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# Extent of Women's Participation in Child-Bearing Decisions in Aniocha –North Local Government Area, Delta StateNigeria

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***Abstract:*** *Participation in child-birth decisions of the family is one of the inalienable fundamental human rights of the individual especially women. The objective of the study is to determine the extent of women's participation in child-bearing decisions of their family in Aniocha –North Local Government Area, Delta State. The study adopted the survey design. From a target population of 3753 women of childbearing age in Aniocha – North LGA, a sample size of 387 was obtained using Power Analysis. Proportionate stratified sampling technique was employed to draw a sample size of 387 women from the six communities which were randomly selected. Data entry and analysis was done using SPSS version (20).*
*Results show 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 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. Therefore, there is need for women to be involved in decision making regarding every aspect of their childbearingas they are the carriers and nurturers of the children of today and the future, to promote spouse intimacy and also taking their health needs into consideration.*

***Keywords:*** *Extent, women, participation, childbearing, decisions*

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## I. Introduction

Participation in child-birth decisions is one of the inalienable fundamental human rights of the individual especially women ,[1]. 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, for example, is a very powerful indicator of involvement in fertility decision making among women globally,[2].

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,[3]. 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 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[4]. Women are seen as having very little or no role in their families' childbearing 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.

Childbearing decision of women is a global concern because of the social and environmental impacts of population growth and maternal mortality[5]. Furthermore, Marger, [6].admitted the gender differences in childbearing decision making and attributed to power relation and traditional gender roles. This view was supported by Vaessen, [7] 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 as children are seen as the reason for marriage[8]. In most developing societies, most women have no option than to succumb to the dictates of their spouses, friends and kinsmen with minimal or no participation over their childbearing decisions [9].

The objective of the study s to determine the extent of women's participation in child-bearing decisions of their family in Aniocha–North Local Government Area, Delta State . Although, there had been similar studies on childbearing decisions of women in both developed and developing countries. In Nigeria, there is paucity of literatures on women's participation in childbearing decisions of their family. The few literatures available were limited to women's empowerment in reproductive decisions , fertility trends and assessment of child bearing decisions. In Nigeria however, much has not been done on extent of women's participation in the childbearing decisions, particularly in South Southern Nigeria where Aniocha North LGA of Delta State is located hence this present study is community based and will fill the gap in knowledge which previous studies have created. The researchers have observe that, women of this communities do have numerous children and most times feel powerless to make decisions especially in emergency situations that could be detrimental to their health while attending antenatal or during delivery. Therefore, the question that comes to mind is: To what extent do women in this local government participate in childbearing decisions of their family?

## II. Methodology

### 3.1 Research Design

The design used for this study was the descriptive research survey design which involved orderly collection of data, analysis, interpretation and reporting of pertinent information about the current situation..

### 3.2 Description of Study Area

The study was conducted in Aniocha-North local Government Area of Delta State. 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 researchers observed women of the area have high parity rate.

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### 3.3 Target Population

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.

### 3.4 Sampling Technique and Sample Size

The multi-stage sampling procedure was used for the study. It involved Simple random sampling with replacement in the first stage, stratified sampling method in the second stage and 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 in the last stage. A total of a total of 387 women were used for this study.

#### 3.4.1 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

### 3.5 Instrument for Data Collection

Data was collected using interviewer administered questionnaire constructed by the researchers according to the objectives of the study on extent of women participation in child-bearing decision.

### 3.6 Data Analysis

Data collected from participants were analyzed using IBM/SPSS version 20. Results was presented in tabular form. The responses for each items in the research was rated on four point scale.

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

## III. Findings Of The Study

**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) |
| OnichaOlona | 59(15.0) |
| OnichaUku | 22(6.0) |
| OnichaUgbo | 70(18.0) |
| IsseleUku | 165(42.0) |
| IsselleMkpitime | 36(10.0) |
| **Educational level** | |
| No formal | 137(35.4) |
| Primary | 98(25.3) |
| Secondary | 88(22.7) |
| Tertiary | 64(16.5) |
| | |
| **Occupation** | 90(23.3) |
| Full time housewife | 236(61.0) |
| Farmer/ petty trader | 58(15.0) |
| Public servant | 3(0.8) |
| Others | |
| | 346(89.4) |
| **Religion** | 5(1.3) |
| Christianity | 33(8.5) |
| Islamic | 3(0.8) |
| Traditional | |
| Others | |

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.Extent of women's participation in child-bearing decisions in Aniocha –North Local Government Area, Delta State**

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

The researchers 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.

## IV. Discussion Of Findings

**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 researchers, 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[6]admitted gender differences in childbearing decision making and attributed this to power relation and traditional gender roles. This view was surported by Vaessen,[7] 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,[8]. 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,[2].

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 ,[2].

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 ,[9]. On the basis of the foregoing submissions, the researchers sought to explore the respondent's role in decision-making on family planning. The data shown in table 1 in above showed Majority of the women are not involved in decision of when and how to use family planning. Buor,[10] 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.

## V. Conclusion

The study 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 and maternal mortality.

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