# FEMALE AUTONOMY AND CHILDCARE PRACTICES IN SOUTH WEST NIGERIA

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DSS/11/0121

A RESEARCH PROJECT SUBMITTED TO THE DEPARTMENT OF DEMOGRAPHY AND SOCIAL STATISTICS, FACULTY OF HUMANITIES AND SOCIAL SCIENCES, FEDERAL UNIVERSITY, OYE-EKITI, NIGERIA

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF BACHELOR OF SCIENCE (B.Sc.) HONS IN DEMOGRAPHY AND SOCIAL STATISTICS

AUGUST 2015

## CERTIFICATION

This is to certify that AJIBADE TemiladeAdebola of the Department of Demography and Social Statistics, Faculty of Humanities and Social Sciences, carried out a Research on the Topic "Female Autonomy and Childcare Practices in South West Nigeria" in partial fulfillment of the award of Bachelor of Science (B.Sc.) in Federal University Oye-Ekiti, Nigeria under my Supervision

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## DEDICATION

This project is dedicated to the Almighty God, my everlasting Father, who in his infinite mercies spared my life from the beginning of this project till this present moment and has continuously been there for me.

Also to my hero, my dad, mentor, Mr. Adebayo Ajibade of blessed memory.

## ACKNOWLEDGEMENTS

I am grateful to the almighty God, my everlasting father, the beginning and the end who has known me and been with me since the day I was born till this present moment. If not for God I would not have made it this far. I give him glory for the successful completion of my first degree.

I express my sincere appreciation to my Supervisor and Head of Department, Dr. OluwagbemigaAdeyemi whose advice, supervision and criticism made this project a reality. Your efforts are highly appreciated.

My gratitude goes to all the lecturers in the department, Prof. Ogunjuyige, Dr. E.O. Adeyemi, Dr. Mrs L.F.C Ntoimo, Dr. E. K. Odusina, Mr. S.B. Shittu, Mr.B. Babalola, Miss C. Alex, and the entire staff, teaching and non teaching staff of the department.

My sincere appreciation also goes to my loving parents Late Mr. Adebayo Ajibade and MrsAdebisiAjibade. My guardians, Mr&MrsFajana.

My profound gratitude goes to my sister, my role model, my sister, my parent MrsAdeolaFajana, thank you for believing in me when everybody thought I couldn't do it. Thanks for making my dream a reality, thanks for standing by my through my hard times. May God bless and prosper your ways.

Appreciation also goes to my friends Ani Destiny, OlafisoyeOlamigoke, OladeleRotimi, Oyebode Paul, AdemolaOsinuga, Elijah Esther and all my course mates, u guys are the best.

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# ABSTRACT

The World Health Organization defines autonomy as the ability to make decision without being influenced by anyone else (WHO, 2013). Health is a state of complete physical, mental and social well-being of an individual. Low status of women seems to be closely related to the low nutritional status of children, not having the right to decide what your children needs to eat, when to eat, when to visit the health centre etc. (WHO, 2008). The 2013 Nigeria Demographic Health Survey (NDHS) data is being used for the analysis of this study. The target population for this study is women from age 15-49 years of age who are currently married which was collected by the Nigeria Demographic Health Survey (NDHS) 2013. Three levels of analysis were employed for the study at univariate, bivariate and multi variatelevels, also Chi-Square and Binary Logistic Regression were used to test the hypothesis. Mothers with high and average autonomy are more likely to give their children nutritious food, take them for immunization and have a good source of hygiene than mothers with low autonomy. Mothers who are working are 0.5% more likely to feed their children nutritiously compared to mothers who are not working. The study therefore suggests that women should be empowered and supported, early marriage should be discouraged.

# CHAPTER ONE

# INTRODUCTION

## 1.1 Background to the Study

Women empowerment has witnessed massive support since 1995 (Beijing Conference, 1995). In Nigeria, while women's active contributions in the social and economic sectors areevident,they are still restricted when compared to the men folk.Mason(1986) states that women's status is a measure on the expectations set by the society. Abadian (1996) describes status as the inequality in the power, prestige and control of resources related to men in the society.This suggests that achieving status does not necessarily reflect autonomy of a woman.Thus autonomy is a term more specific and amenable to empirical measurement (UN, 1987). It captures the capability or ability to achieve well-being, and in particular for this study well-being of mothers and children (Kabeer, 1999).

The World Health Organization(WHO, 2013)defines autonomy as the ability to make decision without being influenced by anyone else. Thisfacilitates access to material resources such as food, land, income and other forms of wealth, and social resources such as knowledge, power, prestige within the family and community. In addition, autonomy has a multi-dimensional aspect such as civil, political, social, economic, cultural participation and rights.Dyson and Moore (2004) defined autonomy or status as the ability to manipulate ones' personal environment as a basis for decision-making about personal concerns.Caldwell(2002) argued that gender inequality in the family level is manifested by a weaker role of women in decision-making and less control over resources and restrictions in physical movements by women. Women are seen as something that can be controlled without minding if they are fit with such situations and this is mostly common among the couples whereby decision is made by the

husband. Thehusband's dominance of the preferences over the wife's also tends to deteriorate if the womenhave greater autonomy among couples that have frequent communication (Masonand Smith, 2000).It is well recognized in the literature that children's well-being is linked to human capital development and long-term labour productivity (Alderman, Hoddinott, and Kinsey, 2006; Behrman, 1996; Pollitt, 1990; and Grantham-McGregor et al., 1999). Children that are well educated and healthy are essential to talent development and earning prospective of individual citizens and the society as a whole. Research also shows that there is strong relationship between children's health and development and their mother's health status and care giving activities (Ramakrishnan, 2002; Huffman et al. 1998; WHO, 2013; Smith et al., 2003). This study will examine the relationship between female autonomy and child care practices.

## 1.2Statement of the Problem

According to UNICEF, child malnutrition remains a major public health problem in developing countries where one third (178 million) of children under-five years of age are stunted (height-for-age below −2 standard deviation of reference values).Thirty-six countries with a stunting prevalence of 20% or more are located mostly in Africa and Asia which accounts for 90% of all stunted children worldwide; of the 52 countries with prevalence of less than 20%, majority of them are found in Latin America and the Caribbean with 16% prevalence(1,215).

Under nutrition encompasses stunting, wasting, and malnutrition in two forms: deficiencies of essential vitamins and minerals as one form, and with obesity or over-consumption of specific nutrients as another form (The Lancet, 2008:243-260). This is as a result of lack of decision making among women most especially when it comes to decision on contraception. The WHO (2008) explains health as a state of complete physical, mental and social well-being of an

individual.Low status of women has been found closely related to the low nutritional status of children

Approximately 10.5 million children less thanfive years of age worldwide die every year and 98% of these deaths reported to occur in developing countries (UNICEF, 2007). Mothers that are dependent in terms of decision making have their children in this category.Recent studies have focused on other psychosocial factors that may influence childhood nutrition, oneof such factor is maternal autonomy, defined as the level of independence in her actions and control over resources a mother has within her household.

## 1.3 Research Questions

i. Is there any relationship between women's socio-economic characteristics and child care practices in Nigeria?

ii. Does female autonomy have any significant effect on childcare practices?

## 1.4 General Objective

Thegeneral objective of this study is to examine if female autonomy has a significant effect on childcare practices.

### 1.4.1 Specific Objectives

The specific objectives are:

i. To determine if socio economic characteristics (age of mother, level of education, occupation, wealth index) influence child care practices; and,

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i. To determine if socio economic characteristics (age of mother, level of education, occupation, wealth index) influence child care practices; and.

ii. To examine if female autonomy (decision making, level of education, income, occupation) have a significant effect on childcare practices (nutrition, immunization, hygiene).

### 1.5 Justification of the Study

Female autonomy is a critical problem most especially in developing countries like Nigeria. Autonomy at the household level is very important for individualbehaviours and outcomes (Basu and Basu, 1991). Recent research has shown that household autonomy may be associated with a woman's ability to access health services for her children. A study in Gujarat, India found that approximately 50% of women interviewed did not feel free to take a sick child to a health care facility without prior approval from their husband or in-laws (Visaria, 1993).

Women's status refers to individual power available to women in order to control the circumstances that affect them.In several literatures, "autonomy" is often used as a term that refers to women's ability to determine events in their lives and enable to make decisions on their health or their families' health. In some developing countries like Nigeria, the fact that women have to face social and cultural disadvantages in a much broader sense than that experienced by women in developed countries is clearly reflected in their largely inferior health, nutrition, education and economic status compared to women in wealthy countries. A large number of women mainly in developing countries experience extreme stressresulting from their children's dead, disabilities and various diseases. (UNESCO, 2002).It has often been argued that child health and investments in children are determined by intra-household resource allocation decisions, which are associated to gender inequalities in the household. In families where women play an essential role in decision making, the proportion of family resources dedicated to the

children is greater in families where women play a less decisive role (Thomas, 1990; Duraisamy and Malathy, 1991; Bruce, Lloyd, and Leonard, 1995; Blumberg, 1991). Women autonomy has something to do with the health of the children and there is the need for it to be studied because it is affecting the key population which is the mothers and the children.

### 1.6 Definition of Terms

1. **Female Autonomy**: it is the act of being independent towards ones thoughts or actions.
2. **Childcare Practices**: is the caring for and supervision of a child or children aged 6weeks to age 13.
3. **Decision Making**: it is the act of choosing between two or more courses of action, it is also the process of problem-solving, it is about choosing between possible solutions to a problem.
4. **Nutrition**: is the science that interprets the interaction of nutrients and other substances in food.
5. **Immunization**: it is the process by which an individual immune system becomes fortified against an agent.
6. **Hygiene**: refers to behaviours that can improve the cleanliness and leads to good health such as frequent hand washing, face washing, access to clean water and soap etc.

# CHAPTER TWO

# LIERATURE REVIEW AND THEORETICAL FRAMEWORK

## 2.1 Literature Review

Studies have compared the perspectives of women and their husbandsonthe women's roles and the extent to which they have a voice of their own. In most of the earlierstudies, women's education and employment were used as alternative measures of women'sautonomy (Beegle et al. 2001; Mason 1987;Upadhyay and Karasek 2010). While these socio-demographic indicators are important, they may notcapture all aspects of autonomy and alsothey mayminimize issues related to power, argument, andnegotiation within the household (Jeffery and Jeffery 1997, Mistryet al. 2009).Itencompasses women's ability to create strategic choices, control assets and participate indecisionmaking. Some of the direct procedures of women's autonomy identified by researchersinclude access to resources and control over resources, partaking in economic decisions, self-worth,mobility, and liberty from domestic violence (Basu 1992, Bloom et al. 2001, KishorandSubaiya 2008).

In the literature on women's autonomy and reproductive health activities, women'sautonomy has been measured by women's involvement in decisionmaking, financialdecisionmaking, freedom of movement, exposure,self-confidence and attitudes toward violence etc. Althoughwomen's autonomy has been measured in many ways, studies have documented greater levelsof contraceptive use and lesser fertility rates among women with more autonomy (Dharmalingamand Morgan 1996, Hogan et al. 1999, Mason 1987, Woldemicael 2009). Women's status and autonomy appear to be among the mostessential explanatory factors in understanding women's reproductive behavior, including morecontraceptive use, lower

fertility, and fewer number of children desired (Balk 1994,Dharmalingam and Morgan 1996, Mason 1987).

A study using DHS data from four sub-Saharan countriesfound out that in two of the countries having unrestricted gender-role attitudes was associated withhaving a smaller ideal number of children (Jeffery and Jeffery, 1997). The overall review of the literature shows that fewstudies from sub-Saharan Africa have looked at the relationship between women's autonomy andtheir reproductive healthcare-seeking behavior.Alternative terms such as women's empowerment, female autonomy, women's position, gender inequality, access to and control over resources and prestige are all frequently used interchangeably in the literature to define women's status (Mason, 2001). Women's status has been examined by comparing women's position versus men's position aeross a range of socioeconomic and demographic factors (Kishor and Neitzel 2003) (Weinberger et al. 2005) (Safilios-Rothschild 1990; Jejeebhoy 2006).

There are a number of ways by which women's decisionmaking power might come to be associated with improved child health outcomes.

1. **Day-to-day health enhancing behavior:**Many actions that lead to better health outcomes emerge from day-to-day health enhancing behaviors, such as better personal hygiene, regular access to preventive treatments such as timely vaccination, and devotion of time to slowly spoon-feeding toddlers instead of leaving them chewing on a biscuit or bread. Many of these actions occur unconsciously and are often related to fundamental rules that households live by, rather than conscious decisions regarding allocation of time and money. While many factors besides gender empowerment affect these behaviorsin situations where women have control over time and money they may be able to make more efficient decisions leading to better health

outcomes for children than when decisions are controlled by men who then delegate these tasks to women.

2. **Intra-household resource allocation:** At any given income level, households must choose where their resources will be spent. Even for poor households, some implicit tradeoffs occur between quality of housing, food expenditure, health and education expenditure, purchase of large consumer durables, and personal consumption items such as tobacco and alcohol. Small scale qualitative studies document that households in which women have more power devote a greater proportion of resources to child-centered expenditures (Caldwell, 2009).

3. **Access to emergency care:** When children are seriously ill, all family members - men or women - may recognize the need to obtain medical care and will do so if they can afford it and if care is available. However, if the primary caregiver needs to consult with husbands and family elders, it is possible that the child will not receive immediate care.

## 2.2 Theoretical Framework

Social dominance theory argues that societies producing stable economic surplus contain three qualitatively distinct systems of group-based hierarchy:

(1) An age system, in which adults have disproportionate social power over children;

(2) A gender system, in which men have disproportionate social, political, and military power compared to women; and,

(3) An arbitrary-set system, in which groups constructed on "arbitrary" bases, that is, on bases not linked to the human life-cycle, have differential access to things of positive and negative social value. Arbitrary-set groups may be defined by social distinctions meaningfully related to power, such as (in various contexts) nationality, "race", ethnicity, class, estate, descent, religion,

or clan. Parallel trimorphic structures (based on age, sex, and coalitions) are found in chimpanzees, bonobos, gorillas, and baboons (Kawanaka, 1982, 1989; Nadler, 1988; Rowell, 1974; Strier, 1994). Such a social organisation may help primate societies transmit skills, knowledge, and ideas, while also transmitting roles and power. Although the trimorphic form of human societies is universal, the hierarchical severity of these three systems can vary quite dramatically across different societies and within a given society over time. There are substantial cultural and class differences in what ages are defined as "childhood" and whether marriage, sexuality, labour, and freedom are expected of or prohibited from children. There are radically different degrees of gender inequality across different societies (though no differences in form such that women dominate men). Definitions of arbitrary-set categories and the permeability of category boundaries also vary across societies and historical periods (Sidanius, Pratto, & Sawyer, 2001b).

Despite several structural and functional similarities among the age, gender, and arbitrary-set systems of group-based social hierarchy, social dominance theory argues that each system is qualitatively different, and hence one system cannot be regarded as merely a special case of another. Specifically, aside from their function in societal reproduction, there are three critical differences among these systems (Sidanius&Pratto, 1999; Sidanius&Veniegas, 2000): flexibility, level of violence, and focus. The age and gender systems have some flexibility as to who is defined as a "child" versus an "adult" and who is "male" versus "female". But the arbitrary-set system is distinguished by a very high degree of plasticity, both in terms of which group distinctions become socially significant and in the permeability of the group boundaries. Second, although coercion and violence are used to maintain the age and gender hierarchies, the degree of lethality associated with the arbitrary-set system is often orders of magnitude greater

than that associated with either the age or gender system. Arbitrary-sets are the only type of system in which total annihilation is found. That is, there are cases in which one clan or race or ethnic group has exterminated another. There are no known cases in which adults killed all the children, or men killed all the women, in a society. Finally, while by definition, the age system is focused on the control of children by adults, and the gender system is focused on men's control of women, social dominance theory argues that arbitrary-set hierarchy primarily focuses on the control of subordinate males by coalitions of dominant males. This, in fact, is a primary reason that arbitrary-set hierarchy is associated with extraordinary levels of violence.

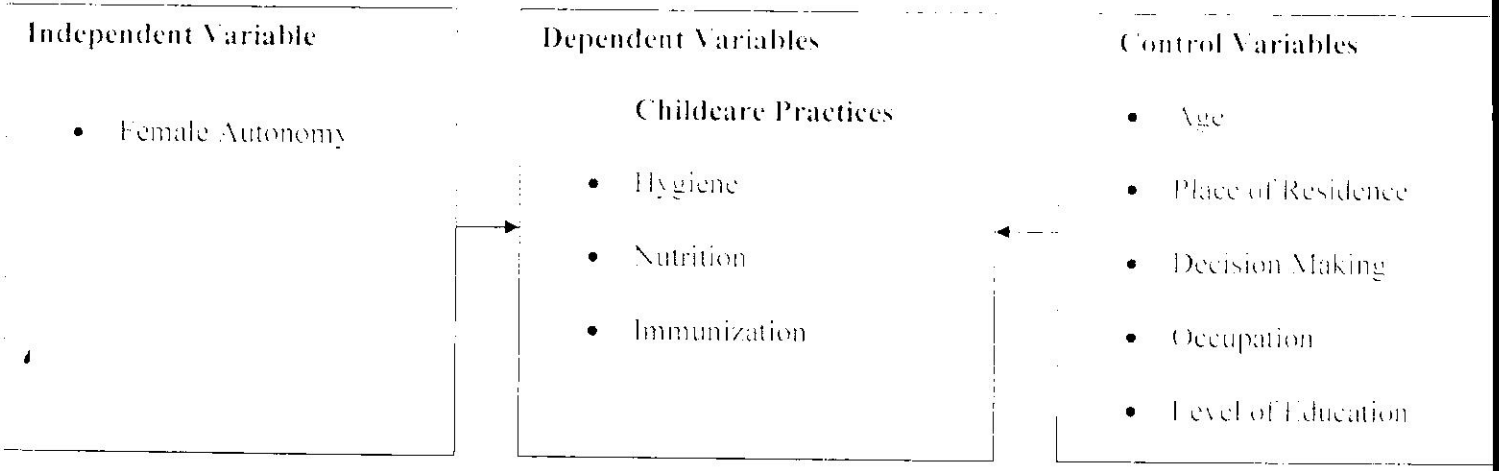
The masculine focus of arbitrary-set conflict can be seen in several ways. Men are the most frequent perpetrators of both lethal interpersonal violence (e.g., Archer, 2000; Daly & Wilson, 1988) and of intergroup violence (see Goldstein, 2001; Wrangham& Peterson, 1996). Indeed, collective violence ranging from military campaigns to gangs to lynchingsare almost exclusively instigated, organized, and controlled by men (Edgerton, 2000; Keegan, 1993). Equally important, men are not only the primary perpetrators of intergroup violence, but also the primary lethal targets. Even the widespread practice of raping enemy women during war often appears intended to dishonour and humiliate the rape victim's male relatives (United Nations, 2002).

This is not to diminish the suffering of women and children in arbitrary-set conflicts, which is often atrocious. Rather, it is to emphasize that violence in the gender and age systems may stem from arbitrary-set conflict (see United Nations, 2002). The male-on-male focus of arbitrary-set conflict can be seen in everyday forms of group discrimination as well. At the level of social stereotypes, Eagly and Kite (1987) found that negative national stereotypes are really differentiated stereotypes of men in those nations; stereotypes of women, regardless of their

nationality, reflect women's nurturing roles across nations. At the level of individual discrimination, the assumption that arbitrary-set prejudice primarily concerns men seems implicit in the fact that most studies of race discrimination use only men as targets (Correll, Park, Judd, &Wittenbrink, 2002). At the level of institutional discrimination, there is substantial cross-cultural evidence that men rather than women are the primary and most ill-treated targets of arbitrary-set discrimination across a range of domains, including the labour market, the criminal justice system, the housing market, and the retail market (Sidanius&Pratto, 1999). The thesis that both arbitrary-set violence and arbitrary-set discrimination are primarily male-on-male projects is known as the "subordinate male target hypothesis" (Sidanius&Pratto, 1999; Sidanius&Veniegas, 2000).

### 2.3 Conceptual Framework

This study seeks to examine the association between women's autonomy andChild care practices among women in South West Nigeria. Figure 1 shows the conceptual framework of the study. Variables of women's autonomy,which include participation in domestic decision making, level of education, level of exposure etc., are seen as determinants for child care.



*Source: Author's Construct*

## 2.4 Hypothesis

H0: There is no significant relationship between female autonomy and socio economic characteristics.

H1: There is a significant relationship between female autonomy and socio economic characteristics.

H0: There is no significant relationship between female autonomy and childcare practices.

H1: There is a significant relationship between female autonomy and childcare practices.

# CHAPTER THREE

# RESEARCH METHODOLOGY

## 3.0 Introduction

This chapter provides information on the background information of the study area, the sample size, method of sampling used, data collection technique, procedure for data analysis and field experience.

## 3.1 Description ofthe Study Area

The study area for this research is the south western part of Nigeria which comprises Lagos, Oyo, Osun, Ekiti, Kwara and Ondo states.It is majorly a Yoruba speaking area, although there are different languages even within the same state and it comprises of six different states which are; Lagos State ,Ogun State ,Oyo State ,Osun State,Ondo State and Ekiti State.The zone has a land mass of 76,852 square kilometers and population of 27.5million (NPC,2006). The zone controls 60 percent of the nation's industrial capacity, 44 percent of banking assets, 67 percent of insurance assets and is house to the nation's three deep sea ports of Apapa, Tin Can Island and Roro; the busiest international airport of Ikeja, three terminal stations of Igbin, Papalanto and Omotosho.The vegetation is Southwest Nigeria is made up of fresh water swamp and mangrove forest at the belt.

## 3.2 The Target Population

The target population for this study is women from age 15-49 years of age who are currently married. This was extracted from the Nigeria Demographic Health Survey (NDHS, 2013).

### 3.3 Data Source

The Nigeria Demographic Health Survey (NDHS, 2013) data isusedin this study. The survey is a nationally representative and was carried out at an interval of five years. It also provides up-to-date information on background characteristics of the respondents. Majorly information on health issues like fertility levels ,maternal health, domestic violence,child health status, adult and child mortality,and other health indicators related to women, men and children were also considered. The survey used samples of women between ages 15-49. Households in this survey were identified using a two-staged cluster design procedure based on type of place of residence: urban and rural.

### 3.4 Sample Design

The NDHS sample provided population and health indicator estimates at the national, zonal, and state levels. The sample design allowed for specific indicators to be calculated for each of the six zones, 36 states, and the Federal Capital Territory, Abuja.The survey sample was selected using a stratified three-stage cluster design consisting of 904 clusters, 372 in urban areas and 532 in rural areas. A representative sample of 40,680 households was selected for the survey, with a minimum target of 943 completed interviews per state.

### 3.5 Methods of Data Analysis

The analysis of the quantitative data was done using STATA 12.0 software and was done at three levels. Theunivariate analysis provided percentage distribution and frequency count of the socio-demographic characteristics of the respondents. The bivariate analysis involved cross tabulations of two or more variables. The chi-Square table was used to analyze some selected socio-

demographic characteristics and the dependent variable. The multivariate analysis involved using Binary LogisticRegression to analyze the effect of each level of the socio-demographic characteristics on the dependent variable.

# CHAPTER FOUR

# PRESENTATION AND ANALYSIS OF DATA

## 4.0 Introduction

This chapter presents the relevant socio-economic characteristics related to female autonomy and child care practices.

## 4.1 Presentation of Findings

The results of the analysis at different levels are shown in this chapter, which includes univariate, bivariate and multivariate analysis. The socio economic characteristics include age in 5year age group, level of education, religion, wealth index etc.

**4.1 Percentage Distribution of Socio Economic Characteristics of Respondents.**

| *Characteristics* | *Frequency* | *Percentage* |
|---|---|---|
| **Age** | | |
| 15-19 | 1133 | 19.48 |
| 20-24 | 848 | 14.58 |
| 25-29 | 973 | 16.73 |
| 30-34 | 892 | 15.34 |
| 35-39 | 794 | 13.65 |
| 40-44 | 605 | 10.40 |
| 45-49 | 570 | 9.80 |
| **Total** | **5815** | **100.00** |
| Level of Education | | |
| No education | 487 | 8.37 |
| Primary | 1081 | 18.59 |
| Secondary | 3218 | 55.34 |
| Higher | 1029 | 17.70 |
| **Total** | **5815** | **100.00** |
| **Place of Residence** | | |
| Urban | 4276 | 73.53 |
| Rural | 1539 | 26.47 |
| **Total** | **5815** | **100.00** |
| **Religion** | | |
| Christianity | 4038 | 69.58 |
| Islam | 1740 | 29.98 |
| Traditional | 25 | 0.43 |
| **Total** | **5803** | **100.00** |
| **Wealth Index** | | |
| Poor | 456 | 7.84 |
| Moderate | 773 | 13.29 |

| | | | |
|---|---|---|---|
| Rich | 4586 | | 78.87 |
| **Total** | **5815** | | **100.00** |
| **Level of Autonomy** | | | |
| Low | 861 | | 23.35 |
| Average | 469 | | 12.72 |
| High | 2358 | | 63.94 |
| **Total** | **3688** | | **100.00** |
| **Occupation** | | | |
| Not Working | 1582 | | 27.21 |
| Working | 4233 | | 72.79 |
| **Total** | **5815** | | **100.00** |
| **Immunization** | | | |
| No | 253 | | 18.40 |
| Yes | 1122 | | 81.60 |
| **Total** | **1375** | | **100.00** |
| **Hygiene** | | | |
| Unprotected | 3617 | | 62.20 |
| Protected | 2198 | 37.80 | |
| **Total** | **5815** | | **100.00** |

**SOURCE:NDHS 2013**

Age is an important demographic variable. It is very important in a research study and cannot be overlooked.Immunization was measured by the number of respondents that took their children forimmunization: nutrition was measured by categorizing the food the children were given into protein, carbohydrates, vitamins etc. while hygiene was measured with respondents source of drinking water. The table above shows the ages of the respondents and was grouped into 5yr age group in seven categories. Respondents in age group 45-49 have the lowest percentage of respondents with 9.80%, while age group 15-19 with the highest number of respondents with

19.48%.A large proportion of the respondents have secondary school education with 55.34%, while respondents that have the lowest number are respondents with no education with 8.37%.From the focus group discussion, more than half of the participants have secondary school education while just a few have higher education.

The numbers of respondents who live in urban areas are 73.53% which comprises of a larger percent while 26.47% live in rural areas.Most of the respondents are Christians with 69.58% respondents while 29.98% claimed to be Muslims.The result indicates that the largest proportions of the respondents are Rich with 78.87% while those who belong to the middle class have the larger proportion of respondents with 13.29% while the poor constitutes of 7.84% respondents.The numbers of respondents that are currently working are 72.79%. The number of respondents with high autonomy is the highest with 63.94%.Respondents that gave their children balanced diet have a higher number with 75.99%. Respondents that took their children for immunization are 81.60%. Respondents that have a good source of hygiene were 57.80%.

Focus group discussion was also carried out to support the above analysis and the respondents that were interviewed ranged between the ages of 32-45 years and comprises of more Yoruba and just two Ibos, the respondents were majorly Christians and they are all working (civil servants and self-employed).

## 4.2 Bivariate Analysis

Percentage Distribution of Immunization, Nutrition and Hygiene by Background Characteristics of the Respondents

| VARIABLE | IMMUNIZATION | | NUTRITION | | HYGIENE | |
|---|---|---|---|---|---|---|
| | No(%) | Yes(%) | No(%) | Yes(%) | No(%) | Yes(%) |
| Age in 5-yr groups | | | | | | |
| 15-19 | 19(46.34) | 22(53.66) | 49(4.32) | 1084(95.68) | 710(62.67) | 423(37.33) |
| 20-24 | 39(20.86) | 148(79.14) | 254(29.95) | 594(70.05) | 530(62.50) | 318(37.50) |
| 25-29 | 64(19.34) | 267(80.66) | 423(43.47) | 550(56.53) | 581(59.71) | 392(40.29) |
| 30-34 | 55(16.13) | 286(83.87) | 362(40.58) | 530(59.42) | 552(61.88) | 340(38.12) |
| 35-39 | 49(16.12) | 255(83.88) | 221(27.83) | 573(72.17) | 486(61.21) | 308(38.79) |
| 40-44 | 16(12.90) | 108(87.10) | 73(12.07) | 532(87.93) | 393(64.96) | 212(35.04) |
| 45-49 | 11(23.40) | 36(76.60) | 14(2.46) | 556(97.54) | 365(64.04) | 205(35.96) |
| Total | 253(18.40) | 1122(81.60) | 1396(24.01) | 4419(75.99) | 3617(62.20) | 2198(37.80) |
| | Pr=0.000 | | Pr=0.000 | | Pr=0.441 | |
| Level of Education | | | | | | |
| No Education | 94(44.55) | 117(55.45) | 146(29.98) | 341(70.02) | 383(78.64) | 104(21.36) |
| Primary | 80(20.20) | 316(79.80) | 309(28.58) | 772(71.42) | 764(70.68) | 317(29.32) |
| Secondary | 73(12.27) | 522(87.73) | 694(21.57) | 2524(78.43) | 1930(59.98) | 1288(40.02) |
| Higher | 6(3.47) | 167(96.53) | 247(24.00) | 782(76.00) | 540(52.48) | 489(47.52) |
| Total | 253(18.40) | 1122(81.60) | 1396(24.01) | 4419(75.99) | 3617(62.20) | 2198(37.80) |

| | | | |
|---|---|---|---|
| | Pr=0.000 | Pr=0.000 | Pr=0.000 |
| **Occupation** | | | |
| Not Working | 45(30.61) 102 (69.39) | 218(13.78) 1364 (86.22) | 985(62.26) 597(37.74) |
| Working | 208(16.94) 1020 (83.06) | 1178(27.83)3055(72.17) | 2632(62.18) 1601(37.82) |
| Total | 253(18.40) 1122(81.60) | 1396(24.01)4419(75.99) | 3617(62.20) 2198(37.80) |
| | Pr=0.000 | Pr=0.000 | Pr=0.953 |
| **Level of Autonomy** | | | |
| Low | 95(29.87) 223(70.13) | 365(42.39) 496 (57.61) | 571(66.32) 290(33.68) |
| Average | 31(18.90)133(81.10) | 200(42.64) 269(57.36) | 304(64.82) 165(35.18) |
| High | 113(14.09) 689(85.91) | 760(32.23) 1598(67.77) | 1444(61.24) 914(38.76) |
| Total | 239(18.61) 1045(81.39) | 1325(35.93)2363(64.07) | 2319(62.88) 1369(37.12) |
| | Pr=0.000 | Pr=0.000 | Pr=0.020 |
| **Wealth Index** | | | |
| Poor | 103(49.52) 105(50.48) | 133(29.17) 323(70.83) | 390(85.53) 66(14.47) |
| Moderate | 51(23.08) 170 (76.92) | 201(26.00) 572(74.00) | 597(77.23) 176(22.77) |
| Rich | 99(10.47) 847 (89.53) | 1062(23.16)3524(76.84) | 2630(57.35) 1956(42.65) |
| Total | 253(18.40) 1122(81.60) | 1396(24.01)4419(75.99) | 3617(62.20) 2198(37.80) |
| | Pr=0.000 | | |
| | | Pr=0.006 | Pr=0.000 |

**SOURCE: NDHS 2013**

The table above shows the percentage distribution of the dependent and independent variables of the study. The table shows that 54% of the respondents in age group 15-19 took their children for immunization, also 96% of respondents in this same age group gave their children a balanced diet and 37% had good source of hygiene.21% of respondents in age group 20-24 did not take

their children for immunization while 79% took their children for immunization. 30% of the respondents did not give their children a balanced diet while 70% gave their children balanced diet. 63% did not give their children good hygiene while 37% gave their children good hygiene.81% of the respondents in age group 25-29 took their children for immunization.57% gave their children balanced diet, while 40% had good source of hygiene.84% of respondents in age group 30-34 took their children for immunization. 59% gave their children balanced diet and 38% gave their children god hygiene. 84% of respondents in age group 35-39 took their children for immunization while 84%, 72% of the respondents gave their children balanced diet. 38% had good source of hygiene.87% of respondents in age group 40-44 took their children for immunization.88% gave their children balanced diet, and 35% gave their children good hygiene.77% of respondents in age group 45-49 took their children for immunization, 98% gave their children balanced diet, 36% had good source of hygiene.

From the table above, the respondents with no education that took their children for immunization are 55%, 70% of the respondents gave their children a balanced diet, 22% have good source of hygiene. Respondents with primary education that took their children for immunization are 80%, 71% gave their children balance diet, 29% have a good source of hygiene. Respondents with secondary education that took their children for immunization are 88%, 78% gave their children balanced diet, 40% of them have good source of hygiene. Respondents with higher education that took their children for immunization are 97%, 76% gave their children balanced diet, 48% have good source of hygiene.

69% of respondents that are not working took their children for immunization, 86% gave their children balanced diet, 38% have good source of hygiene. 83% of respondents that are working did not take their children for immunization, 72% gave their children balanced diet,

38% have a good source of hygiene.70% of respondents that have low autonomy took their children for immunization, 58% gave their children balanced diet.and 34% have a good source of hygiene.81% of respondents with average autonomytook their children for immunization, 57% gave their children balanced diet, and 35% have a good source of hygiene. 86% of respondents with high autonomy took their children for immunization, 68% gave their children a balanced diet, and39% had good source of hygiene.

These were supported by participants in the focus group discussion that was carried out.When asked who takes decision on household purchases, most of the respondents said they are the ones that take decision.

Respondent 1 said, *'Iam the woman of the house, he tells me what he needs and I get it for him'*.

When asked if they can go out alone or go out without their husbands' permission, all the respondents said they can go out alone but cannot go out without their husbands' permission.

Respondent 1 said, *'I tell him about my movements. He is the head of the family'*.

Respondent 2 said, *'he is the head of the home, so he knows my plans for the day and I know his own plans too'*.

Those that are poor that took their children for immunization are 50%,71% gave their children balanced diet, 14% had good source of hygiene.77% of respondents in the middle class took their children for immunization.74% gave their children balanced diet, 23% had good source of hygiene.90% of those that are rich took their children for immunization, 77% gave their children balanced diet, 43% had good source of hygiene.

Participants in the focus group discussion also confirmed the statements above. When asked if they read newspapers and magazines regularly, have a social media account, take part in public interest discussions or belong to any religious or secular community organizations to measure

their level of autonomy, most of the respondents said they listen to news, have social media accounts but don't really read newspapers and magazines. Most of them belong to religious organizations and few belong to other secular organizations.

Respondents 1 said, *'I listen to news regularly and read magazines and newspapers but not as a listen to news. I take part in public interest discussion and I belong to the global partners in church and also I have other secular organizations with friends at work and outside work'.*

Respondent 2 said, *'I listen to news, read newspapers and magazines once a while. I take part in public interest discussions. I belong to religious and secular organization'.*

When asked if they make decision on their own or would seek other people's opinion and who they would ask, most of the respondents said they can take decision on their own but will also seek opinion from other people like their husband, mother, sister and friend.

Respondent 1 said, *'I can make decision on my own but also need peoples advice and I would rather seek advice from my husband than any other person'.*

Respondent 2 said, *'I take some decisions on my own but will seek my husband and mother opinion'.*

To measure child care practices and hygiene, respondents were asked the following question in the focus group discussion.

When asked who takes care of their children when they are not around and who spends most time with the children them and their husbands, most of the respondents said they spend more time with their children the their husband and when they are not around, their husband, sister or mother.

Respondent 1 said, *'I have a house help and she takes care of the children if I am not around and I spend more time with my children than my husband'.*

Respondent 2 said, *'I spend more time with my children than my husband'.*

When asked how they prepare their children food and how often do they give their children fruits, most of the respondents said they prepare their food normally as every other person's food in the house and give them food occasionally.

Respondent 1 said, *I prepare my children food in the normal way with every other person's food. I give more children fruit less frequently'*

Respondent 2 said, *'once my child is over two years I start cooking their food with every other person's own but those that are less than two years I give them cereals, and cook their food separately and give them fruits frequently'*

### 4.3 Multivariate Analysis

**Logistic Regression Predicting the Interaction of Nutrition, Immunization and Hygiene of Respondents and Their Background Characteristics**

| Background Variables | Odd Ratio(P value) Immunization Model 1 | Odd Ratio(P value) Nutrition Model 2 | Odd Ratio(P value) Hygiene Model 3 |
|---|---|---|---|
| **Age group** 15-19(RC) | 1.00 | 1.00 | 1.00 |
| Age group 20-24 | 2.373 | 0.529 | 0.662 |
| | (0.066) | (0.020)** | (0.171) |
| Age group 25-29 | 1.824 | 0.765 | 0.792 |
| | (0.181) | (0.308) | (0.420) |

| | | | |
|---|---|---|---|
| Age group 30-34 | 2.110 | 1.038 | 0.654 |
| | (0.098) | (0.889) | (0.145) |
| Age group 35-39 | 2.165 | 2.031 | 0.740 |
| | (0.091) | (0.008)** | (0.304) |
| Age group 40-44 | 3.515 | 5.780 | 0.646 |
| | (0.015)** | (0.000)** | (0.141) |
| Age group 45-49 | 2.029 | 27.262 | 0.718 |
| | (0.223) | (0.000)** | (0.269) |
| **Education**(no edu)(RC) | 1.00 | 1.00 | 1.00 |
| Education(primary) | 1.545 | 0.981 | 0.925 |
| | (0.052) | (0.902) | (0.613) |
| Education(secondary) | 2.258 | 0.926 | 1.408 |
| | (0.001)** | (0.610) | (0.021)** |
| Education(higher) | 11.558 | 0.923 | 1.696 |
| | (0.000)** | (0.648) | (0.001)** |
| **Residence**(Urban)(RC) | 1.00 | 1.00 | 1.00 |
| Residence(rural) | 0.753 | 1.000 | 0.311 |
| | (0.224) | (0.998) | (0.000)** |
| **Religion**(Christianity)(RC) | 1.00 | 1.00 | 1.00 |
| Religion(Islam) | 1.110 | 0.984 | 1.080 |
| | (0.542) | (0.849) | (0.329) |
| Religion(traditional) | 0.924 | 0.902 | 1.333 |
| | (0.926) | (0.848) | (0.621) |

| | | | |
|---|---|---|---|
| **Wealth Index** (Poor)(RC) | 1.00 | 1.00 | 1.00 |
| Wealth Index (Middle) | 2.130 | 0.854 | 0.948 |
| | (0.002)** | (0.365) | (0.791) |
| Wealth Index(Rich) | 3.560 | 1.130 | 1.214 |
| | (0.000)** | (0.486) | (0.323) |
| **Autonomy** (Low)(RC) | 1.00 | 1.00 | 1.00 |
| Autonomy (Average) | 1.082 | 0.750 | 0.956 |
| | (0.767) | (0.027)** | (0.725) |
| Autonomy(High) | 1.426 | 1.010 | 1.063 |
| | (0.069) | (0.913) | (0.513) |
| **Occupation**(Not working)(RC) | 1.00 | 1.00 | 1.00 |
| Working | 2.023 | 1.509 | 1.134 |
| | (0.006)** | (0.001)** | (0.337) |

**SOURCE: NDHS 2013.RC** stands for Reference Category. **P Value**= 0.05.

The table above represents the result of logistic regression analysis of the relationship between female autonomy and childcare practices in three models. The three models are significantly associated in the multivariate model which contains the variables of female autonomy and background characteristics (age, level of education, wealth index, religion, place of residence, occupation, level of autonomy.) and childcare practices (immunization, nutrition and hygiene).

The table above shows that mothers aged 40-44 is 2.51% more likely to immunize their children compared to mothers aged 15-19(RC). Mothers with secondary education are 1.25% more likely to immunize their children compared to mothers with no education (RC). Also, mothers with

higher level of education are 10.5% more likely to immunize their children compared to mothers with no education (RC).

Mothers with middle wealth category are 1.13% more likely to immunize their children compared to mothers who belong to the poor wealth category (RC). Also, mothers with the rich wealth category are 2.56% more likely to immunize their children compared to mothers who belong to the poor wealth category (RC).Mothers who are working are 1.02% more likely to immunize their children compared to mothers who are not working (RC).The table also shows that, mothers aged 20-24 are less likely by 0.47% to feed their children nutritiously compared to mothers aged 15-19 (RC). Also, mothers aged 35-39 are 1.03% more likely to feed their children nutritiously compared to mothers aged 15-19 (RC). Mothers aged 45-49 are 26.2% more likely to feed their children nutritiously compared to mothers aged 15-19 (RC).

Mothers with high and average autonomy are more likely to give their children nutritious food, take them for immunization and have a good source of hygiene than mothers with low autonomy. Mothers who are working are 0.5% more likely to feed their children nutritiously compared to mothers who are not working.Mothers with secondary school education are 0.4% more likely to have good personal hygiene compared to mothers with no education (RC). Also, mothers with higher education are 0.69% more likely to have good personal hygiene compared to mothers with no education (RC).Mothers who are rural dwellers are 0.69% less likely to have good personal hygiene compared to mothers who are urban dwellers (RC).

### 4.4 Discussion of Findings

From the above analysis, female autonomy, decision making, occupational status, immunization, nutrition and hygiene were considered using qualitative and quantitative data. Immunization was

generated by how often the respondents took their children for immunization and nutrition was generated by the number of respondents that gave their children balanced diet and hygiene was generated using the source of drinking water for the respondents. All the variables have a significant relationship except age and occupational status which is not significant with hygiene.

It was discovered that in the study area, early marriage is common because respondents in age group 15-19 are more than respondents in the other age groups. Educational status is a very important variable which affects level of autonomy and also childcare practices but from the research carried out a larger number of respondents do not continue their schooling after they complete their secondary education because just a few have higher education. Most people now move from rural center to urban centre due to civilization and globalization, those that live in urban areas are more enlightened than those in the rural areas and take care of their children very well and also know how to combine foods on a daily basis to give a balanced diet and overcome under nutrition, a large percentage of those that were interviewed are rich which explains that they have money to take care of their children, buy good food for them, hire a nanny or house help to take care of the children when they are at work or when they are busy.

From the results above we can conclude that a large number of women have the ability to make decisions on their own without being influenced by people around them, it also shows that the rate at which women now have their independence, self-confidenceis growing at an increasing at a double rate than it used to be in the olden days, women are now allowed to work, visit friends, etc and not be the full house wife that used to exist in time past. Women are now being empowered and they now have a say in the family, among friends, society etc. Also, the numbers of women that are economically active and participate fully in the activities of the economy have increased drastically. Women are not seen as liabilities any longer. Women are

now conscious of their health and that of their children, the traditional ways of taking care of children are gradually going into extinction, and the mother-in-laws that enforce herbs and co on their daughter-in-laws have also reduced, even those in the rural areas now visit health centers frequently. It was found out from the research carried out those respondents in age group 15-19 have the least number of people who take their children for immunization and that those in age groups 15-19 and 45-49 have the highest number of respondents that give their children balanced diet.

Those that claimed to be Christians are much more in south west than other religion and those that say they are Christians are the ones that give their children balanced diet and are also the ones that take their children for immunization more than the other respondents that practice other religions.A large percentage of those that are rich give their children balanced diet and also a large percentage of those with high level of autonomy also give their children a balanced diet and also take their children for immunization.

# CHAPTER FIVE

# SUMMARY, CONCLUSION AND RECOMMENDATION

## 5.0 Introduction

This study set out to examine the relationship between female autonomy and childcare practices.The objectives were to determine if socio economic characteristics influence child care practices and to examine if female autonomy has a significant effect on childcare practices.

## 5.1 Summary of Findings

Socio-economicand demographic factors such as age of mothers, level of education, wealth index, place of residence, and occupation influencing female autonomy and child care practices were examined in this study. We observed that a significant relationship exists between all the variables.Focus Group Discussion was carried out to further explain the level of autonomy of women in south west Nigeria and the socio economic characteristics of the respondents and their effect on childcare practices. The Focus Group Discussion revealed that men are key players in influencing their wives, positively or negatively, directly or indirectly on their way of life, care of the children etc.

## 5.2 Conclusion

It was identified that a large number of the respondents have high level of autonomy. Also a large number of the respondents are economically active.They are working, which means they are exposed and can make decisions on their own. They also have a number of rich people is higher than those that are rich and poor which means that women are allowed to work and have savings and also come from rich background or have a rich partner.

Findings also showed that most of the respondents in the study area have high educational qualification ranging from secondary education to higher education to primary then no education. Educational status of women enhances and influences the quality of childcare practices. Place of residence also has a greater effect on childcare practices because most of those that live in the urban area take their children for immunization than those in rural areas.

### 5.3 Recommendations

Based on my findings, after analyzing the data on female autonomy and childcare practices, I hereby make the following recommendations:

- Women should be empowered and supported.
- Gender based violence should be prevented.
- Early marriage should be discouraged; women should be given the opportunity to choose who to marry and when to marry.
- Women should be allowed to make a choice of career and not what their parents want them to do or what their siblings or partners what them to do.
- Women should be allowed to study up till the level they want; even if they get pregnant they should be forced to continue schooling after giving birth to their children.
- Sex education should be taught to the girl child at early stages and contraceptives should be made available.
- An optimal model of an integrated gender-sensitive program and a long-term strategy for its implementation is lacking and needs to be developed.

- Women should be educated better on child care practices by the government and childcare policies that will guarantee proper and adequate childcare should be formulated and implemented.
- Society should mobilize support to put as much pressure on men as on women- research should identify the constraints on mobilizing men.
- Improvement should be made on the policies for gender equity and equality. Women should be allowed to participate actively in the economy.
- The sensitization of women on the importance of immunization for their children should be improved on.
- Childcare is seen as women's responsibility on our community but it should be noted that two ways are always involved: the father and the mother not the mother only.
- Men should also play a role in childcare practices. All members of the family assist the women and share the task of taking care of the children.
- Naturally women undertake the responsibility of the childcare. Therefore they have to create more time and see to proper and adequate care of their children especially during infancy and childhood days.
- Studies on female autonomy and childcare practices should be encouraged.

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