

**EMPOWERMENT AND FERTILITY INTENTION AMONG MARRIED WOMEN OF
REPRODUCTIVE AGE IN IFE EAST LOCAL GOVERNMENT AREA OF OSUN
STATE**

By

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ABSTRACT

Background: This study investigates empowerment and fertility intention among married women of reproductive age. This study documents different patterns of fertility intention among married women of reproductive age in Ife East Local Government area of Osun State.

Method: The study was community based and Cross sectional in design, and employed the use of quantitative and qualitative methods of data collection. A total of 742 married women of reproductive age (15-49 years) were interviewed face to face via a questionnaire, while 3 focus group discussions were also conducted alongside Key informant interviews with 2 health workers at 2 different health facilities. The data was analysed using descriptive statistics, chi-square and multiple logistic regression at a level of significance of 95%.

Result: Findings revealed the mean age was 33.8 ± 5.0 years, and the mean number of children born to the women interviewed is 3.3 ± 1.4 , while the mean number of children surviving was 3.0 ± 1.2 . Factors such as age, children ever born, husband's education, family type and women empowerment ($p < 0.05$) are negatively associated with the intention to give birth. Also, 98.7% of the women are aware of contraceptives, while the prevalence of contraceptive use was 24.0%, and 63.5% of the women have the intention to give birth. Some of the factors positively associated with current contraceptive use are level of education, religion, occupation, husband's level of education, family type, children ever born and women empowerment ($p < 0.05$). Women who have ever given birth to 5 children or more were less likely ($OR=0.05$; $C.I=0.02-0.11$, $p < 0.001$) to have the intention to give birth than women who have never given birth or have ever given birth to one or two children. Also, highly empowered women were more likely ($OR=2.96$; $C.I=1.51-5.80$, $p < 0.05$) to currently use contraceptives than poorly empowered women.

Conclusion: It is evident from the study that a majority have the intention to give birth among married women of childbearing age in Ife East Local Government area. It is also concluded that while more women are aware of contraceptive methods and recognize it as a possible step towards reducing the challenges of high fertility a lot of them are not accessing in it due to the fear of side effects and other negative health outcomes. Women in the study area needs to be enlightened on how to choose the best contraceptive method that suites them in order to reduce the fear of negative health outcomes, and possibly the side effects.

Key Words: Fertility Intention, Children ever born, Women Empowerment.

Word Count: 414 words

DEDICATION

This work is dedicated to Almighty God who saw me through this programme.

I also dedicate this project to my wonderful Mother Mrs. K.B. Adeyemo, who the Lord has made to supply my needs, making sure that I do not lack any basic thing from birth till this very moment. You have been more than a Mother, you are also a Father.

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CERTIFICATION

I certify that this project was carried out under my supervision by Oguns Oluwaseun Oluwasunmisola in the Department of epidemiology and medical statistics, Faculty of Public Health, College of Medicine, University of Ibadan, Ibadan, Oyo state, Nigeria.


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CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND

Empowering women means women acquire at least basic knowledge and skills, they can have access to financial resources, make vital decisions independently, are aware and protected of their rights in the society, and men must also come to terms with the fact that women are not mere baby producers, and as such women must be respected and seen as partners. When considering empowerment there are many factors that come to mind, this could be responsible for the various definitions on women empowerment. Women's empowerment is the process by which unequal power relations are transformed and women gain greater equality with men (Haque, 2005).

Kabeer, in 2001 defined empowerment as the expansion in people's ability to make strategic life choices in a context where this ability was previously denied to them. Ahmed and others in 2010 defined women's empowerment as a woman's ability to make decisions related to personal health care choices, freedom to visit family and friends, ability to make household purchases and to decide on key activities. Through empowerment, women can achieve resourceful life with freedom and autonomy to marry after late adolescence (18+), freely decide to have small family size (1 or 2 children), live a healthy life following an appropriate life style and free from all discriminations (Mahadevan, et al., 2005).

The United Nations in its Beijing declaration stated that Women's empowerment and their full participation on the basis of equality in all spheres of society, including participation in the decision making process and access to power, are fundamental for achievement of equality, development and peace. However, the promotion of women's economic independence was recommended including employment, the eradication of persistent and increasing burden of poverty on women by addressing the structural causes of poverty through changes uneconomic, ensuring equal access for all women, including those in the rural areas, as vital development agents, to protective resources, opportunities and public services.

Issues relating to empowerment of women are always tied with fundamental human right issues, this is because ordinarily men enjoy these forms of empowerment but women are almost always left at the mercy of men, thereby creating some sort of gender imbalance. The effect of which limits the potentials of a country, no wonder the 1994 International Conference on Population and Development-Program of Action held in Cairo, placed women's empowerment and reproductive rights at the centre of development.

Similarly, the Nairobi forward looking strategies for the advancement of women in 1985 reaffirmed that the realization of equal rights for women at all levels and in all areas of life will contribute to the achievements of a just and lasting peace, to social progress and to respect for human rights and fundamental freedoms, and that the integration of women in the mainstream of the development process requires not only commitment at the national, regional and international levels, but also continuing financial and technical support, and also requires the establishment of a new international economic order. The third goal of the United Nation Millennium development directly focuses on promoting gender equality and women empowerment and targets that by the year 2005, all forms of gender disparity in primary and secondary education

are eliminated, and eliminated in all levels not later than 2015. That being said, the realization of this goal could lead to the realization of many other Millennium development goals, for instance, gender equality and the empowerment of women will help eradicate extreme poverty and hunger, achieve universal primary education, reduce child mortality, improve maternal health, combat HIV/AIDS, malaria and other diseases, and so on.

From the foregoing, there is no gainsaying in stressing the importance of women empowerment to the health, finance, and development of women, family, community and the nation at large. However, there is no second guessing the grave consequences that could follow lack of women empowerment are better imagined. When a woman is not empowered she feels inferior about herself and she is not able to stand shoulder high with men, or even with her empowered counterparts. Such a woman does not bear these consequences alone, as she would not be able to make adequate decisions about the welfare of her children and husband. Such women are also economic liabilities to their families, especially at this trying time when things are perceived to be hard financially in most African countries. A lack of women empowerment will also see few or no women at the helms of affairs of a country, especially at the parliamentary level and this will mean that there are no laws that are formulated towards issues related to women and their wellbeing, this could also affect the wellbeing of the nation as a whole because, apart from the fact that women are seen as the basic care giver in a home, the nation will not be able to harness and utilize the potentials of these set of people that have been neglected.

Fertility is the actual birth performance of a woman. Fertility has remained the only natural means by which population increases. Fertility of women can be affected by two factors, namely; proximate and underlying factors. The proximate factors include the proportion of women in a sexual union, use of contraception, induced abortion to mention a few, while the underlying

factors that affects fertility are those socio-economic, cultural, health and programmatic factors that result in changes in reproductive behaviors in populations. All underlying factors operate through the proximate determinants to influence the level of fertility in a population. According to the demographic transition theory which generally states that populations will move from a period of high fertility and high mortality to a period of low fertility and mortality. All countries are expected to experience this trend but at different period and at a different pace. Most African countries are still at a stage where fertility is still high with a relatively low level of mortality, thereby resulting in a high population growth rate.

The International Conference on Population and Development noted that it has taken lesser years for the world population to add successive one billion after the first one billion was reached, and even though efforts are being made to reduce the rate of population growth, the efforts are not uniform across regions and countries. As a result of this, population growth rate is still high in some regions, especially in sub-Saharan Africa, most of whose countries are backwards economically. Bearing this in mind, it was identified at the conference that the ultimate goal is the improvement of the quality of life of present and future generations, and was recommended that the demographic transition be completed as soon as possible in countries where there is an imbalance between demographic rates and social, economic and environmental goal, while respecting human rights, and countries that have concluded the demographic transition should take steps to optimize their demographic trends. These steps include economic development and poverty alleviation, especially in rural areas, improvement of women's status, ensuring of universal access to quality primary education and primary health care and so on. It was also recommended that countries should recognize the interrelationship between fertility and

mortality levels and aim to reduce high levels of infant, child and maternal mortality in order to reduce the need for high fertility and the occurrence of high risk births.

Similarly, the fifth Millennium Development Goal also addressed issues relating to the improvement of maternal health. As previously mentioned, fertility is easily measured through birth performance. The goal is set to achieve that the occurrence of maternal deaths and complications arising from pregnancies and deliveries are reduced. A clear way to achieve this is to make people adequately plan their family size, with their desired space, and also to make them aware they could totally be in control of their desired family size and space, as well as the benefits involved. The realization of this would also mean that extreme poverty and hunger will be reduced if not eradicated, more children will be able to complete a full course of primary schooling, gender disparity in all levels of education will be reduced if not eliminated, and more than all, it will help to reduce child mortality.

Fertility intention refers to a desire to have a child or another child, or choice of number of children women or couples initially planned to have during their reproductive years. Fertility intention is always influenced by behavioral, socio-economic and cultural factors. Bongaarts (2001) pinpoints certain factors that may cause couples to revise their fertility plans upward, such as a previous unplanned birth, the death of a child, or the desire to have a child of a particular sex. However, reasons such as delayed entry into childbearing, fecundity problems or activities that compete with fertility plans may cause couples to revise their fertility plans downward.

High fertility always results in an increase in population, especially with low mortality. Some of the factors responsible for high fertility include early commencement of marriage and

childbearing, increased proportion of sexually active women exposed to pregnancy risks and but with low uptake of contraceptives, and reduced spacing between births. High fertility increases the risk of mortality in infancy and early childhood for higher order births, closely spaced births, and when the mother is too old. The risk of maternal mortality is also greater at higher parities, at younger and older ages. High fertility could present a challenge to reducing poverty levels in a country, this is because most programmes focused towards alleviation of poverty in a country will only yield a less significant result, if it yields at all, due to rapid population growth. It could also lead to overcrowding, which could result in conflict, especially when jostling for space or the already limited and scarce resources. However, it is not all doom for high fertility. High rate of population growth resulting from high fertility can lead to a large number of human capital, if which adequately harnessed could lead to an economic growth for the country. Also, it could be useful in the claim for more resource allocations, especially in countries where resources are shared based on the population of an area. It could also give an advantage of more representatives at the parliamentary level to such areas that have more populations.

The relationship between fertility and women empowerment is a cause and effect type. While it has been recognized by international bodies and at various conferences that to achieve economic empowerment conscious effort must be made to reduce fertility, various studies have also shown that fertility is lower among empowered women compared to their un-empowered counterparts. The explanation of this could be that it would be easier to focus on the empowerment of a few people compared to empowering a large number of people, owing to the fact that resources are scarce and limited. Meanwhile, on the other hand empowered women are aware of the various risks that a high fertility poses to their health, the health of their children, and their financial resources. As a result of their empowerment, they are also at liberty to discuss their planned

family size with their spouses, all of which are very unlikely with un-empowered women. The un-empowered woman is likely to see fertility as an expression of God's commandment or as a natural process which must occur as often as possible.

1.2 STATEMENT OF THE PROBLEM

Nigeria is the most populous black nation in the world. Like many countries in sub-Saharan Africa, Nigeria still has a high fertility rate despite efforts by the government to reduce fertility rate in the country. While the uptake of contraception has been identified as a possible solution to this problem, there are still many people who would want to practice contraception today, but lacked the access. While some have the access, but have bluntly refused to practice contraception due to some misconceptions.

According to the Federal office of statistics (1992), the country's total fertility rate was approximately 6, and eleven years later the Nigeria demographic health survey report revealed that the rate has only dropped marginally to 5.7, and remained 5.7 as at 2008, only to marginally drop again to 5.5 in the latest edition of the report (2013). Similarly, the contraceptive prevalence rate of women as revealed by the Federal office of statistics for 1991 and 1992 are 17.8 and 20.2 percent respectively, while the same rate according to the Nigeria demographic health survey for years 2008 and 2013 have remained the same at 15%. This means that with all the efforts and resources being spent by the government and international organizations, the desired results are not forthcoming.

Ife East Local Government area of Osun State is largely underdeveloped when compared to Ife Central Local Government, this is because a part of the local government is located within Ife town, while another part is located entirely outside Ife town. Women empowerment is an issue in

Ife East Local Government area of Osun State, this is because most women located outside Ife town of the Local Government are illiterates, while those within the town are a mixture of literates and illiterates. As a result, they are not well informed of their rights, neither can it be said that they are self-reliant financially. Also because of the richness in tradition and culture in the area, husbands are seen as a small god and wives must submit totally to the wishes of their husbands, even if it is going to be at their detriment. Furthermore, there are inadequate number of schools and health facilities, with the available ones not adequately equipped and not conducive for the services which they are supposed to render.

Fertility in Ife East is also likely to be influenced by the belief of women and the condition of health care in the area. The health centers in this area are barely staffed, with most having just a nurse manning the post, and in most cases the nurse does not live in the neighborhood. Thereby, anyone who requires urgent medical attention during the time the nurse is away can only hope the nurse returns sooner, especially in the case of pregnant women falling into labor. The situations in health facilities in this area coupled with the general belief of the Yorubas that no one assists a goat during delivery could also encourage more people to deliver at home, exposing both the mother and child to the risk of mortality, and it is well known that high infant and child mortality rate itself could lead to high fertility rate. Women in this area are not also likely to practice contraception and it remains a doubt if they are aware of the various forms and methods of contraception. A lot of women generally in the Local Government are involved in trading, with most of them trading in their houses or a nearby place, thereby making it easy for frequent meeting between husbands and wives, especially amongst husbands who are not gainfully employed.

1.3 RATIONALE

Most studies in Ile-Ife that are related to the subject matter have been conducted a long time ago.

The fact that the area consists of a semi urban setting and considering that more women are not likely to be empowered in such an area compared to urban settings makes the study worthwhile.

This study will also recruit a large sample of respondents, about 750 of them, as opposed to a relatively small sample size used in the Nigerian Demographic and Health Survey (NDHS) data.

This will allow for more representativeness and generalization. Also, unlike the NDHS report, this study will take into cognizance the Yoruba culture. Again, this study will address high fertility, a problem that has been facing the country for more than twenty two years now. The study will also look at ways in which more people can be involved in contraception, the realization of which would help reduce fertility and in turn lead to more people being empowered.

1.4 RESEARCH QUESTIONS

In regard to the problem that needs to be researched on, research questions that need to be answered at the end of this research among women of reproductive age in Ife East local government area are:

1. What are the patterns of fertility intention among women of reproductive age?
2. Is there an association between women empowerment and fertility intention?
3. Is there an association between women empowerment and contraceptive use?
4. What are the challenges associated with high fertility?

1.5 OBJECTIVES OF THE STUDY

GENERAL OBJECTIVE: To document information about empowerment and fertility intention among women of reproductive age in Ife east local government area of Osun State.

SPECIFIC OBJECTIVES: The specific objectives of the study are to;

1. Examine the patterns of fertility intention among women of reproductive age in Ife east local government area.
2. Determine an association between women empowerment and fertility intention among women of reproductive age in Ife east local government area.
3. Determine if there is an association between women empowerment and contraceptive use.
4. Explore opinion of women on challenges associated with high fertility.

1.6 RESEARCH HYPOTHESIS

1. There is no association between women empowerment and fertility intention among women of reproductive age in Ife east local government area.
2. There is no association between women empowerment and contraceptive use.

CHAPTER TWO

2.1 LITERATURE REVIEW

In order to have a clearer insight into the subject of study, some of the existing related literatures on women empowerment and their health seeking behavior are reviewed.

The notion of empowerment has been used in a bewildering variety of ways, from the mundane to the profound, from the particular to the very general. Empowerment is seen to occur at a number of different levels, to cover a range of different dimensions and to materialize through a variety of different processes. The notion of empowerment is thus inescapably bound up with disempowerment, and refers to the processes by which those who have been denied the ability to make choices acquire such ability. In other words, empowerment entails a process of change. People who exercise a great deal of choice in their lives may be very powerful, but they are not empowered in this sense, because they were never disempowered in the first place (Kabeer, 1999).

2.2 Empowerment of Women

2.2.1 Globally

Through empowerment, one is able to better understand the social determinants of health and better act upon this understanding to alter or improve these underlying factors consequently, improving health. A study conducted by WHO evaluating SEWA, Self Employed Women's Association, an Indian organization for the "social and economic wellbeing of women," summarizes this idea: "It is believed that in the process of empowering itself, a group or community would tackle the underlying social, structural and economic conditions that impact

on its health. As a result, it would gain more control over the social determinants of health.”(Aggarwal) (Enlazadas, 2009).

In a cross sectional study conducted by Dalal (2011), on Economic empowerment and protection of women from intimate partner violence in India, among those that were eligible 35% were working. It was concluded that Economic empowerment is not the sole protective factor. Economic empowerment, together with higher education and modified cultural norms against women, may protect women from intimate partner violence.

Also, in another study conducted in Bangladesh, by Rahman et al (2008) on women's empowerment and reproductive health experience, it reveals that women are found less concerned and deprived to take decisions about their own health as well as that of their children.

The study shows that 55% of women received antenatal care during their last pregnancy but only about 4.5% of these women have participated in decision making about their antenatal care.

Similarly, at post natal period, about 51.65 and 58.78% of women took treatment for themselves and their children respectively, out of which only 5.14% of the women participated in the decision making about their postnatal care. It was concluded from the study that current age, education, occupation, husband's education, per capita yearly income, assistance during delivery and decision for household affairs are mostly associated with antenatal care seeking behavior of married women.

Again, in a qualitative study on if Empowered Mothers Foster Gender Equity and Better Reproductive Health in the Next Generation, sponsored by Interagency Gender Working Group,

The qualitative methods included semi-structured in-depth interviews and small group discussions — 186 individual open ended interviews with married women and 13 with men, 14

female and two male group discussions, and one mixed-sex group discussion. The findings reveal widespread awareness of the statutory minimum age at marriage for females (18 years) and the beginnings of change in attitudes on early marriage. Many respondents stated higher “ideal” ages at marriage for girls than actual marriage ages in the community. Many interviewees also articulated disadvantages of early marriage, especially negative health consequences, and acknowledged that there are certain instances where it is desirable to marry later. There was also some evidence in the qualitative data that, despite strong social pressures for early childbearing, empowered mothers and mothers-in-law often successfully encourage their sons, daughters, and daughters-in-law to delay the birth of their first child and to space subsequent births. They cited economic welfare of the family and maternal/child health concerns as reasons for postponement. The study also revealed that empowered women value physical mobility and support their daughters’ and daughters-in-law’s involvement in the public sphere.

Similarly, in a study conducted in Pakistan by Samina et al (2013), on Female Educational Empowerment and Fertility Behaviour, a total of 733 married women were recruited into the study and 392 women were literate. Of the literate women, 81% were matriculate and above. Among the literate women 74.7% were user of contraceptive methods compared with 51.3% illiterate women. Number of children of respondents with level of education showed that significant relationship was found. It was observed that 51.2% of low, 71.1% of medium and 75.6% of high educational level women were using contraceptives. It was concluded that level of education has a direct relationship with use of contraceptive and an inverse relationship with number of children.

Again, Sarah and Paul (2008) in a study titled Empowering women to obtain high quality care: evidence from an evaluation of Mexico’s conditional cash transfer programme, which was

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designed to evaluate the impact of Mexico's conditional cash transfer programme on the quality of health care received by poor women. The data describe retrospective reports of care received from 892 women in poor rural communities in seven Mexican states. The women were participating in an effectiveness study and randomly assigned to incorporation into the programme in 1998 or 1999. It was established that Oportunidades beneficiaries received 12.2% more prenatal procedures compared with non-beneficiaries. Therefore, it was concluded that The Oportunidades conditional cash transfer programme is associated with better quality of prenatal care for low-income, rural women in Mexico.

A study conducted in the MENA (Middle East and North African) Countries by Farzaneh and Valentine in 2003 revealed that access to education has improved dramatically over the past few decades, and that there have been a number of encouraging trends in girls' and women's education. The study further reveals that, primary school enrollment is high or universal in most MENA countries, and gender gaps in secondary school enrollment have already disappeared in several countries. Women in MENA countries are also more likely to enroll in universities than they were in the past.

2.2.2 Africa

In addition, a study on Women's Empowerment as a Determinant of Contraceptive Use in Ethiopia conducted by Mekonnen et al (2013), data from the 2011 Ethiopia Demographic and Health Survey (EDHS) was obtained. Women numbering 10,204 who were currently married or living with a partner were included in the analysis. The outcome of interest in this analysis was use of any (modern or traditional) contraceptive method. Analysis showed the indicators of women's empowerment, dimensions representing women's attitude towards domestic violence,

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In addition, a study on Women's Empowerment as a Determinant of Contraceptive Use in Ethiopia conducted by Mekonnen et al (2013), data from the 2011 Ethiopia Demographic and Health Survey (EDHS) was obtained. Women numbering 10,204 who were currently married or living with a partner were included in the analysis. The outcome of interest in this analysis was use of any (modern or traditional) contraceptive method. Analysis showed the indicators of women's empowerment, dimensions representing women's attitude towards domestic violence,

Women's involvement in household decision making, and exposure to sources of knowledge were positively associated with contraceptive use. Conversely, the factor representing ownership of assets was negatively associated with contraceptive use. When fitted with indicators of women's empowerment most of the socio-economic and other gender-related variables were significantly associated with contraceptive use, except for the education level of the respondent.

Also, in a study on Healthcare utilisation and empowerment among women in Liberia by (Heather et al 2013), 65.6% of women had been to a healthcare facility for herself or her children in the past 12 months. It further revealed that women with no education, compared with women with some education, were less likely to have been to a healthcare facility as were women who had experienced sexual abuse, and women who were married. Women in higher wealth quintiles, compared with women in the next lower wealth quintile, and women with more decision-making power had greater odds of having been to a healthcare facility. It was concluded that strong associations exist between healthcare utilisation and empowerment among women in Liberia, and gender imbalances are prevalent.

Again, in a study on Women's Empowerment and Choice of Contraceptive Methods in Selected African Countries namely; Namibia, Zambia, Ghana and Uganda, conducted by Mai and Nami (2012). Women aged 15-49 were analyzed for six dimensions of empowerment and the current use of female-only methods or couple methods. It was revealed that Positive associations were found between the overall empowerment score and method use in all countries. In multivariate analysis, household economic decision making was associated with the use of either female-only or couple methods, as was agreement on fertility preferences and the ability to negotiate sexual activity. In Namibia, women's negative attitudes toward domestic violence were correlated with the use of couple methods.

Similarly, a study on Women's Autonomy and Reproductive Healthcare-Seeking Behavior in Ethiopia by Yohannes (2013), data from the 2005 Ethiopian Demographic and Health survey (EDHS) was analysed. The result showed that women's autonomy is an important influence on their reproductive healthcare-seeking behavior. It was further revealed that women's participation in domestic decision making is strongly associated with ever-use of family planning, but not with use of antenatal care, after controlling for socio-demographic factors. It was also established that the lack of association between women's participation in decision making and antenatal care is mediated by factors such as women's education and place of residence. Women's attitudes toward refusing sex with husband, an indicator of gender-role attitudes, and the ease of getting permission to seek medical help are significantly associated with both ever-use of contraception and use of antenatal care services, after controlling for the effects of other socio-demographic variables.

2.2.3 Nigeria

Aremu et al (2011) conducted a study on Neighborhood socioeconomic disadvantage, individual wealth status and patterns of delivery care utilization in Nigeria: a multilevel discrete choice analysis. The study was conducted using the 2008 Nigerian Demographic and Health Surveys data of women aged between 15 and 49 years. The analysis was restricted to 15,162 ever-married women from 888 communities across the 36 states of the federation including the Federal Capital Territory of Abuja. The study shows that the choice of place to deliver varies across the socioeconomic strata, it also reveals that the household wealth status, women's occupation, women's and partner's high level of education attainment, and possession of health insurance were associated with use of private and government health facilities for child birth relative to home delivery. The results also show that higher birth order and young maternal age were

associated with use of home delivery. Living in a highly socioeconomic disadvantaged neighborhood is associated with home birth compared with the patronage of government health facilities. More specifically, the result revealed that choice of facility-based delivery is clustered around the neighborhoods.

Similarly, in a study conducted by Meghan et al(2014) on The Role of Gender Empowerment on Reproductive Health Outcomes in Urban Nigeria, in the cities of Ibadan, Ilorin, Benin, Zaria, Kaduna, and Abuja, dimensions of empowerment: economic freedom, attitudes towards domestic violence, partner prohibitions and decision-making were examined. The study shows that more empowered women are more likely to use modern contraception, deliver in a health facility and have a skilled attendant at birth. It was also revealed that trends vary by empowerment dimension and by city or region in Nigeria.

2.3 FERTILITY INTENTION

Many factors affect the fertility intention of women, they include previous unplanned birth, the death of a child, the desire to have a child of a particular sex, delayed entry into childbearing, fecundity problems or other activities that compete with fertility plans. Fertility intention is integral to matters relating to issues of family planning and fertility. Whether implicit or explicit, behind the emphasis on fertility intentions is the assumption that, at least in developed countries with readily available contraception, having a child is the result of a reasoned decision. That this issue is more complicated than may appear at first glance is indicated by the fact that, even in developed countries, a large number of pregnancies are unintended and result in abortions or unwanted deliveries (Ventura et al 2012; Morgan and Bachrach 2011, Ick and Jane 2013).

2.3.1 Globally

A study on Attitudes, Norms and Perceived Behavioural Control: Explaining Fertility Intentions in Bulgaria (Billari et al 2009), focused on fertility decision-making through timing parity-Progression intentions. The theoretical framework builds on Ajzen's social-psychological "Theory of Planned Behavior": intentions are seen as directly dependent on three components: attitudes, norms and perceived behavioural control. The case of Bulgaria was studied, a "lowest-low" fertility country. In 2002, a sample survey containing a specially designed module was conducted. This module included an implementation of our framework, with a special attention to the links between normative pressure and the social network of respondents. Results show that the three components are broadly predictive of fertility intentions. More specifically, attitudes are more relevant than norms for higher parities. Socio-economic, ideational, psychological and social capital-based factors are relevant background determinants.

Another study on Fertility intentions of women of reproductive age living with HIV in British Columbia, Canada (Ogilvie, 2007). Women with HIV at all HIV clinics and AIDS service organizations in the province of British Columbia, Canada, to complete the survey instrument 'Contraceptive Decisions of HIV-positive Women'. Logistic regression analysis was conducted to calculate adjusted odds ratios to identify factors that may be significant predictors of the intention of women living with HIV to have children. It was found that the predictors of fertility intention of women with HIV were age, ethnicity and marital status. Women who were HIV-positive described an intention to have children at levels approaching those among the general population and regardless of their clinical HIV status. Public policy planners and health practitioners need to consider and plan for the implications of increased numbers of women with HIV who may choose to have children.

A study on Gender equity and fertility intentions in Italy and the Netherlands (Mills et al 2008), Provides an empirical test of gender equity theory by examining whether the unequal division of household labour leads to lower fertility intentions of women within different institutional contexts. Italy constitutes a case of low gender equity, low female labour market participation and the lowest-low fertility. The Netherlands has moderate to high gender equity, high part-time female labour market participation and comparatively higher fertility. Using data from the 2003 Italian Multipurpose Survey – Family and Social Actors and the Dutch sample from the 2004/5 European Social Survey, a series of logistic regression models test this theory. It was found that an unequal division of household labour only significantly impacts women's fertility intentions when they already bear a heavy load (more work hours, children), a finding that is particularly salient for working women in Italy.

Another study on Fertility awareness, intentions concerning childbearing, and attitudes towards parenthood among female and male academics, the aim was to investigate university students' intentions and attitudes to future parenthood and their awareness regarding female fertility. Postal survey of a randomly selected sample of 222 female (74% response) and 179 male (60% response) university students, shows that Female and male university students in Sweden have largely positive attitudes towards parenthood and want to have children. Women, in comparison to men, were significantly more concerned about problems related to combining work and children. Both women and men had overly optimistic perceptions of women's chances of becoming pregnant. About half of women intended to have children after age 35 years and were not sufficiently aware of the age-related decline of female fecundity in the late 30s. It was concluded that University students plan to have children at ages when female fertility is decreased without being sufficiently aware of the age-related decline in fertility. This increases

the risk of involuntary infertility in this group, which is alarming in view of the great importance they put on parenthood.

2.3.2 Africa

A study on Fertility desire and intention of people living with HIV/AIDS in Tanzania: a call for restructuring care and treatment services by Mmbaga et al (2013). A cross-sectional study of all PLWHA aged 15-49 residing in Kahe ward in rural Kilimanjaro Tanzania was conducted. Participants were recruited from the community and a local counseling centre located in the ward. Data on socio-demographic, medical and reproductive characteristics were collected through face-to-face interviews. It was revealed that a total of 410 PLWHA with a mean age of 34.2 and constituting 264 (64.4%) females participated. Fifty-one per cent reported to be married/cohabiting, 73.9% lived with their partners and 60.5% were sexually active. The rate of unprotected sex was 69.0% with 12.5% of women reporting to be pregnant at the time of the survey. Further biological children were desired by 37.1% of the participants and lifetime fertility intention was 2.4 children. Increased fertility desire was associated with living and having sex with a partner, HIV disclosure, good perceived health status and CD4 count ≥ 200 cells for both sexes. Reduced desire was associated with having more than 2 children among females, divorce or separation, and having a child with the current partner among both males and females. It was concluded that Fertility desire and intention of PLWHA was substantially high though lower than that of the general population in Tanzania. Practice of unprotected sexual intercourse with higher pregnancy rate was observed. Fertility desire was determined by individual perceived health and socio-family related factors. With increasing ART coverage and subsequent improved quality of life of PLWHA, these findings underscore the importance of

Integrating reproductive health services in the routine care and treatment of HIV/AIDS worldwide.

Similarly, another study on Fertility intentions among HIV positive women aged 18-49 years in Addis Ababa Ethiopia: across sectional study (Asfaw and Gashe 2014) revealed that among 1855 HIV positive, women aged 18-49 years selected from different public health facilities in Addis Ababa; from June to October 2012. Logistic regression models were used to predict the association of study variables and adjusted for possible confounders. It revealed that 44% of women reported fertility intention. ART users had higher fertility intention (AOR; 1.26, 95%CI; 1.01 to 1.60) than ART. In addition to this, having partner being on sexual relationship, young age, being single and having fewer or no children were found to be predictors of fertility intentions. The presence of ART, improvement of health condition and the influence of husband were the main reasons for childbearing intentions of women in the study area. It was concluded that a considerable proportion of women reported fertility intention. There was an association between fertility intentions and ART use. It is important for health care providers and policy makers to strengthen the fertility need of HIV positive women along with HIV care so that women may decide freely and responsibly on their fertility issues.

Also, in a study on the population impact of HIV on fertility in sub-Saharan Africa (Lewis et al 2004), Data from sub-Saharan Africa were collected from published studies, personal communications and the Demographic and Health Surveys. A mathematical model was used to demonstrate the impact of the HIV/AIDS epidemic on the number of births in Uganda. It was revealed that fertility was lower among HIV-infected women than HIV-uninfected women, with the exception of those aged 15-19 years, in whom the selective pressure of sexual debut on pregnancy and HIV infection led to higher fertility rates among the HIV infected. This fertility

differential resulted in a population-attributable decline in total fertility of 0.37% (95% confidence interval 0.30%, 0.44%) for each percentage point of HIV prevalence. The evidence for fertility changes in HIV-uninfected women was ambiguous. An estimated reduction of 700 000 births occurred in Uganda, as a result of the reduced fertility in HIV-infected women and premature mortality among reproductive age women. It was concluded that large fertility differentials existed between HIV-infected and uninfected women, with substantial variation by age. The extent to which these could be attributed to the direct impact of the epidemic on both infected and uninfected women, as opposed to pre-existing differences in their fertility, merits further study.

2.3.3 Nigeria

A study on Fertility Intentions, Contraceptive Awareness and Contraceptive Use among Women in Three Communities in Northern Nigeria conducted by Avidime et al in 2010, measured contraceptive knowledge, contraceptive use and fertility intentions among 1408 women of reproductive age in three communities in Kaduna state, Nigeria. Contraceptive knowledge was relatively high, with 64.6% of women having heard of at least one method. Radio and health facilities were the primary sources of information. The pill was most widely known (54.1%), followed by female sterilization (47.5%) and injectables (47.4%). Knowledge did not reflect use, however, as only 3.1% were current users of any method, among which injectables, pills and traditional waist bands were the most popular. Nearly 10% of non-users intended to begin using a method in the coming year, of which 37.3% wished to use injectables. When asked about their last birth, 87% of women had desired to become pregnant and only 15% felt that their last pregnancy was mistimed. It was concluded from the study that a sensitive and community-

friendly approach is needed to reduce risks associated with high fertility while being respectful of community preferences.

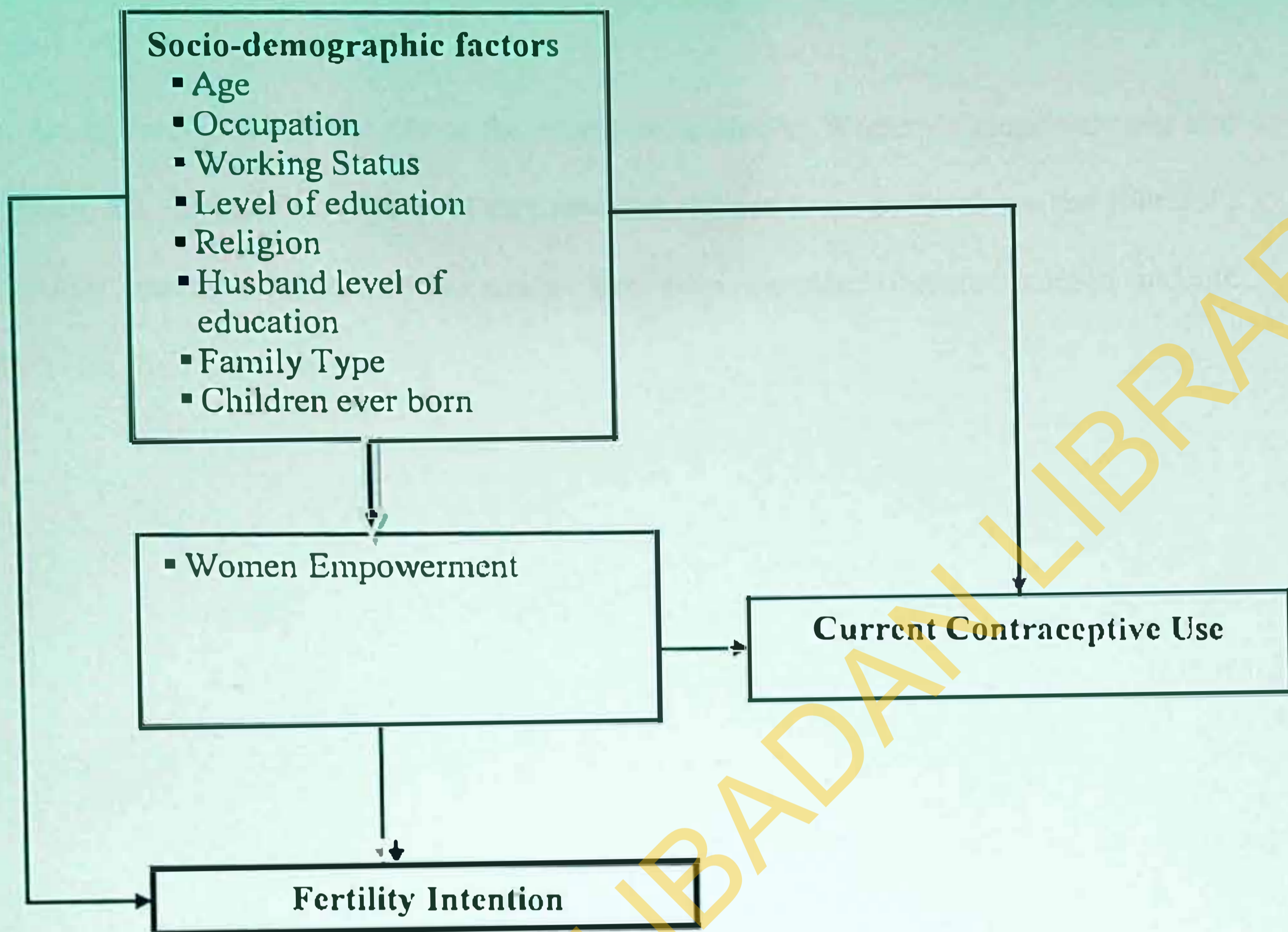
2.3.4 South Western Nigeria

Another study conducted on interconnections among changing family structure, childrearing and fertility behavior among the Ogu, southwestern Nigeria: A qualitative study by Wusu and Isiyo-Abanihe in 2006, revealed the interconnections of family transformation, childrearing and fertility behavior. Data were generated through nine focus group discussion. The study reveals that although the family system is still largely dominated by extended structure, the strong traditional kinship ties have begun to undergo serious strain. Child fostering and other means of spreading childrearing cost among relatives are fading out. Consequently, desired family size and ideal number of children in the society now gravitate to four children relative to over eight in the past. Given dwindling extended family resources for the support of a large number of its members, innovative reproductive behavior is permeating the society, such as the adoption of family planning.

2.4 Conceptual Framework

Fertility intention has been shown to be affected by the interplay of various social and cultural factors.

Figure 2.1 below shows the conceptual framework applied in studying empowerment and fertility intention among married women of reproductive age in Ife East Local Government area of Osun State.



This chapter has covered several aspects of the literature related to Women's empowerment and fertility intention, the domain of inquiry of this research. Major areas covered are the literature review on fertility intention, contraceptive usage, how empowerment liberates women and the resultant effects on their wellbeing.

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CHAPTER THREE

METHODOLOGY

3.0 STUDY AREA

Ile-Ife is an ancient Yoruba city in south-western Nigeria. Evidence of urbanization at the site has been discovered to date back to roughly 500 AD. It is located in present day Osun State, south east of Osogbo, the State capital. It has a population over 2.5million. According to the Yoruba people, Ife is where the founding deities Oduduwa and Obatala began the creation of the world, as directed by the paramount Deity Olodumare. Odùduwá is thought to have created the earth before he became the first divine king of the Yoruba, while Obàtálá is believed to have created the first humans out of clay. The Oòni (King) of Ife claims direct descent from the god Oduduwa, and is counted first among Yoruba kings. Ife East is a Local Government Area in Ile Ife, Osun State. Its headquarters is located at Oke Ogbo area of the town. It has an area of 172 km² and a population of 188,087 at the 2006 census. Ife east local government also host the popular Oranmiyan staff, a location if well harnessed could becoming one of the leading tourism sites in Nigeria.

3.1 STUDY DESIGN

This study was a community based cross-sectional in design and made use of mixed method approach which consisted of quantitative and qualitative research methods.

3.2 SAMPLE SIZE DETERMINATION

Sample size will be calculated using the formula for single proportion: $n = Z^2 \alpha P(1-P)/d^2$

Where: n = sample size Z = standard normal deviate, (a constant set at 1.96 on the basis of using the 95% confidence interval for estimation). P = Estimated proportion of empowered women in the south west who participate in all four indices for measuring decision making is 49.5% (NDHS,2008) d = margin of error (5 %)

Therefore $n = Z^2 \alpha P(1-P)/d^2 = 1.96^2 \times 0.495 \times (1-0.495)/0.05^2 = 384$

Adjusting the sample size for non-response rate, using nq Where: n = sample size $q = 1/(1-f)$ where f = estimated non response rate.

Taking $f = 0.15$, then: $q = 1.18$

Therefore minimum sample size: $384 \times 1.18 = 453$.

For the accuracy of result the sample size was increased to 742. Therefore, the estimated sample size will be 742 married women of childbearing age (15-49).

3.3 SAMPLING METHOD

Multistage sampling method was used in selecting the study respondents. Ife east local government has a total of 10 wards namely, Moore, Ilode ward 1 and 2, Okeirewe ward 1, 2, and 3, Modakeke ward 1,2 and 3, and Yekemi. Simple random sampling technique was used to select a ward each from Ilode, Modakeke, and Okeirewe. The selected ward were Ilode ward 2, Modakeke ward 3 and Okeirewe ward 3. Therefore, respondents were chosen from these 3 selected wards alongside Moore and yekemi. Simple random sampling was then used to select

Streets and areas from the chosen wards. There was a full housing and household unit listing of eligible respondents in the streets of these selected wards to develop a sampling frame, after which systematic sampling procedure was used to select the households from which participants were drawn. In cases where more than one household belong to a housing unit, simple random sampling was used to select a household. Simple random sampling was also be used to select another household as a replacement from the housing units that are not selected.

3.4 INCLUSION CRITERIA AND EXCLUSION CRITERIA

All married women aged 15- 49 years available during the interview were included, while married Women aged 15-49 years who were unable to respond to the interviewer were excluded.

3.5 DATA COLLECTION PROCEDURE

3.5.1 Quantitative

A semi-structured questionnaire was used to collect information on socio-demographic characteristics of the study participants, contraceptive use, fertility intention and women empowerment indices.

3.5.2 Qualitative

Key Informant Interview (KII) with two Family Planning Care Providers was conducted in the study area. Three Focus Group Discussions (FGD) were also conducted at different locations in the study area

3.6 RECRUITMENT OF RESEARCH ASSISTANT

Seven research assistants were recruited and trained for the purpose of this study. These research assistants helped in house numbering and interviewing the respondents.

3.7 DATA MANAGEMENT AND ANALYSIS

Safety of data was ensured through the use of locks for the bags that were used to transfer data from the field to a safe place and also data was transferred to a password protected computer to ensure protection from a third party. Data was edited, entered and cleaned appropriately for analysis. Analysis was done using IBM SPSS 20. The coded data was used to generate frequencies, tables, and cross-tabulations. Chi-square goodness of fit test was used in testing each hypothesis at a level of significance of 95%. Multivariate analysis was also done to determine the association between socio-demographic characteristics, empowerment indices and currently using contraceptives, and fertility intention.

3.8 LIMITATION OF THE STUDY

Some of the problems that were encountered in the course of the study included non response, respondents refused to respond to certain questions on the questionnaire, there were also difficulties in meeting some respondents at home during the day. Some respondents also did not declare their true age, which usually is the normal trend in the country. Some respondents also outrightly rejected to participate in the study.

Another limitation was recruiting research assistants on this work, as potential research assistants (Obafemi Awolowo University students) were writing exams at the time and a lot of

them left for their homes as soon as they concluded their exams because the Christmas season was drawing near. There was also a communal clash in part of the areas where data was collected, and we could not access these areas during the period of the clash, thereby slowing the work down.

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CHAPTER FOUR

RESULTS

This chapter presents the findings of the study that was carried out in five wards of Ife East Local Government area. A total of 742 married women aged 15- 49 years participated in the study.

4.1 Socio-Demographic Characteristics of Respondent

Table 4.1.1 presents the socio-demographic variables of the respondents in the study area. The data show that the mean age of the women was 33.8 ± 5.0 years. The mean number of children born to these women was 3.3 ± 1.4 , while the mean number of children surviving was 3.0 ± 1.2 . A majority of the respondents (29.8%) are between the ages of 35-39 years, while only 4.7% of the respondents are between the ages of 15-24 years. Most of the respondents (62.1%) are Christians, while 36.8% were Muslims. Similarly, majority of the respondents (60.8%) interviewed had secondary education, while only 11.7% had a higher education.

A majority of the respondents (98.8%) were currently working. Most of the women (57.2%) are traders, while only 5.9% of them are civil servants. 50.7% of the women claimed their husband had a secondary education, while 18.2% of the women reported their husband had a primary or no formal education. More women (64.0%) belong to a monogamous family. A majority of the respondents (49.2%) reported their number of children ever born as between 3-4, while only 20.4% reported their number of children ever born as 5 or more. 63.5% of the women intend to give birth to another child, 27.4% of them do not have the intention of giving birth again, while 9.2% were undecided.

Table 4.1.1 Frequency distribution by socio-demographic characteristics of respondents

Socio demographic characteristics	Frequency (N=742)	%
Age		
15-24	35	4.7
25-29	164	22.1
30-34	194	26.1
35-39	221	29.8
40-49	128	17.3
Religion		
Christianity	461	62.1
Islam	273	36.8
Traditional	8	1.1
Level of education		
≤primary	204	27.5
Secondary	451	60.8
Higher	87	11.7
Currently working		
Yes	733	98.8
No	9	1.2
Occupation		
Civil Servant	43	5.9
Artisan	170	23.2
Trader	419	57.2
Farmer	91	12.4
Others	10	1.3
Husband's level of education		
≤primary	135	18.2
Secondary	376	50.7
Higher	231	31.1
Family type		
Polygamous	267	36.0
Monogamous	475	64.0
CEB		
0-2	226	30.5
3-4	365	49.2
5+	151	20.1
Fertility Intention		

Have Another Child	471	63.5
No More Child	203	27.4
Undecided/Don't Know	68	9.2

Table 4.1.2 shows the frequency distribution of respondents by their knowledge and use of contraceptives. A majority of the respondents (98.7%) were aware of contraceptive methods, while only 24.0% of them were currently using contraceptives. A fewer women (22.5%) reported that the decision to use contraceptive was made by their husbands, while 42.7% of the women claimed the decision to use contraceptives was a joint one between them and their husbands. Most of the respondents (48.0%) claimed that their husbands' desire for children is the same as theirs, while 13.6% of the women reported that their husband's desire for children is less than theirs. 15.4% of the women have not heard any information on family planning in the last 4 weeks, 50.2% of the women claimed to have heard of information on family planning through the media, 63.5% in the hospital, and 22.1% through a relative, friend or neighbor in the last 4 weeks.

Table 4.1.2 Frequency distribution of respondents by knowledge and use of contraceptives

Background characteristics	Frequency (N=742)	%
Awareness of contraceptive use		
Yes	732	98.7
No	10	1.3
Currently using contraceptives		
Yes	178	24.0
No	564	76.0
Decision on contraceptive use		
Mainly the Woman's	62	34.8
Husband	40	22.5
Both	76	42.7
Husband's desire for children		
Fewer	101	13.6
Same	356	48.0
More	254	34.2
Don't know	31	4.2
Source of information on FP in the last 4 weeks		
No information	114	15.4
Media	315	50.2
Hospital	399	63.5
Relative/friend/neighbor	139	22.1

4.2 Empowerment indices

Women empowerment was measured and scored using the following variables: Currently working, Decision to use contraceptives, Decision on spending woman's income, Decision on spending husband's income, Decision on health care, Decision on major household purchase, Decision on daily household purchase, Decision to visit relatives, Husband's seek of consent before sex, Husband seek of advice on personal decision, and Problem getting permission for treatment when sick. Each of the women was scored based on their responses to these questions, and scores were summed for each woman. The respondents were ranked according to their total scores, and based on this, they were divided into three groups namely poorly, fairly, and highly empowered.

Figure 4.1 show the percentage frequency chart of women empowerment scores. It shows clearly that 14.6% of the women scored 8.00 points and 50.4% of them scored below 9.00 points, while 49.6% scored 9.00 points and above.

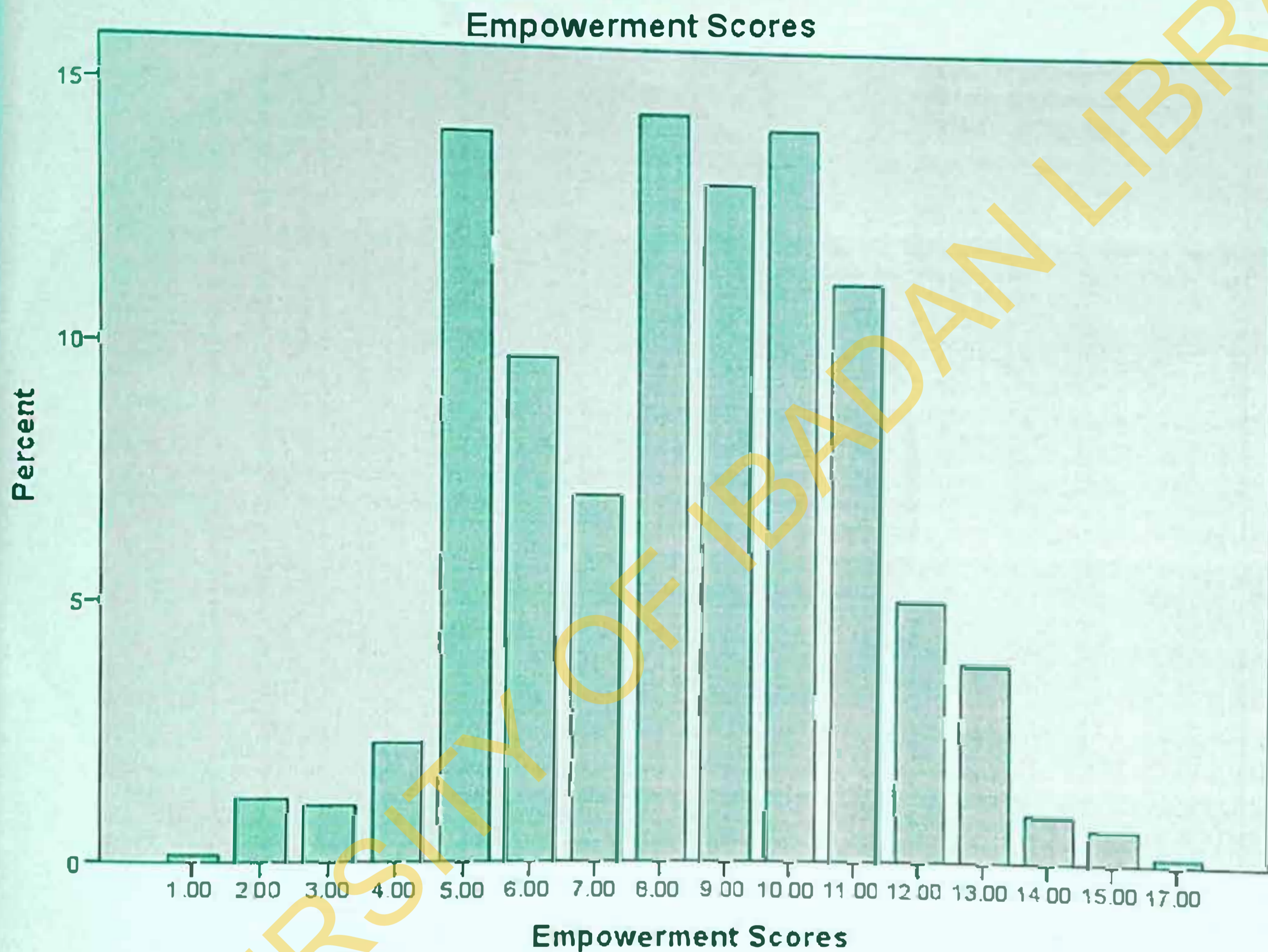


Figure 4.1 Percentage distribution of women by empowerment scores

Figure 4.2 shows the percentage distribution chart of respondents by level of empowerment. Majority of the women (50.4%) were classified as poorly empowered, 38.8% were classified as fairly empowered, and only 10.8% were classified as highly empowered.

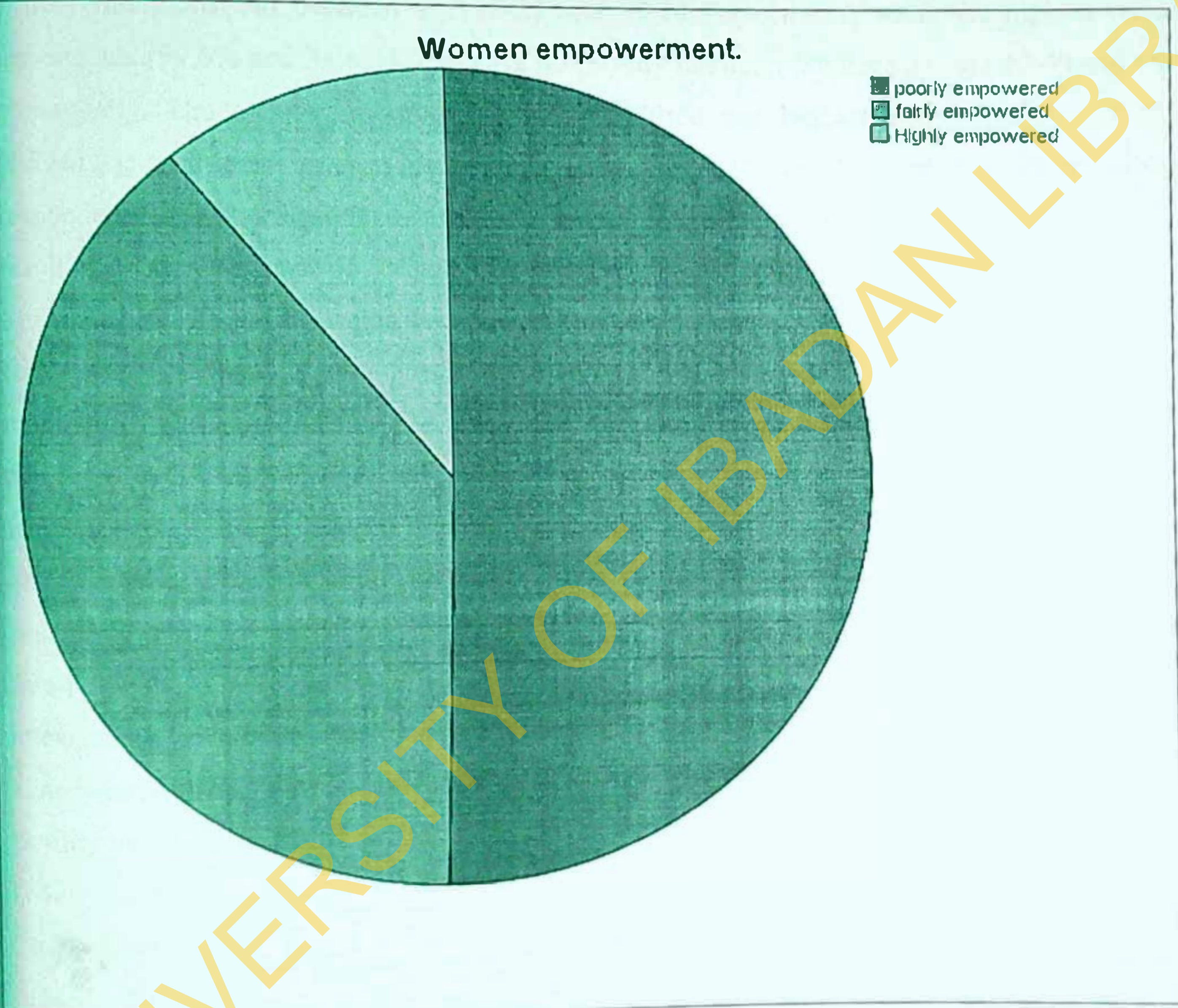


Figure 4.2 Percentage distribution of respondents by level of empowerment

4.3 Distribution of respondents according to fertility intention by socio-demographic characteristics

Table 4.3.1 Show the distribution of respondents according to fertility intention by socio-demographic characteristics. The highest rates of respondents (82.3% and 80.0%) who have fertility intentions fall between age 25-29 and 15-24 respectively, while the highest rates of respondents (59.6% and 34.6%) who have no fertility intention fall between age 40-49 and 35-39 respectively. The mean number of surviving children was highest among those aged 40-49 (3.57 ± 1.3), and least among respondents aged 15-24 (1.71 ± 1.1). The association between respondents' age and fertility intention was found to be a statistically strong one ($p = 0.000$). The result also showed that 66.6% of Christians had fertility intention, compared to 58.6% of Muslims and 50.0% of traditional worshipers ($p = 0.008$). The mean number of surviving children was highest among Muslims (3.41 ± 1.1) and least among Christians (2.83 ± 1.3). A majority of the respondents (74.7%) with high level of education have fertility intention, compared to 59.8% of those with primary or no education ($p = 0.014$). The mean number of surviving children was highest among respondents who had primary or no education (3.65 ± 1.1) and least among respondents who had a higher education (2.24 ± 1.2). There was no statistically significant association between respondents' working status and fertility intention ($p = 0.061$). Similarly, there was no statistically significant association between occupation and fertility intention ($p = 0.062$). The result showed that there was a strong statistically significant association between respondents' husbands' level of education and fertility intention. The rate of fertility intention seems to be highest among respondents whose husbands have higher education (74.9%), compared to 55.3% among respondents whose husbands have secondary education, and 66.7% among respondents whose husbands have primary or no education ($p < 0.001$). The mean number of children surviving is highest among respondents whose husbands have primary or no education (3.78 ± 1.1), and least among respondents whose husbands have higher education (2.58 ± 1.1). The data also show that 66.9% of respondents who claimed to belong to monogamous families have fertility intentions, compared to 58.0% of respondents who belong to a polygamous family ($p = 0.001$). The mean number of children surviving is higher among polygamists (3.28 ± 1.2), and lower among monogamists (2.91 ± 1.2).

It was also shown that there was a strong statistically significant association between respondents' number of children ever born and fertility intention. 86.3% of respondents who have ever born 0-2 children have fertility intention, compared to 59.5% among respondents who have ever given birth to 3-4 children, and 39.1% of respondents who have ever given birth to 5 or more children ($p < 0.001$). The mean number of surviving children is highest among respondents who have ever given birth to 5 or more children (4.41 ± 0.7), and least among respondents who have ever born 0-2 children (1.56 ± 0.6). There was a strong statistically significant association between women empowerment and fertility intention. The data show that 64.2% of respondents who are poorly empowered have fertility intention, compared to 45.0% of those who are highly empowered ($p < 0.001$). The mean number of surviving children is highest among the poorly empowered women (3.28 ± 1.3), and least among highly empowered women (2.91 ± 1.1).

Table 4.3.1 Percentage distribution of respondents according to fertility intention by socio-demographic characteristics

Background Characteristics	Fertility intention			Total women	X ² value	P value	Mean ± α number of surviving children	95% Confidence Interval for Mean
	No intention	Undecided	Intends to give birth					
Age								
15-24	2.9 (1)	17.1(6)	80.0 (28)	35	108.789	0.000	1.71±1.1	1.35-2.08
25-29	12.2(20)	5.5(9)	82.3(135)	164			2.58±1.3	2.38-2.78
30-34	19.1(37)	10.3(20)	70.6(137)	194			2.93±1.1	2.78-3.08
35-39	32.1(71)	11.8(26)	56.1(124)	221			3.39±1.0	3.26-3.52
40-49	57.8(74)	5.5(7)	36.7(47)	128			3.57±1.3	3.34-3.79
Religion								
Christianity	24.1(111)	9.3(43)	66.6(307)	461	12.895	0.008	2.83±1.3	2.71-2.94
Islam	33.3(91)	8.1(22)	58.6(160)	273			3.41±1.1	3.28-3.54
Traditional	12.5(1)	37.5(3)	50.0(4)	8			3.00±0.8	2.37-3.63
Level of education								
Primary	26.5(54)	13.7(28)	59.8(122)	204	12.477	0.014	3.65±1.1	3.50-3.80
Secondary	28.6(129)	8.4(38)	63.0(284)	451			2.92±1.2	2.92-3.03
Higher	23.0(20)	2.3(2)	74.7(65)	87			2.24±1.2	1.99-2.50
Currently working								
Yes	27.4(201)	8.9(65)	63.7(467)	733	5.004	0.061	3.04±1.2	2.95-3.13
No	22.2(2)	33.3(3)	44.4(4)	9			3.11±1.5	1.99-4.23
Occupation								
Civil Servant	32.6(14)	4.7(2)	62.8(27)	43	14.854	0.062	2.44±1.3	2.04-2.84
Arisan	28.2(48)	11.8(20)	60.0(102)	170			2.93±1.1	2.76-3.10
Trader	23.6(99)	8.6(36)	67.8(284)	419			3.00±1.2	2.88-3.12
Farmer	40.7(37)	8.8(8)	50.5(46)	91			3.88±0.8	3.72-4.04
others	30.0(3)	10.0(1)	60.0(6)	10			2.32±1.6	1.56-3.07

Husband's level of education								
≤primary	19.3(26)	14.1(19)	66.7(90)	135	32.245	0.000	3.78±1.1	3.60-3.96
Secondary	34.6(130)	10.1(38)	55.3(208)	376			3.06±1.2	2.94-3.19
Higher	20.3(47)	4.8(11)	74.9(173)	231			2.58±1.1	2.44-2.72
Family type								
Polygamous	29.2(78)	13.9(37)	56.9(152)	267	13.367	0.001	3.28±1.2	3.14-3.42
Monogamous	26.3(125)	6.5(31)	67.2(319)	475			2.91±1.2	2.80-3.02
CEB								
0-2	6.2(14)	7.5(17)	86.3(195)	226	102.549	0.000	1.56±0.6	1.48-1.63
3-4	31.0(113)	9.6(35)	59.5(217)	365			3.40±0.6	3.33-3.46
5+	50.3(76)	10.6(16)	39.1(59)	151			4.41±0.7	4.29-4.53
Women empowerment								
Poorly empowered	27.3(102)	8.6(32)	64.2(240)	374	27.008	0.000	3.28±1.3	3.15-3.41
Fairly empowered	21.2(61)	11.1(32)	67.7(195)	288			2.77±1.1	2.64-2.90
Highly empowered	50.0(40)	5.0(4)	45.0(36)	80			2.91±1.1	2.67-3.15

4.4 Distribution of respondents according to current use of contraceptives by socio-demographic characteristics

Table 4.4.1 Show the distribution of respondents according to current use of contraceptives by socio-demographic characteristics. The data show there was no statistically significant association between respondents' age and contraceptive use ($p = 0.206$). Conversely, there was a strong statistically significant relationship between respondents' religion and current use of contraceptives. The prevalence rate was highest among Christians (30.6%), compared to 13.2% among Muslims, the rate was lowest among traditional worshipers (12.5%) ($p < 0.001$). Similarly, there was a strong significant relationship between respondents' level of education and

current use of contraceptives. The rate of current use of contraceptive is highest among respondents who have a higher education (82.8%), compared to 6.4% of respondents with primary or no education ($p < 0.001$). There was no statistically significant association between respondents' working status and current contraceptive use ($p = 0.901$). Conversely, there was a statistically strong association between respondents' occupation and current use of contraceptives, the prevalence of current contraceptive use was highest among civil servants (69.8%), and least among farmers (1.1%) ($p < 0.001$). Similarly, there was also a statistically strong association between respondents' husbands' level of education and current contraceptive use, the prevalence of current contraceptive use was highest among respondents whose husbands have a higher education (37.7%), and least among those whose husbands have a primary or no education (1.5%) ($p < 0.001$).

Also, there was a statistically strong association between family type and current use of contraceptives, 32.4% of those who belong to a monogamous family were currently using contraceptives, compared to 9.0% of those who belong to a polygamous family ($p < 0.001$). Similarly, the association between children ever born and current contraceptive use was a strong statistically significant one, the prevalence of current contraceptive use was highest among respondents (32.7%) who have ever born between 0-2 children, compared to only 10.6% among those who have ever given birth to 5 or more children ($p < 0.001$).

Finally, there was also a strong statistically significant association between women empowerment and current contraceptive use. The data show that 41.1% of respondents who are highly empowered are currently using contraceptives, compared to 13.1% of those who are poorly empowered ($p < 0.001$).

Table 4.4.1 Percentage distribution of respondents according to current contraceptive use by socio-demographic characteristics

Background Characteristics	Current contraceptive use		Total women	X ² value	P value
	Not using	Using			
Age					
15-24	74.3(26)	25.7(9)	35	5.912	0.206
25-29	72.6(119)	27.4(45)	164		
30-34	72.6(141)	27.3(53)	194		
35-39	81.4(180)	18.6(41)	221		
40-49	76.6(98)	23.4(30)	128		
Religion					
Christianity	69.4(320)	30.6(141)	461	29.051	0.000
Islam	86.8(237)	13.2(36)	273		
Traditional	87.5(7)	12.5(1)	8		
Level of education					
≤primary	93.6(191)	6.4(13)	204	202.317	0.000
Secondary	79.4(358)	20.6(93)	451		
Higher	17.2(15)	82.8(72)	87		
Currently working					
Yes	76.0(557)	24.0(176)	733	0.016	0.901
No	77.8(7)	22.2(2)	9		
Occupation					
Civil Servant	30.2(13)	69.8(30)	43	77.740	0.000
Artisan	78.8(134)	21.2(36)	170		
Trader	74.2(311)	25.8(108)	419		
Farmer	98.9(90)	1.1(1)	91		
Others	80.0(8)	20.0(2)	10		
Husband's level of education					
≤primary	98.5(133)	1.5(2)	135	61.211	0.000
Secondary	76.3(287)	23.7(89)	376		
Higher	62.3(144)	37.7(87)	231		

Family type					
Polygamous	91.0(243)	9.0(24)	267	51.468	0.000
Monogamous	67.6(321)	32.4(154)	475		
CEB					
0-2	67.3(152)	32.7(74)	226	24.356	0.000
3-4	75.9(277)	24.1(88)	365		
5+	89.4(135)	10.6(16)	151		
Women empowerment					
Poorly empowered	86.9(325)	13.1(49)	374	51.175	0.000
Fairly empowered	66.7(192)	33.3(96)	288		
Highly empowered	58.8(47)	41.2(33)	80		

The data as shown in table 4.4.2 revealed that highly empowered women were less likely (OR=0.38; C.I=0.23-0.64, $p<0.001$) to have fertility intention than poorly empowered women. Meanwhile, when women empowerment was adjusted for by other socio-demographic factors, the result did not change much as it was revealed that highly empowered women were less likely (OR=0.33; C.I=0.17-0.65, $p<0.05$) to have fertility intention than poorly empowered women. The data also show that women in age group 40-49 were less likely (OR=0.06; C.I=0.01-0.51, $p<0.05$) to have fertility intention than women in age group 15-24. Women whose husbands have a secondary education were less likely (OR=0.26; C.I=0.12-0.54, $p<0.001$) to have fertility intention than women whose husbands have primary or no education. It was further revealed that respondents who have ever born between 3-4 children were less likely (OR=0.14; C.I=0.07-0.27, $p<0.001$) to have fertility intention than women who have never given birth or have ever given birth to one or two children, likewise women who have ever given birth to 5 children or more were less likely (OR=0.05; C.I=0.02-0.11, $p<0.001$) to have fertility intention than women who have never given birth or have ever given birth to one or two children

Table 4.4.2: Logistic regression of factors influencing Fertility intention among respondents

Background Characteristics	Unadjusted			Adjusted		
	P value	OR	95.0% C.I. for OR	P value	OR	95.0% C.I. for OR
Women empowerment						
Poorly empowered (Ref. Cat.)		1.000			1.000	
Fairly empowered	0.104	1.359	0.94-1.97	0.730	1.089	0.67-1.76
Highly empowered	0.000	0.382	0.23-0.64	0.001	0.334	0.17-0.65
Age						
15-24 (Ref. Cat.)		1.000			1.000	
25-29	0.174	0.241	0.03-1.87	0.650	0.607	0.07-5.23
30-34	0.050	0.132	0.02-1.00	0.402	0.401	0.05-3.40
35-39	0.007	0.062	0.01-0.47	0.102	0.170	0.02-1.43
40-49	0.000	0.023	0.00-0.17	0.010	0.060	0.01-0.51
Religion						
Christianity (Ref. Cat.)		1.000			1.000	
Islam	0.008	0.008	0.45-0.81	0.102	0.660	0.40-1.09
Traditional	0.743	0.743	0.16-13.08	0.615	0.548	0.05-5.74
Level of education						
≤primary (Ref. Cat.)		1.000			1.000	
Secondary	0.894	0.974	0.67-1.43	0.867	1.053	0.58-1.93
Higher	0.231	1.439	0.79-2.61	0.195	0.511	0.19-1.41
Husband's level of education						
≤primary (Ref. Cat.)		1.000			1.000	
Secondary	0.002	0.462	0.28-0.75	0.000	0.258	0.12-0.54
Higher	0.824	1.063	0.62-1.83	0.509	0.737	0.30-1.82
Family type						
Polygamous (Ref. Cat.)		1.000			1.000	
Monogamous	0.123	1.310	0.93-1.84	0.834	0.946	0.56-1.59
CEB						
0-2 (Ref. Cat.)		1.000			1.000	
3-4	0.000	0.138	0.08-0.25	0.000	0.141	0.07-0.27
5+	0.000	0.056	0.03-0.11	0.000	0.049	0.02-0.11

Table 4.4.3 show that fairly empowered women were more likely (OR=3.32; C.I=2.25-4.89, $p<0.001$) to currently use contraceptives than poorly empowered women, likewise highly

empowered women were more likely (OR=4.66; C.I=2.72-7.97, $p<0.001$) to currently use contraceptives than poorly empowered women. When Women empowerment was adjusted for by other factors, the result revealed that fairly empowered women were more likely (OR=2.54; C.I=1.56-4.14, $p<0.001$) to currently use contraceptives than poorly empowered women, likewise highly empowered women were more likely (OR=2.96; C.I=1.51-5.80, $p<0.05$) to currently use contraceptives than poorly empowered women. Women who have a secondary education were more likely (OR=2.10; C.I=1.04-4.25, $p<0.05$) to currently use contraceptives than women who have no education or a primary education, also, women who have a higher education were more likely (OR=59.37; C.I=19.42-181.56, $p<0.001$) to currently use contraceptives than women who have no education or a primary education. The data show further that those women whose husbands have a secondary education were more likely (OR=4.68; C.I=1.01-21.66, $p<0.05$) to currently using contraceptives than women whose husbands have primary or no education. Respondents who belong to monogamous homes were more likely (OR=2.38; C.I=1.37-4.12, $p<0.05$) to currently use contraceptives than respondents from polygamous homes.

Table 4.4.3: Logistic regression of factors influencing current contraceptive use among respondents

Background Characteristics	Unadjusted			Adjusted		
	P value	OR	95.0% C.I. for OR	P value	OR	95.0% C.I. for OR
Women empowerment						
Poorly empowered (<i>Ref. Cat.</i>)		1.000			1.000	
Fairly empowered	0.000	3.316	2.25-4.89	0.000	2.541	1.56-4.14
Highly empowered	0.000	4.657	2.72-7.97	0.002	2.955	1.51-5.80
Religion						
Christianity (<i>Ref. Cat.</i>)		1.000			1.000	
Islam	0.000	0.345	0.23-0.52	0.269	0.751	0.45-1.25
Traditional	0.294	0.324	0.04-2.66	0.975	0.966	0.11-8.54
Level of education						
≤primary (<i>Ref. Cat.</i>)		1.000			1.000	
Secondary	0.000	3.817	2.081-7.00	0.039	2.099	1.04-4.25
Higher	0.000	70.523	31.987-155.49	0.000	59.371	19.42-181.56
Occupation						
Civil Servant (<i>Ref. Cat.</i>)		1.000			1.000	
Artisan	0.000	0.116	0.06-0.25	0.526	0.710	0.25-2.05
Trader	0.000	0.150	0.08-0.30	0.572	1.344	0.48-3.74
Farmer	0.000	0.005	0.01-0.04	0.203	0.225	0.02-2.24
others	0.000	0.081	0.02-0.33	0.262	0.354	0.06-2.18
Husband's level of education						
≤primary (<i>Ref. Cat.</i>)		1.000			1.000	
Secondary	0.000	20.622	5.00-85.01	0.048	4.681	1.01-21.66
Higher	0.000	40.177	9.70-166.45	0.431	1.911	0.38-9.59
Family type						
Polygamous (<i>Ref. Cat.</i>)		1.000			1.000	
Monogamous	0.000	4.857	3.06-7.70	0.002	2.378	1.37-4.12
CEU						
0-2 (<i>Ref. Cat.</i>)		1.000			1.000	
3-4	0.023	0.653	0.45-0.94	0.243	1.329	0.82-2.14
5+	0.000	0.243	0.14-0.44	0.953	1.023	0.48-2.18

QUALITATIVE RESULTS

Nigeria is the most populous black nation in the world. Like many countries in sub Saharan Africa, Nigeria still has a high fertility rate despite efforts by the government to reduce fertility rate in the country. While the uptake of contraception could be a possible solution to this problem, there are still many people who would not practice contraception today, because of one barrier or the other, or because they are scared of side effects. According to the Federal office of statistics (1992), the country's total fertility rate was approximately 6, and eleven years later the Nigeria demographic health survey report revealed that the rate has only dropped marginally to 5.7. It remained 5.7 as at 2008, only to marginally drop again to 5.5 in the latest edition of the report (2013).

Focus group discussion was conducted among groups of women to gain a deeper insight on fertility preference and what they consider as challenges of high fertility.

During the focus group discussions, when the question on their position on bearing more children was asked it was unanimously agreed upon that childbearing is a thing of joy and something they all look forward to, but one needs to be careful to limit the number of children to what one can adequately take care of. Here are some of the responses, *"Childbearing is a good thing, it is believed that when a lady enters into the house of a man (gets married) it is expected that she gives birth within 10 months, so as to make the husband and his family happy, otherwise they may suggest that he marries another wife"* (Iya Segun 34 years).

Mrs Kolawole, 33 years, said *"if not for the realities of things today, one can even give birth to 10 children, but the way things are one must be careful to only give birth to the number of children they can cater for, but for our mothers in the olden days, they just give birth anyhow. It should not be so now, we must not even try that now. Some people have 3 or 4 children now and still complain they cannot take care of them. So now we should only give birth to the ones we can take care of"*.

Iya Lekan, 30 years *"if you want the children to have a sound education, you must not give birth to more than four children nowadays because if you give birth to more than four..... some people even give birth to four and are not able to take care of them, but if you have like four you will*

know how to struggle to take care of them. If you see that the four children will be too much for your job (earnings) you can give birth to two. We can see that those who are well educated and rich give birth to 2,3 children or even 1 child and it is enough for them, but now if you want more children and you want them to have a sound education 4 children is enough". All from the same location.

Iya Onome, 28 from the second location also said "It is a good thing to give birth because whoever comes to this world and doesn't give birth has lived a wasted life (supports it with a proverb in Yoruba saying Omolabara ka fi asho sile, literary translation is 'we should have bought children instead of buying cloths). So it is good but you should only give birth to ones you can cater for, and not that you should have much and will now be misbehaving. If you can give birth to 2 or 3 give birth on time and train them with good education, not that the children will be going to school barefooted and the mother will tie head gears. That is not good".

"Giving birth.... the olden days is when people give birth to much children because they don't know the ones that will not live long, but now those that give birth to much children have a maximum of 4 or 6, but the young ladies now have 4" (Mrs. Bolarinwa 49 years, third location).

When probed on how many she thinks is too much she said 6

These women were also asked the challenges of high fertility. Most of them cited inability to feed well, lack of proper education, financial pressure on parents, and children growing up to become miscreants as part of the challenges that could arise as a result of high fertility.

"It is difficult to even eat and drink now. Some people do not have anything and they will continue giving birth, they only want the children to grow up and become armed robbers, when they are not adequately taken care of, because a child that does not get adequate care will look at another person's property, but if you have what it requires to take care of the children, no problem, you can give birth to as many as possible and the Lord will take care of them, but if you do not have anything and see that your earnings is low and having more children, the way things are now if one's children are not educated they will become slaves to their mates. When you told us where you came from we were happy and we want our children to get there also and surpass there, not that one should give birth to too many children and they will be wandering the streets"(Iya Jide 32, first location).

"If you have many children it will be difficult to eat at times, you will start thinking that the children will want to go to school, you have to buy books. If you do not have money it is a challenge, before they buy clothes and shoes that is another challenge" (Iya Victor, 33, second location). "When children are much it is not good because the money you should use to take care of 2 children would not be enough when the children are 12. That is why some parents will tell their children to go and learn crafts, when there is no power to send them to school. There is no parent that does not feel like training their children, but there would not be power when children are much" (Iya Praise, 30, second location).

"Before the parent can succeed it might be difficult and secondly, the children would not have good education". (Iya bola, 31, third location). "The parents will not be able to stand shoulder tall with their peers and the children will not attend the school they should attend, and they will become slaves to their mates. It could also cause untimely death for the parents"(Iya Tunde, 30, third location).

These women were also asked how to overcome these challenges. "To avoid unwanted pregnancies one should go to the hospital to be tested for the best family planning option that will suit her, because if a mistake occurs the husband will start giving problems when the wife says she is pregnant, because when some men say they want 2 children, if you give birth to more children you might be the only one to take care of them....(Iya Tayo, 29, first location) Iya Jide 32 cuts in "Family planning failure(IUD was displaced) made me give birth to this child (points to the child). Even when doctors want to administer a drug they pray that it works. When I did family planning my last kid then was 2 years old, and my husband said I should go and do it so as not to become pregnant. It was after then I became pregnant and gave birth. When you do that thing....if there is understanding between husband and wife, the husband must hold on for some days after the wife's menstruation, because if he does not the wife will become pregnant. If there is understanding, they will have a time to have sex and would not become pregnant. When I did family planning, I went to OAUTHIC (Obafemi Awolowo University Teaching Hospital) my blood was tested and they did different counseling for me for one month". I probed on how long after she did the IUD before it got displaced. She said "11 years (The rest of the women laughs and say it has been long that she did it. She made the mistake, she should have gone back earlier before that time)".

"Family planning or go to chemists and buy drugs, they are sold for 3 for N10, it works well". (Iya onome, 28, second location)

"Family planning, because if you give birth today, the husband can still request for sex and you must satisfy him so that he won't look elsewhere.... (Iya tinu, 32, third location,)

Iya nifemi cuts in "I have a relative that IUD was removed from her child's hand after birth".

It is worthy to note that only in the second location was the choice of family planning not opposed even though they also suggested buying drugs from chemists which may not be a safe practice.

Finally they were asked on how contraceptives can be made more acceptable by the community some of their responses go thus; in the first location, the women said that if there could be a solution to the various side effects and someone does it and sees that it is effective with no side effects she will recommend to others.

"It should be acceptable to many because it is good, especially the 3 months injection. That is what I use and it is good and it is good." (Iya Ola, 31, second location). I probed to say that some say when they use injection it would delay pregnancy beyond the time it was meant to delay it. She said *"No, if it was so I won't be carrying this baby with me here".*

"when you go to the hospital to get tested. I did it once, I collected injection and was menstruating twice a month. I stopped it and still continued menstruating twice a month for 6 months after I had stopped it. It was after 6 months that it became stable and I got pregnant. So if it suits you, you should do it and if it doesn't you should stop. Since then I have been calculating or even put salt inside water immediately after mating, I will just go and urinate everything afterwards". (Iya tunde, 30, third location)

Two health facilities were also visited, so as to find out situation of things as regards family planning utilization in these facilities. A private facility and a government facility.

At the private facility, when asked about the turnout of people regarding family planning, the health official met, a Doctor said *"People are responding in the little understanding they have".* She was asked if there is anything they do that to make sure that more people assess family planning. She said *"Just by enlightening them when they come for immunization or antenatal*

care, so that they will accept it after delivery. We don't do any propaganda outside the hospital, there is no time". When asked if she thinks there has been an improvement on family planning utilization in the past 3 months at the facility, she said "Not much". She was also asked the type of contraceptive methods available at the facility, her response was "we have copper T, then we have injectables, we also have tablets and condoms but they used to buy, they don't come here purposely because of tablets. It is just the copper T and the injectables". She was asked about the failure rate they have encountered, her response was "not really for those 2 (copper T and the injectables) we do here, no failure". When asked if the methods are readily available, her response was "yes, anytime". She was pressed on the cost of the methods, she said "for now because we have a program going on, the SHF program, for their own sake we charge little for the program. Personally by our own making, before, we charge N500 for injectables, the 3 months, the copper T we charge N1500, but now we charge N500 for copper T and N300 for injectables".

At the public facility, when asked about the turnout of people regarding family planning, the health official met, a nurse said "People are trying their best to come to the health facility for family planning and we are doing all we can. All the materials that are here, those are the things we are giving them and they are coming out en mass. The turnout has been encouraging". I tried to press on the number of cases per day, her response was "on our routine immunization days, as parents bring their babies we give health education on family planning. We discuss family planning with them, but some of them will refuse, but we try to encourage them just to accept family planning commodities and they try to do that by collecting condoms. We do give condoms every clinic both female and male condoms, but if it is injectables we like to advise them to come back for it and we are giving them. They do patronize". I asked if they demonstrate how to use female condoms, her response was "We do, yes...we explain because it's at the back of that female condom, they described how they will use it and we too, we used to describe how they will insert it whenever they want to use it". When asked if she thinks there has been an improvement on family planning utilization in the past 3 months at the facility, she said "yes yesyes... the turnout has been increasing, people are coming out. They will come and ask questions about it, and we discuss with them and later they will come back and collect the commodities". When I probed on the type of questions they ask, based on my findings during household survey that a lot complained on injection that it delays pregnancies, her response was "Yes they do say that

after collecting injection, particularly the depot, the 3 months injection, that 6 months after some will not see their menstruation, some may not be able to conceive, but we do explain to them that those people that have 1 or 2 kids are not supposed to collect the depot, we do explain to them that the Norethisteranteis the one they are supposed to collect, and they are taking to our instructions, but they do give complaints. Series of complaints". I further asked about what they tell people who complain about IUD to assure them that it remains a safe practice. She responded by saying "we usually tell them that the IUD is more effective for a client that sticks to a particular partner, not for them to be going around doing whatsoever pleases them. If they do that, there is a probability that the IUD will shift inward or for it not to be effective, but if they stick to one particular person, maybe their husband, there is no problem". She was also asked the type of contraceptive methods available at the facility, her response was "we have tablets, condoms (both male and female), Injectables (Norethisterante and depot), we do have IUCD, but the norplant, we are not doing it here, sterilization not here". When asked if the methods are readily available, her response was "yes, it is regularly available here, anytime they come we do give them". She was pressed on the cost of the methods, she said "No we are not collecting a penny it is free of charge, we do give people free of charge. Everything we are doing here is free".

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 DISCUSSION

This study focused on the pattern of fertility intention and the impact of women empowerment on fertility intention and contraceptive use among married women of reproductive age in Ife East Local Government area of Osun State. This section discusses the result of the study in relation to the objectives, literature review and key variables of the research.

The analysis of the findings of this research indicated that a majority of the respondents had at least a secondary education. This corroborates the findings of a recent study in Osogbo, Southwest Nigeria, on fertility intention of people living with HIV AIDS, which found that a majority of the respondents had a secondary or higher education (Olowookere et al. 2013). A possible reason for this is a value placed on education by the people of Southwestern Nigeria, another factor could be the free education policy by successive governments in this region of the country.

This study shows almost all the women were currently working, this is as opposed to a study in India where it was found that majority of the women were not working (Dalal, 2011). A possible reason for this could be a difference in culture and economic hardship, while in Southwest Nigeria you can hardly find a house without a shop located within its premises, in a bid to escape from poverty, and this is evident from the percentage of women who reported they are traders, there are also no financial supports provided to women on a regular basis in form of stipends to women in Nigeria.

This study further reveals that a majority of the women interviewed, intend giving birth to another child. This is in contrast to a previously held study on Fertility desire and intention of people living with HIV/AIDS in Tanzania which revealed that a majority of the women do not intend to give birth to more children (Mmbaga et al 2013). Possible explanations for these are the love and value placed on childbearing in Southwestern Nigeria. Also HIV/AIDS positive women are not likely to want to give birth to more children as a result of fears of transferring the virus to their newly born children. Also, the findings from this study on fertility intention is consistent with the result of a previously held study in Netherland and Italy, where it was found that a majority of the respondents do not intend to give birth to any other child (Melinda et al, 2008).

In this study, it was also revealed that awareness of contraceptives is high among the study participants, while only a few of them were currently using contraceptives. While this finding corroborates the pattern of a previously held study in three communities in Northern Nigeria (Avidime et al 2010), the proportions from this study are higher than those of the North. This could probably arise as a result of a much higher level of awareness in the Southwest compared to the North. Most of the respondents claimed that their husbands' desire for children is the same as theirs. This agrees with the findings of a previously held study in Guatamela (Kathryn, 2010)

The study also show that as the number of children ever born increases among the respondents, the rate of those who intend to give birth to another child reduced. This is consistent with the findings of a recently held study in four European countries where it was established that mothers who have only one child are more likely to report that they intend to have another child than mothers who have already at least two children (Tanskanch and Rotkirch 2014; Balbo and Mills 2011; Buhler and Fraczak 2007) The reason for this could possibly be because as the

number of children increases, people's fertility desires are met and once met they are not likely to have the intention of giving birth again.

The study also showed that respondents who had a higher level of education or secondary education were more likely to be currently using contraceptives than those who had primary or no education. This is in agreement with a recent study in Pakistan on Female Educational Empowerment and Fertility Behaviour (Samina et al 2013), which concluded that level of education has a direct relationship with use of contraceptives. It further agrees with another study in Uganda, where it was stated that female education especially at secondary and post secondary school level increases the likelihood of using contraceptives (Bbaale et al 2011).

When adjusted for by other factors it was revealed that there was a lesser odds ratio among highly empowered women than poorly empowered women with respect to having fertility intention. A possible reason for this is because highly empowered women are likely to enjoy their present financial status and they probably know the financial implication of adding another child.

Conversely, there was a higher odds ratio among highly and fairly empowered women than poorly empowered women with respect to current contraceptive use, after adjusting for other factors. This finding is consistent with the findings of a recent study in Ethiopia, which revealed that women's empowerment was positively associated with contraceptive use (Mekonnen et al 2013).

5.2 CONCLUSION

The study was educative and challenging with regards to the findings and the discussions. While the love of these women for childbearing was established, a number of factors were found to be associated with the delay of childbearing or a lack of fertility intention altogether among married women of reproductive age in Ife East Local Government area of Osun State. It is therefore concluded that Fertility intention was strongly influenced by factors such as respondents' age, women empowerment, husbands' level of education, and number of children ever born.

The key predictors of contraceptive use were women empowerment, respondents' level of education, and husband's level of education.

It was also concluded from the study that while more women are aware of contraceptive methods and recognize it as a possible step towards reducing the challenges of high fertility a lot of them are not accessing in it due to one fear or the other and a lot of the fear seems to be genuine, even though they can be overcome with the right counseling and guidance. The study also show that these women are engaged in birth control methods other than modern contraceptive methods, and also a lot of them believes contraceptive methods only entails injectables and IUCDs.

5.3 RECOMMENDATION

1. Women of reproductive age below the age group 40-49 should be encouraged to practice contraception so that they can at least postpone their next birth since most of them have intention to give birth. Women in this age group who have already given birth should also be discouraged from given birth to another child. The Government can come up with a welfare policy for children whose parents did not give birth to more than 2 children. Men should also be

encouraged to have at least a secondary education as the study as shown that women married to men with a secondary education were less likely to have fertility intention.

2. Parents should make sure that their female children are not discriminated against in favour of their male counterparts. They should provide quality education to their female children, and also encourage them to advance their education to the top level. This would increase the chances of this children gainfully employed in the future and put them in a pole position to be responsible for taking decisions on their own. This will help reduce fertility intention among women.

3. Government should consciously embark on women empowerment programmes. They should make sure that these women are well educated so that they can be better informed. Skill acquisition and provision of soft loans for businesses should also be used to encourage the women who are willing to work but are currently not working. Women should also be more involved in key positions in the society, as this could help boost their self-esteem, thereby encouraging participation in more decision making processes both at home and in the society. This will also go a long way in promoting contraceptive use.

4. Contraceptives acceptance and use should be promoted among these women, health facilities must also ensure that women are properly counseled and tested before recommending a contraceptive method. More applied research should also go into minimizing the side effects and failure rates of these methods, so that the acceptance can increase. Similarly, research should go into the discovery of more reversible contraceptive methods for men too apart from the male condom, so as to relief the burden on women. This will go a long way in solving the challenges of high fertility in the area.

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APPENDICES

SPECIFIC OBJECTIVES	VARIABLES	ANALYSIS
Examine the patterns of fertility intention among women of reproductive age in Ife east local government area.	Fertility intention	Descriptive Statistics
Determine an association between women empowerment and fertility intention among women of reproductive age in Ife east local government area	<u>Dependent:</u> Fertility Intention <u>Independent:</u> _____ women empowerment	Chi-square Logistic regression
Determine if there is an association between women empowerment and contraceptive use	<u>Dependent:</u> Contraceptive use <u>Independent:</u> _____ women empowerment	Chi-square Logistic regression
Explore the opinion of women on challenges associated with high fertility	FGD	Thematic approach from verbal reporting

EMPOWERMENT AND FERTILITY INTENTION AMONG MARRIED WOMEN OF REPRODUCTIVE AGE IN IFE EAST LOCAL GOVERNMENT

QUESTIONNAIRE

INTRODUCTION AND INFORMED CONSENT

Greetings. My name is Oguns Oluwaseun, I am an MPH student of University of Ibadan, working on Women Empowerment and Fertility Intention. I would very much appreciate your participation in this survey. The information collected shall be mainly for academic purposes. Your name will not be recorded, only codes shall be given to questionnaires. Whatever information you provide will be kept strictly confidential and will not be shown to other persons. Participation in this survey is voluntary. You can stop the interview at any time. However, I hope that you will participate in this survey since your views are important. Please I need you to sign below that you have agreed to voluntarily take part in this survey. Thanks.

Signature _____ Date _____

Socio Demographic Characteristics

1. Age as at last birthday? _____
2. Religion? (i) Christianity () (ii) Islam () (iii) Traditional ()
3. Level of education? (i) No formal education () (ii) Primary education ()
4. (iii) Secondary education () (iv) Tertiary education ()
5. What is the total number of years of your schooling? _____
6. Are you currently working? (i) Yes () (ii) No () if No, skip to 8
7. Occupation? _____
8. What is your average monthly income? _____
9. Husband's level of education? (i) No formal education () (ii) Primary education () (iii) Secondary education () (iv) Tertiary education ()
10. Type of family? (i) Polygamous () (ii) Monogamous ()

Fertility Preference

11. How many children have you ever given birth to? _____
12. How many children do you have alive? _____ No. of males () No. of females ()

13. Are you currently pregnant? (1) Yes () (2) No () if yes go to 21 otherwise go to 22
14. After the child you are expecting now, would you like to have another child, or would you prefer not have any more children? (1) Have another child () (2) No more () (3) Undecided/Don't know () if Have another child go to 23 otherwise go to 24
15. Would you like to have (a/another) child, or would you prefer not to have any (more) children? (1) Have (A/Another) Child () (2) No more/None () (3) Says she can't get pregnant (4) Undecided/Don't know () if 2, or 4 go to 24 if 3 go to 28.
16. Are you aware of any contraceptive methods? (1) Yes () (2) No ()
17. Are you currently using any contraceptive methods (1) Yes () (2) No () if No skip to 27
18. Does your husband/partner know that you are using a method of family planning? (i) Yes () (ii) No ()
19. Do you think you will use a contraceptive method to delay or avoid pregnancy at any time in the future? (1) Yes () (2) No () Don't know
20. In the last few months have you heard about family planning? (i) Yes () (ii) No ()
21. Where did you hear the information? (i) Television () (ii) Newspaper or magazine () (iii) Radio () (iv) Others specify _____
22. Would you say that using contraceptive is mainly your decision, mainly your
23. husband's/partner's decision, or did you both decide together? _____
24. Does your husband/partner want the same number of children that you want, or does he want more or fewer than you want? _____

Empowerment Indicators

56. Who decides how your income is being spent? (i) Solely by you () (ii) You and Husband/Partner () (iii) Mainly husband/partner () (iv) Others specify _____
57. Who decides how your husband's/partner's income is being spent? (i) Solely by you () (ii) You and husband/partner () (iii) Mainly husband/partner () (iv) Others specify _____
58. Who makes decision about your health care (i) Solely by you () (ii) You and husband/partner () (iii) Mainly husband/partner () (iv) Others specify _____
59. When you are sick and want to get medical advice or treatment, is getting permission to go a big problem? (i) Yes () (ii) No ()
60. Who makes decision about major household purchases? (i) Solely by you () (ii) You and husband/partner () (iii) Mainly husband/partner () (iv) Others specify _____
61. Who makes decision about purchases of daily household needs? (i) Solely by you () (ii) You and husband/partner () (iii) Mainly husband/partner () (iv) Others specify _____

62. Who makes decision about visits to your family or relatives? (1) Solely by you ()
You and husband/partner () (3) Mainly husband/partner () (4) Others specify _____
63. Does your husband/partner seek your consent in any way before having sex with you? (i) Yes ()
(ii) No ()
64. Does your husband/partner seek advice from you on major personal decisions?(i)Yes () (ii) No ()

Thank you.

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**EMPOWERMENT AND FERTILITY INTENTION AMONG MARRIED WOMEN
OF REPRODUCTIVE AGE IN IFE EAST LOCAL GOVERNMENT AREA.**

Health Research Ethics Committee assigned number IPH/OAU/12/293

Applicant's Name: Oguns Oluwaseun.

Applicant's Address: Dept. of Epid. and Med. Statistics, Fac. Of Public Health, University of
Ibadan

Date of receipt of valid application: Nov. 7th, 2014

Date of meeting when final determination of research was made: Dec. 29th, 2014

This is to inform you that the research described in the submitted protocol (HREC No:
IPH/OAU/12/293), the consent forms and other participant information materials have been
reviewed and given full approval by the Health Research Ethics Committee

This approval dates from Dec. 29th, 2014 to Dec. 26th, 2015. If there is delay in starting the
research, please inform the HREC so that the dates of approval can be adjusted accordingly.

Note that no participant accrual or activity related to this research may be conducted outside
of these dates. All informed consent forms used in this study must carry the HREC assigned
number and duration of HREC approval of the study. In multiyear research, endeavor to
submit your annual report to the HREC early in order to obtain renewal of your approval to
avoid disruption of your research.

The National Code for Health Research Ethics requires you to comply with all institutional
guidelines, rules and regulations and with the tenets of the Code including ensuring that all
adverse events are reported promptly to the HREC. No changes are permitted in the research
without prior approval by the HREC except in circumstances outlined in the Code. The
HREC reserves the right to conduct compliance visit to your research site without previous
notification.



Your Ref: _____

Notice of Full Approval after Full Committee Review**EMPOWERMENT AND FERTILITY INTENTION AMONG MARRIED WOMEN OF REPRODUCTIVE AGE IN IFE EAST LOCAL GOVERNMENT AREA.**

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