(12.7)	33(8.5)	60(15.5)	1.76(1.13)
Space in your house	253(65.4)	54(14.0)	27(7.0)	54(14.0)	1.72(1.08)
Husbands occupation	241(62.3)	67(17.3)	25(6.5)	51(13.2)	1.66(1.07)
Age	257(66.4)	56(14.5)	23(5.9)	62(16.0)	1.82(1.13)
Availability of social amenities	224(57.9)	69(17.8)	32(8.3)	158(40.8)	2.49(1.38)
Costs of raising children	161(41.6)	35(9.0)	33(8.5)		

The result in this table shows that these socio economic factors did not affect the women’s child bearing decision. Apart from the cost of raising children which has a mean score of 2.49, the mean values were below 2.5. The means values 1.84, 1.76, 1.69, 1.72, 1.66, 1.82 .

Table 5:3b: Cultural factors that influenced the decisions made by women on child bearing matters

Cultural factors	Not at all F(%)	Not so much F(%)	Quite a bit F(%)	Highly F(%)	Mean (SD)
My family and in laws make childbearing decisions	265(68.5)	43(11.1)	39(10.1)	40(10.3)	1.62(1.03)
Women are not allowed to make decision when it comes to child bearing	212(54.8)	50(12.9)	27(7.0)	98(25.3)	2.03(1.28)
Children as old age security	48(12.4)	11(2.8)	32(8.3)	296(76.5)	3.49(1.03)
To continue my husband's lineage	43(11.1)	10(2.6)	36(9.3)	298(77.0)	3.52(0.99)
Fewer children is not allowed in my culture	99(25.6)	26(6.7)	36(9.3)	226(58.4)	3.01(1.30)
To have children to care for me when I 'm	47(12.1)	11(2.8)	17(4.4)	312(80.6)	3.53(1.02)
To have children that will help the family in farming and running errands	120(31.	11(2.8)	26(6.7)	230(59.4)	2.95(1.37)

The result shows that a good number of the cultural factors influence the child bearing decisions of the women. The mean values showed that factors like to have children to care for them when they are old and to continue their husband lineage were the upper most in the factors that affected child bearing decisions. This is because the mean values were 3.53 and 3.52 respectively. This was followed by the statement that children are old age security and it has a mean value of 3.49. However, the result showed that they did not consider their family and in laws making childbearing decision for them as a factor that affects their child bearing decision hence the mean is 1.62.

Table 6: 3c: Biological factors that influenced the decisions made by women on child bearing matters

Biological factors	Not at all F(%)	Not so much F(%)	Quite a bit F(%)	Highly F(%)	Mean (SD)
Age at marriage	324(83.7)	22(5.7)	4(1.0)	37(9.6)	1.36(0.91)
Infertility	328(84.8)	13(3.4)	7(1.8)	39(10.1)	1.37(0.94)
Infertility treatment	333(86.0)	9(2.3)	2(0.5)	43(11.1)	1.37(0.95)
Sex selection	310(80.1)	6(1.6)	13(3.4)	58(15.0)	1.53(1.10)

The result shows that none of these biological factors affect the women child bearing decisions. This is because the mean values for each of the variables were less than 2.5.

Table 7:3d: Religious factors that influenced the decisions made by women on child bearing matters

Religious factors	Not at all F(%)	Not so much F(%)	Quite a bit F(%)	Highly F(%)	Mean (SD)
The commandment to increase and multiply	109(28.2)	76(19.6)	45(11.6)	157(40.6)	2.65(1.237)
My religion supports women having a lot of children	171(44.2)	90(23.3)	45(11.6)	81(20.9)	2.09(1.18)
My religion does not accept/practice family planning	109(28.2)	30(7.8)	16(4.1)	232(59.9)	2.96(1.34)
Abortion is not allowed in my religion	58(15.0)	4(1.0)	5(1.3)	320(82.7)	3.52(1.08)

Concerning the religious factors, it shows that the highest that affected child bearing decision was the fact that their religion does not allow abortion which has mean value of 3.52. This was followed the fact that their religion does not accept/practice family planning as the mean value was 2.96. However, the result showed that the women did not affirm the statement that their religion supports women having lots of children.

Summary of major findings

Many of the respondents have low literacy level hence about 137(35.4%) had no formal education while 98(25.3%) had primary education with 236(61%) having farm work or petty trade as their major economic activities.

The mean value on the number of children that are alive is 4.68. Age at first birth showed that an average women makes sexual debut at 16 years old hence the mean value is 16.18 and the age with highest frequency is 13-17 years.

Majority of the women take some part in making decision about their child bearing. Here the means values for these statements When to become pregnant, Number of children, when to have sexual intercourse and child spacing period were 2.93, 2.93, 2.93 and 2.96 respectively and where to receive antenatal and where to deliver have mean values of 3.15 and 3.14 respectively.

Majority of the women are not involved in decision of when and how to use family planning hence the mean value is 1.84 .

Majority of the women's childbearing decisions were not influenced by socio economic factors. This is because, apart from the cost of raising children with 2.49 as mean score, the mean values of others were below 2.5. The means values 1.84, 1.76, 1.69, 1.72, 1.66, 1.82. Majority of the child bearing decisions of the women were influenced by cultural factors. The mean values showed that factors like; to have children to care for them when they are old and to continue their husband lineage were the upper most in the cultural factors that affected child bearing decisions. This is because the mean values were 3.53 and 3.52 respectively. This was followed by the statement that children are old age security and it has a mean value of 3.49.

None of the biological factors affect the women's child bearing decisions. This is because the mean values for each of the variables were less than 2.5.

Majority of the women were not influenced by religious factors apart from the fact that their religion does not allow abortion and does not accept/practice family planning hence their mean value was 3.52 and 2.96 respectively.

CHAPTER FIVE

DISCUSSION OF FINDINGS

This chapter presented the discussion of major findings based on specific objectives, implication for nursing, limitations of the study, suggestion for further studies, summary, conclusion and recommendations.

Discussion of major findings

Respondent's characteristics

It was revealed from the findings that majority of the respondents have low literacy level and are poorly empowered economically. This was shown by the findings that respondents 137(35.4%) had no formal education, 98(25.3%) had attained primary school education and 88(22.7%) had attained secondary school education. Only as few as 64(16.5%) had attained tertiary education qualifications and Majority of the women (236) were self employed farmer and petty trader and they account for 61% of the respondents. About 90(23.3%) were full time housewives. Education and enhanced economic power of women has been seen as a pre-requisite to effective decision making of all kinds including that pertaining to the childbearing decision among women. Hence this finding was not in conformity with the assertion made by Weeks, (2010) who saw fertility and its decisions in the family to be influenced by ideas and changes that occur in the life of the individual associated with such characteristics as education and income levels. Thus as women climb the educational ladder and men are faced with economic challenges of life, coupled with the pressure from the family to provide and satisfy their physiological needs, women are faced with the need to make choices with respect to the number of children they should give birth to and the size of their families (Weeks, 2010).

The findings was also contrary to the assertion made by Miller,(2010) who noted that; In the developed and industrialized societies, the trend towards smaller family sizes has emerged due to the spread of formal education for women and the enhanced economic status of women (Miller, 2010). Education, for example, is a very powerful indicator of involvement in fertility decision making among women globally (United Nation, 2005). It has been widely recognized as a key concept in understanding fertility behaviour (Miller, 2010). This shows that women who were not enlightened educationally as well as on their rights are not likely to be knowledgeable about their child-bearing decisions and will not show positive attitude to fertility regulation programmes. Generally, the occupation/economic activities conformed with the general employment trend where women are mostly found in the informal sector. The higher concentration of respondents in the informal sector is attributed to the few respondents with higher education which is a requirement for recruitment into the formal sector. This explanation is in line with Momsen, (2004) submission that female access to education would expose them to better-paid jobs. Here, Momsen has established the relationship between education and employment. Education and employment also influence childbearing decision. When women are exposed to opportunities of education and employment, 'time' becomes an important factor in household decision on number of children to bear (Monsen, 2004). With a higher percentage of women in employment, it is expected that they would be exposed to the stress of the double burden of childrearing and productive roles and their leisure would become valuable (Momsen, 2004). The effect would be women's preference for fewer children. It is contended that as the wealth of women increases through their engagement in economic activities with children no longer used as source of wealth, the opportunity cost of raising children becomes higher and the incentive to have children declines.

Objective 1; To determine the pattern of child bearing among women in Aniocha North LGA.

The mean value on the number of children that are alive per woman is 4.68 and what this means that pattern of child bearing in the local government is almost 5 children per woman. It was also

revealed that some women had more than 5 children as findings showed that an appreciable number of women had between 6-10 children. This is an indication of high fertility which exist in most rural areas of various communities of the L.G.A. This findings agree with the report released by the United Nations Population Division which revealed that between 1995 and 2000, 49 countries with a total population of 770 million, most of which could be located in the developing world, have fertility levels of 5 children or more per woman (UN, 2009). The World Population Data Sheet places the most regions within the 3.9 to 5.5 children per woman range with East and West/ Middle Africa falling within the fertility ranges of 5.1 to 7.0 and 5.1 to 7.5 children per woman respectively (Population Reference Bureau,2000).

This findings also confirms National Population commission (2014) report that Delta State in Nigeria health demographic and survey (NHDS)-2013, recorded a fertility rate of 5.7 and there existed fertility differentials between the rural and urban community of the state of 7.0 and 4.7 respectively. The survey also revealed that higher frequency of birth among women result in serious health risk, economic stagnation and poverty, marital burden and inabilities of the families to educate most of their children, resulting in higher illiteracy rate in the rural communities of the state.

Secondly on the pattern of childbearing, age at first birth showed that an average women starts sexual debut at 16 years old hence the mean age is 16.18 and the age with highest frequency is 13-17 years. This could also determine the number of children a woman in Aniocha-North would like to have or had already hence Weeks, (2010) asserted that age at marriage which also influences the time of first birth is another factor that influences the reproductive decisions and fertility levels of women and also determines the number of children they give birth to during their reproductive years. Thus, many women in the rural communities of the developing world who marry at an early age either consciously or unconsciously have many children (Weeks, 2010), because of lengthened period of fecundicity

Objective Two: Identify the extent of women's participation in child-bearing decisions in Aniocha –North Local Government Area, Delta State

The importance of women's control over their childbearing decision-making includes an affirmation of their reproductive health and the prevention from exposure to precarious health conditions due to undue pressure to have large family size. Other benefits include prevention of unwanted pregnancy and the opportunity to engage in other activities such as education and employment which would enhance their status in the society. The researcher, therefore, asked whether women are the sole decision makers their childbearing but findings from this objective showed that majority of the women take some part in making decision about their child bearing. Here the means values for these statements; When to become pregnant, Number of children, when to have sexual intercourse and child spacing period were 2.93, 2.93, 2.93 and 2.96 respectively. This shows that the women would at least take these decisions with their husbands. Women invariably lack total control over decision making in these aspects hence (Marger, 2008) admitted gender differences in childbearing decision making and attributed this to power relation and traditional gender roles. This view was supported by Vaessen, (2004) who argued that women lack total control over decision-making power in reproductive health especially with regards to their childbearing. They commented that women are often pressured by husbands to have large families and maintained that society had not recognized and made use of women's knowledge and capabilities. In most developing societies, most women have no option than to succumb to the dictates of their spouses, with no control over their childbearing decisions (May, 2014). The study therefore revealed that childbearing decision-making was jointly taken by the wife and the husband.

Majority of the women were more involved in making these decisions on where to receive antenatal and where to deliver. Women's control over their antenatal care and place of delivery decision-making was relevant for several reasons. The right of access to appropriate health care services to enable women to go through pregnancy safely and childbirth, and provide couples with the best

chance of having healthy infant, has been emphasized by healthcare providers. The ability of women to exercise control and power in childbearing decision making, especially in antenatal care, is a necessity to guarantee their access to healthcare which, in turn, would ensure safe delivery and prevention of pregnancy related complications (Nkrumah, 2011).

The reasons underlying women's greater participation in antenatal care decision-making may have been the notion shared by many that women were exclusively exposed to the health hazards associated with pregnancy and hence needed to influence antenatal care decision-making.

Apart from the health reasons which informed women's participation, the role of the media, both print and electronic in information dissemination on reproductive health cannot be overemphasized. Women are increasingly becoming aware of their reproductive health needs, and taking advantage of the government policies and programmes on reproductive health (Nkrumah, 2011).

Majority of the women are not involved in decision of when and how to use family planning. Family planning is an asset for both the family and the society. It is the means of preventing unwanted pregnancies and thus making abortions unnecessary. It also has the socio-economic benefits of providing families with better options to plan for nourishment, care, housing and education of their children (Pietila, 2007). On the basis of the foregoing submissions, the researcher sought to explore the respondent's role in decision-making on family planning. The data shown in table 3 in chapter 4 above showed Majority of the women are not involved in decision of when and how to use family planning. Brown, (1994), however, confirms this finding with the assertion that the traditional role of the male as a decision-maker is evident in the area of family planning hence a woman might not be able to take family planning decision alone. Most of the respondents don't know about family planning while those that know said they don't want to hear about it. Furthermore, the trend may be as a result of ineffective communication between couples and the women's religious background as most of their churches condemn family planning together with

abortion. As women remain dependent, and patriarchal dominance in marital relations increases, their bargaining power diminishes.

Objective Three: Determine the factors that influence women's child-bearing decisions in Aniocha –North Local Government Area, Delta State.

3a) Socio-economic factors that influenced the decisions made by women on child bearing matters.

The result in this study shows that these socio economic factors (Level of education, Employment status, Space in your house, Husbands occupation ,Age ,Availability of social amenities) did not have any effect on the women's child bearing decision apart from the cost of raising children which has mean value that is approximately 2.5. This contradicts this view by (Gabriel & Villarreal in UN, 2009;Miller, 2010, Weeks, 2010 & May, 2014) that in the developing nations, socio-economic factors had been identified as the most dominant that influence women's child-bearing decisions especially in the rural communities. Against this back drop however, education, especially women's education has received considerable attention from researchers and scholars with respect to the concept of fertility in demographic literature. Writing on the situation in Bangladesh, (Miller, 2010) reiterated the role education plays in women's child-bearing decisions as influencing their supply of children, their ages at marriage, family size, duration of lactation and post-partum care as well as education and welfare of their children, among others. In corroboration with Miller's view , Weeks, (2010) postulated that the educated females are more conscious and courteous of their family size, quality of life and the functioning of their human bodies, placing a higher premium on their families' living standard, their personal health and the health of their children. To Weeks, the educated women show a more positive attitude toward fertility regulation programmes than their illiterate counterparts.

Linked to these fertility decisions is the issue of residence, rural or urban which (UN, 2007) reveals that rural women in most cases have no role models, little or nothing to compete for and no struggle for the use of land, accommodation and other facilities as compared to their urban counterparts who have to compete for schools, health facilities, land, water, accommodation and other socio-economic facilities at higher cost (Weeks, 2010.). However, the cost of raising children is a factor that affects child bearing decision. This conforms (Gabriel & Villarreal in UN, 2009) that in the developed world where scientific innovations, technology, good and quality healthcare and nutrition coupled with quality and higher education abound, the decisions of women to give birth, when to give birth and the number of children to give birth to depend to some extent, on the cost of child birth, care and the education of the children from their toddlerhood to adulthood when they become independent to cater for themselves. The economic costs of child birth and care are therefore felt by both men and women. Education has been identified as the main economic cost of child birth and care in the developed world (Caldwell, in UN 2009). Gabriel & Villarreal in UN, (2009) also posited that with poor socio-economic background, children from poor households have less chance of acquiring educational and nutritional profile that will secure them productive employment hence the women from the study environment recognized the cost of training the children as a socio-economic factor that they considered or needed to be considered.

Cultural factors that influenced the decisions made by women on child bearing matters

The result shows that a good number of the cultural factors influence the child bearing decisions of the women. The mean values showed that factors like to have children to care for them when they are old and to continue their husband lineage were the upper most in the factors that affected child bearing decisions. This was followed by the statement that children are old age security.

This result was in conformity with (Avatim, 2009; Bleek in Stephenson, 2006 & Oppong & Abu, 2007) that within the traditional sphere, child-bearing ability of women was explained as the means

by which the lineage ancestors were allowed to be reborn. Barrenness was therefore considered the greatest misfortune. It was confirmed that by this traditional view of procreation, about 60% of women in Nigeria's rural communities preferred to have families of five (5) or more children (Avatim, 2009). Cultural beliefs in Nigeria detract women from their ability to negotiate sexual relations, determine the number of children they want to and should have and the method to apply in that regard, resulting in the high fertility levels in the rural corridors of the country (Avatim, 2009). Childbearing decisions within the traditional family system are based on factors such as children as old age security for parents, prestige attached to large family sizes, labour force for agricultural practices, as security against high infant mortality and the social benefits of having children and grandchildren. Children are, therefore, cherished as source of labour in the agrarian and traditional societies. The low status accorded to women made them desire for larger family sizes. They felt secure in the number of children they had, as women's value and status were linked to their reproductive efficiency and this also give them support in the event of unexpected vicissitudes of life such as widowhood, divorce and physical incapacitation (May, 2014). Children in the Nigerian cultural setting was seen as social insurance benefits of the aging parents, social prestige and source of labour in the agrarian societies where food and cash crop farming, fishing and animal rearing are the dominant economic activities. (Bleek in Stephenson, 2006). Thus to (Oppong & Abu, 2007), there is a strong traditional norm of high fertility as children are the *raison d'être* of marriage which also results in higher fertility in the rural communities than the urban communities of the nation. The women's autonomy in the childbearing decision-making, her participation and concern are not the issue to be thought of by the spouse.

However, the result showed that they did not consider their family and in laws in making childbearing decision for them as a factor that affects their child bearing decision. This contradicted May, (2014) view that another aspect of the cultural tradition that influences the child-birth decisions of women is the extended family system and that child bearing decision could be more of

group effort than we could imagine. May, (2014) explained that the extended family has a great influence on the nuclear family members in the child-bearing decision making process which was not the case in this study.

Biological factors that influenced the decisions made by women on child bearing matters

The result shows that none of the biological factors affect the women child bearing decisions. It implies that the women perceived that each of the factors would not all affect or would affect their child bearing decision not so much hence the women didn't have any need for reproductive assistance to enable them mother / father children as their natural inalienable rights (Westoff and Freyka, 2007)

Religious factors that influenced the child bearing decisions of women

Concerning the religious factors, finding shows that the highest that affected child bearing decision of women in Aniocha-North LGA was the fact that their religion does not allow abortion or support family planning thereby confirming what McIntosh & Finkle, (2005) said that conversely, religious beliefs and practices do prevent some persons from accepting or practicing fertility regulation techniques as a means of making reproductive decisions. Thus, the concept of family planning and artificial contraception, reproductive health decisions and any form that follows the policies, tenets and decisions of the Programme of Action of the Cairo Conference (ICPD) 1994, were opposed by the Holy See, The Papacy of the Catholic Church (McIntosh & Finkle, 2005).

Implication of the study for nursing

Gender inequality, is a universal phenomenon which largely confronts women. It has been observed that in no society do men and women receive the same rewards. Globally, women do not enjoy equality with men in terms of political, legal, social and economic rights. The 1995 World Bank report acknowledged the same fact that gender inequality also manifests itself in childbearing decision-making hence gender inequality in decision-making constitutes a major concern in this

study. Childbearing decision of women is a global concern because of the social and environmental impacts of population growth and maternal mortality (Ronsmans & Graham, 2006).

Furthermore Marger,(2008) admitted gender differences in childbearing decision making and attributed the underlying reasons to power relation and traditional gender roles. He commented that women are often pressured by husbands and relatives to have large families and maintained that society had not recognized and made use of women's knowledge and capabilities. In most developing societies, most women have no option than to succumb to the dictates of their spouses, friends and kinsmen with no control over their childbearing decisions (May,2014). The high value traditionally placed on children, has sustained the high fertility rate in the region and made it resistant to the forces that brought about decline in fertility in the developed countries.

Majority of women of childbearing age in the study communities lack control over their childbearing decisions due to lack of knowledge which is a pre-requisite to informed decision making in their families. Nurse Midwives are therefore encouraged to utilize every opportunity to educate women about childbearing issues and the need for effective decision making in issues that affect their well being especially in the rural areas of the states of the federation. It is the responsibility of the nurse to educate women on the need for active participation in decision making on child bearing issues. The education of the woman and family members when opportuned should address the theme such as; concept of childbearing decision making, women reproductive health needs and vulnerability to health complications, the ideal family size, need for family planning, education of children and complications of high fertility including maternal mortality and its externality on the environments. The education sessions must consider the reality of the subject, and aim to provide knowledge to promote independent women who can be active in their childbearing decision making process. The nurse plays an important role in health education and is responsible for articulating the scientific knowledge and ensure the development of autonomy in decision making of individual women.

Limitations of the study

It was not an easy task to access the respondents. Several visits were made before obtaining the required sample size.

It was also very rigorous and time consuming collecting data as most of the respondents could not read ibo nor comprehend the English version of the questionnaire. Each question in the questionnaire had to be interpreted and the answer recorded in the questionnaire.

Paucity of literature as concerned indigenous study on child bearing decisions of women was also a limitation to the study

Suggestions for further study

The study covered only the Aniocha-North L.G.A, which is a mere representative of the state and the country at large. The researcher therefore suggest the following;

1. That a similar study be conducted on a wider scale to cover either the entire state or the entire nation. This will help and serve as additional source of literature for policy makers and technocrats for the development of the national women population.
2. Women's education and it's impact on childbearing decisions of their families
3. The influence of traditional gender role on childbearing decisions of women

Summary

This study was designed to obtain information on the childbearing decisions of women in Aniocha-North L.G.A of Delta State. The specific objectives of the study was to: (i)Identify the pattern of childbearing among women in Aniocha –North Local Government Area, Delta State.(ii)Identify the extent of women's participation in child-bearing decisions in Aniocha –North Local Government Area, Delta state(iii)Determine the factors that influence women's child-bearing decisions in Aniocha –North Local Government Area, Delta State. Literature was extensively reviewed on the

concepts, theory and empirical studies. The descriptive survey research design was used for the study. Using power analysis , sample of 387 participants were enlisted in the study. Interview administered Questionnaire was the only tool used for data collection. The data were statistically analyzed based on the research questions using IBM/ SPSS version 20. Major findings revealed that: A good number of the respondents have low literacy level in the communities hence about 137(35.4%) had no formal education while 98(25.3%) had primary education with 236(61%) having farm work or petty trade as their major economic activities. The mean value on the number of living children is 4.68 . Age at first birth showed that on the average the women make their sexual debut at 16 years old. The means values for these statements When to become pregnant, Number of children, when to have sexual intercourse and child spacing period were 2.93, 2.93, 2.93 and 2.96 respectively. The mean value of where to receive ANC and where to deliver which read 3.15 and 3.14 respectively. Majority of the women are not involved in decision of when and how to use family planning hence the mean value is 1.84. Apart from the cultural factors that have great impact on the women's childbearing decisions , socio-economic, biological and religious factors have little or no influence on Aniocha-North's women's childbearing decisions. Therefore midwives have a role to play by health educating women on the need for their involvement in decision making with regards to their fertility and also the need for family planning as an effective way to reduce their family size ,unsafe abortion, maternal mortality and achieve their MDG 4 & 5 target.

Conclusion

The empowerment and autonomy of women to enable them to take active part in their child-bearing decisions, decide as to when to marry and give birth and either to space or limit their births have been given much prominence at major international and national seminars and conferences on population, women and Development over the years. Particular reference could be made to the Programme of Action at the ICPD of Cairo, 1994 (UN, 1995), and the World Conference on Women in Beijing, China in 1995 (UN, 1996), where governments were expected to apply all the protocols

signed and principles and policies agreed upon to the letter. These notwithstanding, many women in rural communities of most countries in the developing world especially in sub-Sahara Africa (SSA) face the same problems that were discussed in the international circles such as poverty, male dominance, marital instability, high birth rate, ineffective participation in their child-bearing decisions, pregnancy and birth complications among others, and their effects on the women and their children.

The study also revealed that women of the study communities do not independently make decisions in their childbearing issues and most women are not educated hence education is a pre- requisite for effective reasoning and informed decision making.

Therefore midwives have a role to play by health educating women on the need for their involvement in decision making with regards to their fertility and also the need for family planning as an effective way to reduce their family size, unsafe abortion, maternal mortal and achieve their MDG 4 \$ 5 target.

Recommendations

The need for women to make decisions with regards to their fertility is of utmost important for effective growth of the community, state and nation wide cannot be over emphasized hence most birth complications are commonly been experienced by women. Based on this, the researcher recommends the following;

1. The LGA assembly, in collaboration with NGOs should encourage, institute and implement programmes and activities that will enhance adolescent and youth development. These programmes should inculcate in them the concept of responsible sexual behaviour, the small family size norm, pursuit of careers, values of responsible adulthood and mutual respect for the opposite sex.

2. At the community levels, reproductive and maternal health programmes should not be left to the Ministry of Health alone. The Local Government Assembly, NGOs, Faith -Based Organizations (FBOs) and Community- Based Organizations (CBOs) should be funded to undertake regular outreach programmes through public education and community durbars and the training of peer educators in the field who will serve as channels of communication and education to support the efforts of the Ministry of Health in the rural communities.
3. To promote women's autonomy and control over their bodies, there is the need for men to be involved in maternal and child health programmes and be conscientized on the need to allow their wives in child birth decisions and participation in family issues.
4. Women's education, which has been generally and specifically identified as the antidote for fertility reduction should be given extra boost by promoting non-formal education programmes in the rural communities for the unfortunate illiterate female population and those with very low level education to rake them out of the ignorance syndrome to enable them become conscious of their sexual and reproductive rights.
5. Religious institutions which play key role in conjugal relations and marriage contraction have to encourage effective communication among couples. Effective communication is needed to ensure that women are able to negotiate on issues that threaten their lives and also if possible change their stake on family planning programmes
6. The role of the media, both print and electronic is fundamental in reproductive health awareness creation and public education. The public needs to understand and appreciate the positive implications of women's participation in reproductive health decision-making. The benefits that could be derived from such participation include prevention of unwanted pregnancy, unsafe abortion, increase access to education and employment, prevention of large family size, spacing and timing of

childbearing and the prevention of pregnancy related complications such as maternal mortality. The ability of women to participate in reproductive health decision-making would not only enhance their bargaining power but also reduce their vulnerability to STD's including AIDS from diseased or high risk-partners. Other harmful traditional practices such as female circumcision could also be reduced.

7. Women's participation in childbearing decision-making will further be enhanced if reproductive health interventions such as antenatal and postpartum health care and other health packages such as National Health Insurance Scheme which guarantee free access to healthcare services are instituted, properly implemented, promoted and sustained

The effective implementation of these recommendations will not only help in achieving community development, but also the attainment at the fifth component of the Millennium Development Goals (MDG) that aims at improving maternal health (WHO,2012).

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APPENDIX I

Department of Nursing Sciences,
University of Nigeria,
Enugu Campus

Dear respondent,

Assessment of Child Bearing Decisions of women in Aniocha-North Local Government Area

I am conducting a research on Assessment of Child Bearing Decisions Of Women in Aniocha-North Local Government Area Of Delta State as part of my M.Sc programme at the University of Nigeria, Enugu Campus.

I consider you to be an important stake holder in this study and would be very grateful if you could answer these questions to help me gather the required data for the research.

I would like to assure you that the information you provide will be treated with utmost confidentiality and anonymity.

Yours faithfully

Njoku Linda-Chihurumnanya
Student (UNEC)

THE QUESTIONNAIRE

Instruction

Please tick (✓) the appropriate box

Section A: Demographic data

1. Age at last birthday:

2. Marital status

(i) Married [] (ii) Not married [] (iii) Divorce / Separated [] (iv) Widowed [] (v) Living together but not married []

3. Community

(i) Ezi [] (ii) Onicha-Olona [] (iii) Onicha-Uku [] (iv) Onicha-Ugbo [] (v) Issele-Uku [] (vi) Issele-Mkpitime []

4. Highest level of Education attended;

(i) No formal education [] (ii) Primary education []

(iii) Secondary education [] (iv) Tertiary education

5. What is your occupation? (i) fulltime house wife [] (ii) self employed farmer/trader [] (iii) public servant as government/private worker [] (iv) Others specify----- []

6. What is your Religion

(i) Christian [] (ii) Islamic [] (iii) Traditional [] (iv) Others specify-----[]

Section B:

Pattern of childbearing among women in Aniocha-North L.G.A

(7). Obstetric history;

(a) Number of pregnancies you have had []

(b) Number of abortions/miscarriage []

(c) Number of children delivered []

(d) Number of children alive []

(e) Sexes of the children []

(8). What was your age at first child birth? []

(9) what interval would you or did you give in between births or will you give in between birth? []

Section C:

Extent of women's participation in child bearing decisions of their families

Instruction: Below is the list of questions designed to find out the extent of your participation in child bearing decisions. Please tick (√) against each question reflecting your response to the extent at which you participate in childbearing decisions of your family.

Please note; SM= solely mine

SH= shared by husband

RD=relatives decide

NI = Not involved

s/n	Questions	Solely mine	Shared by husband	Relatives decide	Not involved
	To what extent do you participate in taking decisions on the following childbearing issues				
11	when to become pregnant				
12	number of children to have				
13	Where to receive ante-natal care				
14	Where to deliver				
15	Sex combination of the children				
16	When to have sexual intercourse				
17	Child spacing period				
18	To use family planning				

Section D;

Objective three; To determine the factors that influence childbearing decisions of women in Aniocha-North L.G.A.

Instruction:

Below is the list of questions designed to find out your views on factors that influenced your child bearing decisions.

Please tick (✓) the appropriate box, thanks.

s/n	Questions	Highly	Quite a bit	Not so much	Not at all
20	How well did each of the following socio-economic factors influenced your decision on childbearing matters?				
I	Your level of Education				
Ii	Your Employment status				
Iii	The space in your house				
Iv	Your husband's occupation				
V	Your age				
Vi	Availability of social amenities				
Vii	Cost of raising children				
Viii	Others specify-----				
21	How well did each of the following cultural factors influenced your child bearing decisions				
I	My family and in-laws make childbearing decisions				
Ii	Women are not allowed to make decision when it comes to child bearing				
Iii	Children as old age security				
Iv	To continue my husband's lineage				
V	Fewer children is not allowed in my culture				
s/n	Questions	Highly	Quite a bit	Not so much	Not at all
Vi	To have children to care for me when I'm aged				
Vii	To have Children that will help the family in farming and running errands				
Viii	Others specify-----				
22	How did each of the following biological factors contribute to issues influencing your decision on childbearing				
I	Age at marriage				
Ii	Infertility				
Iii	Infertility treatment				
Iv	Sex selection				
V	Others specify-----				
23	How highly did each of these Religious factors influenced your childbearing decisions				
I	The commandment to increase and multiply				
Ii	My religion supports women having a lot of children				
Iii	My religion does not accept/practice family planning				
Iv	Abortion is not allowed in my religion				
V	Others specify-----				

APPENDIX II

Nji kwaba nke ndi nos,

Mahadum nke ala anyi bu Nigeria,

Nji kwaba nke Enugwu

Onye nfunaya Nabata ajuju,

**Ngba kor ife gbasali Nkwa UmuNwayi banyeli imu Nwa Na Aniocha North Nganaba Ochi chi
anyi.**

Anuma Cho ani ifebanye li Ngbakor Nkwa umu nwayi na imu nwa naganaba Ochichi Aniocha North,Delta State.

Ogba nye na olu igu akukwo gbanye norkwa amamife M.Sc na University of Nigeria, Enugu Campus.

Enwen okukwe nidimkpa site niche aka ife na udi olu ni wa. Ekene lui na aka ige nyeli site nikpokoba ichele aka ogugisi gbanye na okwu niwe

E kem u Nkwa na alo obuna itubanyeli okwu ni, na anyi ama kpupue; anyi ama kpor afayi.

Ekwe nye limii,

Njoku Linda-Chihurumnaya

Nwata Akwukwo (UNEC)

Nji kwaba Ajuju

Ozi nzizi

Biko kacha () nkacha odinma nime ekpeti tosieni.

Nganaba Nkizizi: Nchikoba Okwe Olu banyeli uba nmadu

1. Ogboi ahor igba ikpazu

2. Iji di

- (i) Ejim () (ii) Ejinem () (iii) Anyi kpeche kwungor/anyikpeche ()
(iv) Enimozu di () (v) Anyi kpa ngba ()

3. Eboh

- (i) Ezi () (ii) Onicha- Olona () (iii) Onicha-Uku () (iv) Issele- Uku () (vi)
Issele-Mkpitime. (vii) Onicha-Ugbo

4. Ka ki gudobe Akukwo

- (i) O zuzu nwa () (ii) Ngba go ni akukwo Nkiizizi ()
(iii) I cha ka Akukwo Nke Ntukwasi Obanabi ()
(iv) Nkpeche pu ijen akukwo ()

5. Ki bu olui? (i) Nwanyi nor unor () (ii) Onye olugbor/onyeafia()
(iii) Onye oluoyibo/onyealunyeonwea() (iv) Olundiozor, kowa ()

6. Ki buokwukwei (i) Onye Nzukor Christi ()

- (i) Onye Nzuko Muhammed() (iii) Omenani ()
(v) Owenkozor kowa. ()

Nganaba Obanabi

Imu NwaUzor IchenichebanyeliIkpho bi Nganabaochi chi Aniocha North.

7. Ngbakor Omumunwa
(a) Ugbolone itu ime ()
(b) Ugbolone ki kwo ime ()
(c) Umu one ki mu ()
(d) Umu one dindu ()
(e) Ikpho ni ikei one ()
8. Ki bu ogboi ki mu nwaizizi ()
9. Ka ki si kpasa okwu imu nwa no ge ()

Nganaba Oba ator

Ngba nye okwu yu nan di mu ini banyeli imu nwa

Nzigali Ozi: We de anya igafu ajuju we dokwaba kawa we mali ki gbanye do be banyeli imunwa. Biko kacha () na akuku ajuju obuna ga gosi ki si kwenye na okwu imunwa na oha unoi

Biko lote; SM – Nkembunkem

SH - Okalamu na dim

RD - Nkwenye Umuna

NI - Onuh punokwu

s/n	Ajuju	Nkembunkem	Okala mu na dim	Nkwenye Umuna	Onuh punokwu
10	Kaka ine tiedobe onu nokwu banyeli imunwa				
11	Ogilige itu imeh				
12	Umu oneh ki ga mu				
13	Kebi ije unor ugu-ine imeh				
14	Bei I ge si mu				
15	Nkpokoba ikei na ikpoho ka ko ye sidi				
16	Ogilige nmekor yu na dii				
17	Nkposa Nwana ibea				
18	Ogu ikpi aka omu mu nwa				

Nganaba Oba Anor

Ngbanye oba ator; ife ne nyeli aka banyeli imu nwa na gbata ikpoho na Aniocha North nganaba ochi chi anyi.

Ozinzizi:

Ife ibu nobi nokpuluni we bu Ngbakor ife ge nyeli aka ichoputa banyeli imu nwa na alo so eni.

Bikokacha () Nkacha-odima ni me akpeti tosieni. Dalu

s/n	Ajuju	Ngbagoni	Nwantikili	Nbebenua	nchancha
20	Kaka ego na nmekor yu na umu-nmadu si nyeli aka atu elo banyeli imunwa				
I	Kaki gudobe akwukwo				
Ii	Okwai nunor olu				
Iii	Ukpoh odi one na bei				
Iv	Olu dii n alu				
V	Ogboi				
Vi	Ife dini wa jieme saahu				
Vii	Ego waji azu umu				
Viii	Ife ndiozor kowa				
21	Ka ko si enyeli aka ita alo ba nyeli imu nwa bu okwu omenani				
I	Ohunom na ndi ogo m na tu elo banyeli imu nwa				
Ii	Ikpoho a di atu elo nnabata banyeli imu nwa				
Iii	Umuaka na iyele aka na nka				
Iv	Igbabor banyeli ndo kwaba nan du ogonogo ohunor dim				
V	Nbebeta umu a dina nnabata na omenani enyi				
Vi	Imu umu genyeli aka ma na kasha				
Vii	Imu umu genyeli aka igbu ugbo na ijezi				
Vii	Kowa ndiozor.....				
22	Kaka ife gbaseli ahui si enyeli aka itu a lo banyeli imunwa				
I	Ogboi ki nu di				
Ii	Ife na nabu itu ime				
Iii	Ogu negbodo amuna nwa				
Iv	Nhali banyeli nwa okie na nwa okpoho				
V	Ndiozor kowa.....				
23	Kaka okwukwei si a nabui itu alo banyeli imu nwa				
I	Iwu chukwu banyeli uba umu				
Ii	Okwukwem na ba ta ikpoho na mu ko ba umu				
Iii	Okwukwen a nabatana ikpi aka omu mu nwa				
Iv	Okwukwen a naba ta na ite ime				
V	Ndiozor kowa.....				

APPENDIX III

Reliability Test of the Instrument used to collect data using split half reliability co-efficient and Pearson Product Moment Correlation formula

Let the odd numbers represent X and even numbers represent Y. n=30

S/N	X	Y	X ²	Y ²	XY
1	19	20	361	400	380
2	21	18	441	324	378
3	10	19	100	361	190
4	16	19	256	361	304
5	20	19	400	361	380
6	21	17	441	289	357
7	19	18	361	324	342
8	18	20	324	400	360
9	20	20	400	400	400
10	16	19	256	361	304
11	19	19	361	361	361
12	19	17	361	289	323
13	15	15	225	225	225
Total	233	240	4287	4456	4304

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

$$R = \frac{30 \times 4304 - 233 \times 240}{\sqrt{[30 \times 4287 - 233^2] [30 \times 4456 - 240^2]}}$$

$$R = \frac{111904 - 55920}{\sqrt{[111462 - 54289] [115856 - 57600]}}$$

$$R = \frac{55984}{\sqrt{[57173] [58256]}}$$

$$R = \frac{55984}{\sqrt{3330670288}}$$

$$R = \frac{55984}{57711.9597} = 0.970$$

APPENDIX IV

Sample size calculation

$$N = Z^2 P(1-P)/d^2 \text{ . (Creative Research System, 2012)}$$

where N=minimum sample size required

$$Z = 1.96 \text{ (at 95\% confidence interval)}$$

P=proportion or a best guess about the value of the proportion of interest. In this study , there is no information on the proportion of interest on CHILD BEARING DECISIONS OF WOMEN. Therefore the 50% usually used for unknown proportion is used. it is expressed in decimal. that is 0.5

$$d = \text{error margin i.e 0.05}$$

Applying this formular thus;

$$n = 1.96 \times 1.96 \times 0.5(1-0.5)/0.05 \times 0.05$$

$$n = 0.9604/0.0025 = 384.16$$

To calculate the correction sample size

$$1 + \frac{n-1}{\text{pop}}$$
$$1 + \frac{384.16-1}{3753}$$

$$n = 384.16/1.101360778$$

$$= 384.16/1.102360778$$

$$n=348$$

The sample size (n) will be increased by 10% so as to account for the attrition rate.

$$10\% = \text{of } N$$

Which is added thus;

$$\text{Formular; } N = n / (1 - q)$$

N= sample size

N!= number of subject to be recruited to ensure that the final sample size is achieved.

Q=the proportion of attrition and is generally 10%

$$N = 348 / (1 - 10\%)$$

$$= 348 / 0.9$$

$$= 387$$

Sample size (N) = 387.

To get the sample size for each of the community, the researcher calculated the proportionate sample size for each community as follows.

For Ezi

$$334 \times 387 = 35$$

$$3753$$

Onicha-Olona

$$574 \times 387 = 59$$

$$3753$$

Onicha-Uku

$$221 \times 387 = 22$$

$$3753$$

Onicha-Ugbo

$$\underline{675} \times 387 = 70$$

3753

Issele-Uku

$$\underline{1600} \times 426 = 165$$

3753

Issele-Mkpitime

$$\underline{349} \times 387 = 36$$

3753

$$\text{Therefore } 59+35+23+70+165+36 = 387$$

Total sample size = 387

APPENDIX V

Table 1 shows proportionate sample size from each of the six communities and quarters in the communities.

Community Name	Population of childbearing women in each community	Proportionate Sample size for each community	Name of quarters in each community	Population of childbearing women in each quarter	Sample from each quarter	Percentage of the sample
Ezi	334	35	Ogbeobi Ogbeaku Umuolo Ogbeofu	84 78 83 89	9 8 9 9	9%
Issele-Mkpitime	349	36	Ogbe-owerre Azungwu Idumuomu Idumuoizoma Agwachime Umuonyinumi	58 54 76 47 51 63	6 6 8 5 5 6	10%
Issele-uku	1600	165	Ogbe-owerre Ogbe-ofu Ogbe-nti Ishiekpe Ogbe-obi Idumuahaba Ogbe-issee Obidibo Ote-ogbera Ani-ofu Ukpai	145 160 185 136 142 124 178 143 137 154 96	15 17 19 14 15 13 18 15 14 16 9	42%
Onicha-Olona	574	59	Ogbe-obi Agba Ogbekenu Ishiekpe Umuolo Idumuje	90 88 95 96 102 104	9 9 10 10 10 11	15%
Onicha-Uku	221	22	Ogbe-aku Oge-isselle Atuma Ishiekpe Ogbe-ofu	46 42 50 35 48	5 4 5 3 5	6%
Onicha-Ugbo	675	70	Ishiekpe Ogbekenu Ogbe-obi Ogbe-issee	170 193 187 125	18 20 19 13	18%
Total	3753	387	33	3753	387	100%

APPENDIX VI

Population and Sampling procedure of the study

S/N	Communities in Aniocha-North	Communities selected	No of Quarters
1	Obior		
2	Onicha-Olona	X	6
3	Obomkpa		
4	Idumuje-Unor		
5	Issele–Azagba		
6	Ezi	X	4
7	Ukwu-Nzu		
8	Anioma		
9	Issele – Mkpitime	X	6
10	Idumuje-Ugboko		
11	Issele-Uku	X	11
12	Onicha-Ugbo	X	6
13	Idumuogo		
14	Ubulubu		
15	Onicha-Uku	X	6
16	Ugboba		
17	Ugbodu		
Total	17	6	33

APPENDIX VII

CERTIFICATE OF INFORMED CONSENT

Title of project: Assessment of child bearing decisions of women in Aniocha-North Local Government Area of Delta State.

I understand the purpose of the study as well as the potential benefits of participating in the study. I had the opportunity to ask questions and my questions have been answered. I hereby give my informed consent to participate in this study. I understand that by signing this informed consent, I authorize the researcher to obtain information from me regarding child bearing decisions of women in line with procedures for data collection.

I realize that the information obtained from this study, including results of the findings will be held in both computerized and paper filling system without identifying me.

I understand that I am free to withdraw from the study at any time without giving a reason for withdrawal and that it will not affect me.

Respondent's Signature, Date.....

Respondent's Name.....

I the undersigned have fully explained the relevant details of this study to the respondent signed above to consent.

Researcher's signature, Date.....

Researcher's Name.....