Assessment of Childbearing Decisions of Women in Aniocha-North Local Government Area, Delta State, Nigeria

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Abstract: *This study was designed to assess the childbearing decisions of women in Aniocha-North L.G.A of Delta State. The specific objectives of the study were to: identify the pattern of childbearing among women, extent of women's participation in child-bearing decisions and factors that influence women's child-bearing decisions in Aniocha –North Local Government Area, Delta State. The descriptive survey research design was adopted for the study. Using power analysis, sample size of 387 participants were enlisted in the study. Interviewer administered Questionnaire was the only tool used for data collection. The data were statistically analyzed based on the research questions with the aid of IBM/ SPSS version 20.Major findings revealed that: A good number of the respondents had low literacy level in the communities hence about 137(35.4%) had no formal education while 98(25.3%) had secondary 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 were 3.15 and 3.14 respectively. Majority of the women were not involved in decision of when and how to use family planning hence the mean value was 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 there is need to health educate the 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 Millennium Development Goals 4 $ 5 target.*

Keywords: Assessment, Pattern of childbearing, Childbearing decisions, Factors, Delta, Nigeria

1. Introduction

Fertility and its decisions in the family are 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 [1].

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[2], [3]. United Nation, [4] posited that education is a very powerful indicator of involvement in childbearing decision making among women globally. It has been widely recognized as a key concept in understanding fertility behavior [2]. This is in line with Weeks [1], 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 been 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 [5]. 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 [6].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[7]. 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, [8] 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 [9].

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.

Human reproductive behaviour 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, [10].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 much childbirth 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 is what the researchers investigated.

Aims/ Objectives

The aim 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 were to:
1) Identify the pattern of childbearing among women in Aniocha –North Local Government Area, Delta State.
2) Determine the extent of women's participation in child-bearing decisions in Aniocha –North Local Government Area, Delta State
3) Determine the factors that influence the child-bearing decisions made by women in Aniocha –North Local Government Area, Delta State, Nigeria.

2. Research Methodology

The study adopted descriptive survey research design. The study was conducted in Aniocha-North Local Government Area (LGA) Delta State, Nigeria. Delta State is located between longitude $5A^0 00$ and $6A^0 45e$ and latitude $5A^0 00$ and $6A^0 30^0 N$. It has a 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[11]. The population of the study comprised women of child bearing age (15 to 49)years in Aniocha –North Local Government Area who are residents of the communities that constitute the LGA. The total population of females in Aniocha –North Local Government Area is 53, 131 [12]. The population of females from the six selected communities is 17, 036 and 22% amounted to 3753 according to WHO, [13] that is women of childbearing age. The sample for the study was determined using power analysis. The formular for calculating sample size by Creative Research System, [14] as follows;

$N = Z^2 P(1-P)/d^2$ [14]. Applying this formular ; a sample of 387 women were selected for the study. The sampling techniques involved a multi- stage sampling procedure. Aniocha-North Local Government Area was purposefully selected for the study based on the researcher's 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 were elected because the populations for the study geographically are widely dispersed.

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 researchers also used proportionate sampling method to select a representative sample of childbearing women from each quarter using the following formula;

NS=Ns x n/N
Where NS=sample size from the community
Ns=population size of the community
n=sample size for the study
N=total population

Finally, convenience sampling technique was used to recruit eligible women in selected communities.

Data were collected using researcher–developed questionnaire which were designed in both structured and unstructured forms. The questionnaire has 2 sections. Section A was on participant's demographic characteristics, while section B elicited information on 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. Three experts from Maternal and Child Health, Family planning and an expert in the field of Measurement and Evaluation validated the instrument. The reliability was computed using spilt half reliability technique with the application of Pearson Product Moment Correlation formular which yielded a coefficient of 0.87 showing that

the instrument was reliable for the study. 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 the instrument was presented in their respective categories as tables including frequencies, percentage, means and standard deviation for discussion, explanation, general description and summary of the data.

3. Results

Results are presented in accordance with the research objectives. The questionnaires were administered to 387 women who gave their consents. All the questionnaires were completely and correctly filled with a response rate of 100%.

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	
18-22	84	45.7
23-27	58	28.0
28 and above	21	19.3
Mean(SD)	16.18(4.19)	7.0
Child bearing Interval		
Not sure	94	24.3
One year	91	23.5
Two years	116	30.0
Three years	60	15.5
Four years	18	4.7
Five years	2	0.5
Six years	6	1.6

The result in the table showed 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 woman 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	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)

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 on 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)	53(13.7)	1.69(1.09)
Husbands occupation	241(62.3)	67(17.3)	25(6.5)	54(14.0)	1.72(1.08)
Age	257(66.4)	56(14.5)	23(5.9)	51(13.2)	1.66(1.07)
Availability of social amenities	224(57.9)	69(17.8)	32(8.3)	62(16.0)	1.82(1.13)
Costs of raising children	161(41.6)	35(9.0)	33(8.5)	158(40.8)	2.49(1.38)

The result in this table showed 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 showed that a good number of the cultural factors influence the child bearing decisions of the women. This is because the mean values were 3.53 and 3.52 respectively. 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 showed 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 showed 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.

4. Discussion

Regarding the pattern of childbearing, the mean value on the number of children that are alive per woman was 4.68. 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, [15].

This finding also confirms [12] 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. Secondly on the pattern of childbearing, age at first birth showed that an average woman starts sexual debut at 16 years old. This could also determine the number of children a woman in Aniocha-North would like to have or had already hence [1] and Darko.P[16] 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 because of lengthened period of fecundity.

On the extent of women's participation in child-bearing decisions, 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 in their childbearing but findings from this objective showed that majority of the women take some part in making decision about their child bearing. This showed that the women would at least take these decisions with their husbands. Women invariably lack total control over decision making in these aspects hence [6]admitted gender differences in childbearing decision making and attributed this to power relation and traditional gender roles. This view was surported by Vaessen, [8]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 [9].

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 [18].

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 [18].

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 [5]. 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 3 in chapter 4 above showed Majority of the women

are not involved in decision of when and how to use family planning. Brown, [19]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.

Regarding Socio-economic factors that influenced the decisions made by women on child bearing matters, the result in this study showed that the socio economic factors 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 ([20];[2], [9]&[1]) 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. Weeks, [1]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 [21]. Linked to these fertility decisions is the issue of residence, rural or urban which [4]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 [1]. However, the cost of raising children is a factor that affects child bearing decision. This conforms [20] view 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[10]. [20]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.

On the Cultural factors that influenced the decisions made by women on child bearing matters, the result showed 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 ([22];[23], [24]) 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 [1]. 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 [23]. Thus to [24], there is a strong traditional norm of high fertility as children are the *raison d'etre* of marriage which also results in higher fertility in the rural communities than the urban communities of the nation.

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, [9]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. [9]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.

Findings from our study on the biological factors that influenced the decisions made by women on child bearing issues showed 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 [25].

Concerning the religious factors, finding showed 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, [26]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 [26].

5. Conclusion

The empowerment and autonomy of women to enable them 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 [27]and the World Conference on Women in Beijing, China in 1995 [27], 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.

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 there is need for midwives and health care providers to health educate the 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.

6. Acknowledgement

7. Authors' Contributions

All the authors participated in the study.

8. Competing interest

The authors hereby declare that there are no competing interests.

9. Source of funding

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