FACTORS ASSOCIATED WITH FERTILITY INTENTION AMONG WOMEN IN NIGERIA

BY

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CERTIFICATION

This is to certify that this research work, factors associated with fertility intention among women in Nigeria was carried out by **AGBELUSI KAYODE JOHN**, a undergraduate student of the department of Demography and Social Statistics, Faculty of Social Science, Federal University of Oye-Ekiti with Matriculation number **DSS/13/1487.**

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DEDICATION

The project is dedicated to the almighty God who granted me wisdom, strength and has led me thus far. He has made this project work possible. All glory belongs to him. I also dedicate this project work to my parents Elder and Mrs. Agbelusi for their love, care, affection, encouragement, financial and moral support. I pray that God supports you in your endeavors (Amen).

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I give glory to the almighty God for his mercy and love which he have sustained me in the course of my programme at the Federal University Oye-Ekiti.

I am extremely appreciative of my parents, Elder and Mrs. Agbelusi for their words of encouragement and financial assistance throughout my days in school. May the almighty God bless and grant you long life to reap the fruits of your labour. Amen.

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ABSTRACT

This work was designed to examine the factors associated with fertility intention among women in Nigeria. The research had two research questions. The design of the study was sample of the 2013 National Demographic and Health Survey. The research work followed suit through secondary data.

The study was analysed based on three levels which are the Univariate, Bivariate and Multivariate levels respectively. The univariate shows the percentage, bivariate shows the chi-square and multivariate shows the binary regression. A total of 37131 women were considered in this study.

Table 1 showed the socio-demographic and economic characteristics of the respondents in the study. The age of the respondents revealed that 36.5% which is the majority were within the age of 15-24 and 71.3% married. Respondents who resides in the urban areas were 40.2% while those who resides in rural areas were 59.8%, more than half of the respondents practiced Christianity while majority of the respondents had secondary education (51.9%, 36.6%) respectively. In terms of their fertility preference, 27.5% of the respondents desired not to have much children while 72.5% desired to have more.

Furthermore, 16.1% use contraceptives while 83.9% who do not use contraceptives were four times more than those who use contraceptives.

CHAPTER ONE

BACKGROUND TO STUDY

1.0 INTRODUCTION

The current population of Nigeria for year 2017 presently is 190 million based on the latest United Nations estimate. Nigeria population is equivalent to 2.55% of the total world population making it the eight populous nations in the world, and its policy makers are becoming increasingly concerned about its demographic profile and population dynamics. Nigeria is among the fastest growing countries and the most populated in the African continent which means it is a reference point of the population crises in Africa (United Nations 2010). Globally, Total Fertility Rate (TFR) as reduced drastically from 5 children per woman in the 50s to 2.6, and this decline is in part due to economic growth, social and cultural forces such as increased access to education by women (UNFPA, 2011).

Improved reproductive health care which includes the use of modern contraceptive methods to prevent unwanted birth also attributed to this decline especially in the developing world (Bongaarts, 1997; UNFPA, 2011). However, despite the observed decline, most countries in sub-Saharan Africa and some part of Asia still have very high fertility rates. Furthermore, Contraceptive Prevalence Rate (CPR) is low with corresponding high unmet need and unintended pregnancies among women of reproductive ages in these regions (UNFPA, 2011).

Fertility intentions indicate the plan to have a child, a plan that is confronted with individual's current situation. In modern societies, effective contraception is now widely available enabling couples to decide how many children they wish to have and when to have them. Fertility intention incorporates plan for action and may be more responsive to personal circumstances and constraints. In Nigeria, there is high level of fertility rates despite numerous reproductive and health programs which aims to decrease high level of fertility. In recent times, there is an increasing body of literature on the role of women in family planning.

These studies came about as a result of the inconsistency observed in women's inability to match fertility intention despite the fact that most family programs have been concentrated on women. The fertility level in a country is generally regarded as high when fertility level is above five children per woman (United Nations 2009). Nigeria, a country with an average rate of high fertility (NDHS 2013). Contraceptive use is one of the major factors that determines fertility.

An analysis of 22 Latin America, Asian, and African countries between the periods of 1970 to 1990s made use of the world fertility survey (WFS) and demographic health survey (DHS) data. The authors found that increased change in contraceptive use is partly influenced by fertility intention. The concept of fertility intention as a determinant of contraceptive use has had its share of criticism. The critics argued that respondent may not have taken into accounts the effects of social pressure especially from family members as it relates to their stated intention.

It is well known that males exert considerable influence on female's reproductive decision (castle et al, 1999). Fertility intention is a bit different from fertility desire. Fertility intention is what you are planning to have, while that of desire is what you want to do. Fertility intention may not correspond with future fertility outcomes at the individual levels, they do provide information regarding the future course of fertility (Bongaarts 1992). There are other proofs gathered across the world and over several decades also indicates that this assumption is reasonable (Bankole and Westoff, Bongaarts 1992).

There are other evidences on importance of fertility intentions other than those from demographic researches, literatures of social psychology support a strong relationship between individuals plan for future fertility and their response reproductive behavior's. The importance of fertility intention as it may influence behavior was also supported by the theory of reasoned action (TRA) by Martin Fishbein and Icek Ajzen in 1975. These theories postulate that a person's behavior is influenced by his or her intention which is determined by three predictors: attitudes, subjective norms and perceived behavior control. (Ajzen and Fishbein, 1975: Ajzen 1980 as cited in Miller 1995). The importance of involving men in reproductive and health issues in Nigeria is

also buttressed by the evidences that male in Nigeria are the domineering forces in fertility decisions in household (Abanile 1994).

In the area of demography, fertility intentions and the closely related construct of fertility expectations have long been viewed as indicators of fertility decision made and therefore, as potentially important predictor of fertility (Hendershot & Placek, 1981; Ryder & west off 1971; Forest & Singh, 1990). When a woman decides to pursue a particular fertility goal such as getting pregnant or avoiding a pregnancy, this desires are major source of his or her child bearing intentions, which represent what the individual actually plans to do.

1.1 PROBLEM STATEMENT

The Total Fertility Rate (TFR) is 5.5 children per woman in Nigeria (NDHS, 2013). This is considered high and is attributed in part to low use of contraceptives in Nigeria (United

Nations, 2009). In the last three decades, most of the family planning interventions have focused on unmet needs of women. As such, a response to such assumption is the great investment by stakeholders on developing various modern contraceptive methods for few women (Westoff and Bankole, 1995).

In recent times, there is an increasing body of literature about the role of men in contraceptive use (Bankole et al, 2009; Oye-Adeniran et al, 2005, Odu et al, 2006). These studies came about as a result of the observed women's inability to match their reproductive intention despite all the focus on them (Dodoo, 1998).

These studies acknowledged that men in developing regions such as in the Sub-Saharan Africa make most of the decisions that shape family formations and as such, the assumption that the use of contraceptives and pregnancy prevention are domains for women alone is only painting the picture from one perspective. The evidence mismatch in the fertility intention and fertility outcome of women is because of the great influence that men have on family decision. Since the women are influential when it comes to

decision making in households, there is a need to focus studies on women especially with regards to their contraceptive use.

The reason for this is because ambivalence in women's fertility intention is evident and fertility levels continue to be high. Therefore, if male reproductive intention often dominates females the understanding of how men fertility intention is vital to fertility outcome in households. Social pressure also is one of the major problems of fertility intention, women have an increased probability to have another child when there is social pressure from relatives and friends. Studies have shown that those who begin child bearing early and those who begin late have increased odds for unmet fertility intention. Also women with low levels of education, from poor households, rural residents as well as those who experienced child death were at a higher risk of unmet fertility intention.

1.2 RESEARCH QUESTION

- What is the fertility intention of women of reproductive age in Nigeria?
- What are the determinant of fertility intention of women of reproductive age in Nigeria?

1.3 RESEARCH OBJECTIVES

The general objective of the study is to examine the fertility intention of women reproductive age and the determinant of fertility intention of women in Nigeria.

The specific objectives are as follows:

- To describe the fertility intention of women of reproductive age.
- To examine the determinants of fertility intentions.

1.4 SIGNIFICANCE OF THE STUDY

Fertility intention are known to reflect subsequent fertility reproductive age, therefore understanding this fertility intention therefore could help in planning strategies to modify fertility intention. This study will contribute useful information in planning future family strategies in Nigeria and other interventions program.

CHAPTER TWO

LITERATURE REVIEW

2.0 INTRODUCTION

This chapter presents review of factors that are associated with fertility intention among women in Nigeria, theory of planned behavior (TPB) and the relevance to the present study and the conceptual frame work that guides this study.

Intentions have a long and significant history in the field of fertility research. In the area of family planning, unintended pregnancies have been the focus of considerable interest because the all-too-common unwantedness of the ensuing pregnancy often imposes burdensome consequences on both the parents and the child itself (Brown & Eisenberg,1995; Santelli et al., 2003). In the area of demography, fertility intentions, and the closely related construct of fertility expectations, have long been viewed as indicators of fertility decisions made and, therefore, as potentially important predictors of future fertility (Hendershot & Placek, 1981; Ryder & Westoff, 1971; Forrest & Singh, 1990).

A survey in the united states in 2002 found that overall women who reported religion as ''very Important'' in their everyday lives had a higher fertility than those reporting it as important or Not important. For many religions, religiosity is directly associated with an increase in the intention to have children. This appears to be the main means by which religion increases fertility. For example, catholic couples generally have intentions to have more children than Jewish couples who in turn generally intend to have more children than protestant couples.

Catholics generally achieve their intended number of children. Among Catholic's increased religiosity is associated with the intention to have more children while increased religiousness among protestant is associated with intention to have fewer children. Parent's religiosity is positively associated with their children's fertility; therefore, more religious parents will tend to increase fertility. Since couples have the possibility to decide upon their fertility levels, this allows for the analysis of readiness and intention to have children at various points of the life cycle.

A theory which may be used to study such factors is the Theory of Planned Behavior (Ajzen & Fishbein, 1969; Ajzen, 1991; Fishbein & Ajzen, 2010), used for underlining the link between beliefs and behavior. According to this theory, human behavior is the result of the interaction between a person's behavioral, normative and control beliefs. In order to assess the impact of these three categories of beliefs on behavior, intention is measured as a function of attitude towards behavior. Demographers study fertility intention for at least two reasons (Philov 2011).

First, they use fertility intentions to help predict fertility rates in a given Population. Early research suggested that these predictions tend to be quite accurate at themacro level, realized fertility rates were found to correspond quite closely to mean family size intentions (e.g. Bumpass and westoff 1969, hagewen and Morgan 2005, schoen, astone, Kim, and nathauson 1999, mishler, and Kelly 1957). For example, in the 1930s, the mean intended family size is a sample of about 300U.S couples was 2.7, twenty years later the actual family size was 2.6 (westoff et al 1957).

In a later study (Bumpass and westoff 1969) mean desired family size among couples with 2 children and 3.3 and actual completed family size was also total fertility rates are higher among women in rural areas than among women in urban areas. In the rural areas, women tends to have more children than in the urban areas.

2.1 Influence of Religion and culture on fertility intention

A survey in the united states in 2002 found that overall women who reported religion as 'important' in their everyday lives had a higher fertility than those reporting it as important or not important. For many religions, religiosity is directly associated with an increase in the intention to have children. This appears to be the main means by which religion increases fertility. For example, catholic couples generally have intentions to have more children than Jewish couples who in turn generally intend to have more children than the protestant couples. Catholics generally achieve their intended number of children.

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Muslim scholars have allowed birth control methods under these conditions; birth control methods should be used with both parties concept, the method should not bring permanent sterility and should not otherwise harm anybody (Yusuf Al-Qaradawi & Muhammad 2004). The view of different religion concerning fertility intention among Islam and Christian denominations has seriously damaged the work of World Health Organization (WHO) in some fields because of failure by members to agree as to the desirability of certain methods of family limitation (Campbell, 1960).

Also studies have shown that women's fertility intention fairly forecast subsequent fertility behavior of such a woman hence intentions must be taken seriously

and come in useful for policy formulation and strategies for achieving fertility target (Poo and Nai, 1994, Schoen et al 1999, Kodzi et al 2010). The desire and intention to have children among women is influenced by different factors such as socio-cultural factors, economic factors, and the availability of family planning.

Sub-Saharan Africa has the highest average fertility rate in the world. In 2009 the average number of birth per woman was 5.1 almost as twice as many as in south Asia (2.8) (World Bank 2009). Nigeria is a country where agriculture is the major economic activity, around 64% of the country's population live in rural areas, and families often prefer large numbers of children since they are considered as economic assets. In rural areas parents also want to have large number of children to get assistance in farming activities.

Like many countries in sub-Saharan Africa, traditional norms and values in Ethiopia favor high fertility. Having many children is considered as a virtue and an act of respect of God in a number of Ethiopian rural communities (Desta & Seyoum 1998). With a population of about 83 million, Ethiopia is the second most populous country in Africa. The population is increasing at a rate of about 2.5% per annum. Fertility in Ethiopia has declined modestly over the past decade. Like many other African countries, Ethiopia has so far shown little change in fertility. Between 1990 and 2005, the total fertility rate of Ethiopia declined steadily from 5.5 in 2000 to 4.8 children per woman of reproductive age (Ethiopian demographic health survey 2011).

Apart from the increase in fertility, the large variation in fertility between rural and urban areas and between regional states in Ethiopia calls for attention. According to the 2005 Ethiopia demographic and health survey (EDHS) fertility in rural Ethiopia is nearly two and half lines greater than in urban centers (6.0 versus 2.4). among the nine regional states and two city council administration under the federal government of Ethiopia, Oromia region has the highest fertility rate of about 6.2 children per woman, while Addis Ababa has a below replacement level fertility of 1.4 children per woman (Ethiopian demographic health survey 2011).

According to a study conducted in Nyanza province, Kenya on the desire to delay or cease child bearing, out of all, only two participant wanted to delay pregnancy for at least two years or have no more children. Of note the women who desired a child within the next two years were both nulliparous. Of 16 women who desired a future pregnancy, over half wanted to delay the pregnancy for 4-10 tears. Several main themes emerged around participants to delay or cease child bearing as their fertility intention.

Ethiopian women want an average about four children, while Ethiopian men want about five children. Women living in the rural areas desire more children than women living in urban areas (4.5 versus 3.7) women with more than secondary education desire fewer children than women with no education (3.3 versus 5.0) (Ethiopian demographic and health survey 2011).

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2.2 FACTORS INFLUENCING FERTILITY INTENTION.

In sub-Saharan Africa decision related to contraceptives use and the timing and number of births are influenced by men. The ability of women to control their fertility is a precondition to fertility transition. Women require autonomy to make decision in controlling their fertility. Moreover, differences in the socio-economic and demographic characteristics of couples contribute to differences in reproductive preferences. For instance, the difference in age between a husband and a wife is a determinant of

reproductive preference among couples. Family planning programs will have a higher probability of success if they focus on couples, but previously most of them focused on women. Scattered evidence demonstrate that involving couples in reproductive health programs makes a difference (Biruk & Michelle 2007).

To date, studies have shown that cultural affiliation may affect fertility by influencing women's desire for children. On the other hand, studies of the fertility intentions among HIV positive individuals have found ambivalence and produced mixed results, while some studies report HIV positive women as having a strong desire to have children, consistent with the high social value placed on children. The relative strength of these conflicting feelings varies according to individuals and contextual factors, for instance unmarried women express more confidence in their ability to stop child bearing than married women who in many context reports pressure from husbands to have children (Cooper et al 2007).

People who do not know their sero-status but suspect they are having disease may modify their desire for children in response to fears about the disease. The limited evidence about this topic has identified a relationship between the perceived risks of contracting, but the directions and magnitude of this effect remain unclear. Indeed subjective assessment of HIV risk have been shown to be correlated with increased fertility intention is some setting (yeatman 2009); whereas other studies suggest that perceived HIV risk is not associated with the desire for additional children (Moyo & Mbizvo 2004).

For women, the desire for children is determined by social and personal expectations, another most important demographic attribute is the availability of information on the number of living children has manifold implication for almost everybody, specifically for women. As in the study conducted in Mumbai, the indication are that about 13% of the respondent did not want to have a child in spite of the regular counselling. Some of them expressed a desperate need to have a child especially if they had no live children. The various reasons given by them include old age, security, and lineage, being free of the charge of being infertile, and leaving something of themselves behind after their death.

The women who desired to have children were more likely to be married or to have a partner (84%) than those who did not (64%). The men who desired children were no more likely to have had an opposite sex partner than were the men who did not desire children. The percentage of men who identified themselves as bisexuals has somewhat greater among those who desired more children (23%) than among those who did not (18%). Women who desired children were more likely to have a partner of unknown status (32%) than were women who did not desire children (14%) (Ranjans 2006).

According to a study conducted in Nyanza province, Kenya, on the desire to delay or cease child bearing, the participant cited health care providers as influences on their reproductive intentions more often than they mentioned family or other community members. Provider counselling attributed to a range of understanding of the risks associated with infectious diseases in pregnancy; infection possibly depending on the state of human health (Elizabeth et al 2009).

The study in Addis Ababa indicated that the population of women in the age group 18-29 or 30-39, being married or in a relationship with secondary education and above, with no children or one or two children and a partner who wanted children (p0.05) on the other hand the disclosure of a person's sero-status to the partner or spouse was associated with less desire for children (Teman w 2006). Of the respondent in the age group 18-29, those who were married or in a relationship and who had no children were more likely to desire children (Teman w 2006).

The average population growth of most sub-Saharan Africa countries is well above 2.5% with a doubling time of less than 30years. Family planning services have become the intervention to show the intervention of slow population growth (Zewdu et al 2003).

The available literature shows that the relatively high level of fertility that is still being experienced in Africa, especially in sub-Saharan Africa has chiefly to do with the combination of cultural and socio-economic factors which determine the propensity of people to procreate.

In this view, the high fertility rate of the population is attributed to low cultural values favoring large family size, slow socio-economic development and a high infant and child mortality rate. The high incidence of fertility reflects the fact that the production starts early, the age at first marriage is young (Zewdu et al 2003).

Lumani (2014) argued that traditional African society is constructed in such a way that high fertility and large surviving families have usually been economically active and socially rewarding in contrast to modern societies. In this context African societies may offer resistance to contraceptive use and fertility control.

2.3 The theory of planned behavior

In the theory of planned behavior (TPB), intention relates to the expected effect of interest and is thus closely associated with fertility intention it predicts the incidence of certain behavior provided that the behavior is intentional. The intentions therefore the antecedent of behavior, the very precise the person is on the expressed intention to perform the corresponding desire to give birth, the more likely it is that the intention will be realized after a certain stage period, as compared to less certain intentions (Miller and Pasta 1995; Thompson & Brandreth 1997). Succinctly, according to the TPB, the intention to have or not have a child is obstinate by three manner of contemplation (Ajzen & Klobas, 2013). The first is termed behavioral beliefs, it refers to the perceived positive or negative consequences of having a child and the subjective values or evaluations of these consequences.

The impact behavior beliefs has to do with the perceived expectations and behaviors of important referent groups combined with the person's motivation to adhere with the referents in question. Furthermore, the assumed to formulation of a positive or negative attitude towards having a child. In addition to, control beliefs are concerned with the perceived presence of factors that influences a person's ability to have a child. Together with the perceived control or self-efficacy (Bandurz 1997) in relation to having a child.

2.4 Definition of key concept variables

Subjective norm- an individual's perception about the particular behavior, which is influenced by the significant of others e.g. parents, spouse, friends, teachers.

Control beliefs- an individual beliefs about the presence of factors that may facilitate or hinder performance of the behavior. The concept of perceived behavioral control is conceptually related to self-efficacy.

2.5 Importance of TPB on fertility intentions among women

According to the TPB'S principle of compatibility, any well-defined intentions and goal can serve as a criterion for study as long as attitudes, subjective norms and perception of control are assessed with respect to exactly the same criterion in as much a detailed description of nature of the three predictors of intentions are provided (Ajzen 2005). As a general in the attitude and subjective norm with respect to having a child and the greater perceived control, the more likely is that a person will from an intention to have a child.

Fertility intention are expected to result in having or not having a child to the extent that people are in fact capable of attaining their goals. However, the goals of having a child involves a specific action and target and often also a specific context of perceived control which in regards measured and manipulated fewer use of any intention.

2.6 THEORETICALFRAMEWORK

2.6.1 Intentions and Motivation

In order to fully understand fertility intentions it is first important to consider the central role that they play in the process through which fertility motivations produce fertility behaviors in humans. In previous work, I have characterized this process in terms of a traits-desires-intentions behavior sequence (Miller,1994;Miller&Pasta,1995a). In this sequence, motivational traits are conceptualized as latent dispositions to be positively or negatively motivated toward fertility-related experiences, including everything from pregnancy and birth, through child care and child rearing, to interacting with one's partner,

family, and friends in the community as a parent. Motivational traits like these are the major source of child bearing desires (Miller,1994), which represent what the individual would like to do about having or not having a child. When the individual decides to pursue a particular fertility goal, such as getting pregnant or avoiding a pregnancy, those desires are the major source of his or her child bearing intentions, which represent what the individual actually plans to do. Such intentions then lead to instrumental behaviors that are meant either to achieve or avoid the goal of child bearing. In summary then, the TDIB sequence characterizes the process through which latent motivations enter consciousness in the form of specific desires, which then generate specific intentions, which in turn lead to goal-related behaviors.

The TDIB framework proposes that conscious intentions, and the conscious desires that underlie them, derive their motivational force from a system of latent dispositions (traits) that I have called a motivational substrate (Miller&Pasta,2002). Elsewhere, I have described how this substrate consists of neural based nurturant schemas (Miller&Rodgers,2001), which themselves have complex genetic and experiential origins (Milleretal.,1999;Milleretal,2000;Miller,1992). The motivational dispositions that are resident in that Substrate have two important features.

First, they vary in intensity, which accounts for much of the strength of the desires and intentions that flow from them. Second, and more important forth is discussion, they differ in their valence, that is to say, in whether they are positive or negative. These two features correspond to the theoretical model of emotion and motivation developed by Lang, Bradley, and Cuthbert (1998). These authors argue that there are two basic motive systems in the brain, appetitive and defensive, and that each can vary in terms of intensity of activation or arousal. According to Cacioppo, Gardner, and Bertson (1999), the appetitive and aversive (defensive) motivational systems are not reducible to a single valence or good-bad dimension because they are not necessarily reciprocally activated in there levant brain structures. They conclude that two unipolar dimensions, with one varying from high to low positive valence and the other varying from high to low negative valence, fit the observed facts better than a single bipolar dimension, which varies from a high positive to a high negative valence.

In accord with the two dimensional approach to motivational valence, I have developed a measure of explicit child bearing motivation, the Child bearing Questionnaire (CBQ), that separates motivational traits into separate positive and negative components (Miller,1995). Positive Child bearing Motivation (PCM) is based on respondent ratings of 27 positive consequences of having a child, where as Negative Child bearing Motivation (NCM) is based on respondent ratings of 20 negative consequences of having a child. Of particular interest for this discussion and in line with there being two separate dimensions of motivational valence, PCM and NCM tend not to be significantly correlated with each other. Given a sample of sufficient size, it might be anticipated that there would be one group with high PCM and low NCM-those motivated for child bearing-and one group with low PCM and high NCM-those motivated against child bearing. But, infact, there would also be a group with both high PCM and high NCM-those ambivalently motivated for child bearing-and an other group with both low PCM and low NCM- those in differently motivated for child bearing (Miller,2007).

The two unipolar dimensions of motivational trait sex tend their influence forward through the next three steps of the TDIB sequence to find expression in desires, intentions, and behavior. Thus in the formation of desires individuals with high PCM will tend have strong desires to have a child, where as those with high NCM will tend to have strong desires not to have a child. Further, as might be expected, those who are ambivalently motivated will tend to both desire and not desire a child and those who are in differently motivated will tend not to care one way or the other. When it comes to the formation of intentions, the effect of two separate valences changes because intentions involve a decision and a commitment to action. Cognitively, these two features make it virtually impossible to both intend to have a child and intend to not have one, although one might find a few instances where extremely ambivalent individuals vacillated in their intentions across relatively short periods of time.

2.6.2 Conception Oriented Behaviors

When it comes to extending the two motivational valence dimensions all the way to behavior, a further transformation occurs due to the instrumentality of behavior.

Whereas the TDI component of the TDIB framework is related to the motivational push toward the goal (having or avoiding having a child), the B component has to do with real-world implementation of behaviors that achieve that goal. Congruent with the two motivational dimensions, there are two types of instrumental behaviors that are meant to implement the goal, namely proceptive and contraceptive behavior.

Proceptive behavior (Miller, 1986; Miller & Pasta, 1995a; Miller & Pasta,1996) is behavior that is designed to achieve conception. In terms of both the underlying strength of positive motivation and the probability of achieving conception (Miller,1986), it has two forms: passive proception, characterized by the initiation of unprotected sexual intercourse with the intent to conceive; and active proception, characterized by efforts to increase the chances of conception by timing sexual intercourse around the time of ovulation, as well as by other, related behaviors.

In contrast, contraceptive behavior is designed to avoid conception while continuing to have sexual intercourse and makes use of a variety of hormonal, mechanical, and behavioral methods to achieve that goal. In terms of the underlying strength of negative motivation and the probability of preventing conception, contraceptive behavior has many forms. These can be graded along two primary continua: the effectiveness of the method used and the regularity with which that method is used (Miller & Pasta, 2002).

Even more so than is the case with intentions, the two types of conception-oriented behaviors tend not to be present in the same individual at the same time. It would be highly unusual for someone to be simultaneously behaving in a way that both lead to conception and avoided conception, although as in the case of desires it may happen that someone vacillates between these two behaviors during a some short time interval, especially if the individual is involved with two different partners. This mutually exclusive feature of conception-oriented behaviors suggests that they may be placed on a bipolar continuum that extends from a highly effective proception pole through a middle point that involves neither proception nor contraception to a highly effective contraception pole.

Indeed, both Lang, Bradley, and Cuthbert (1998) and Cacioppo, Gardner, and Berntson (1999) argue that the exigencies of motor systems and reality constraints both act to channel multi dimensional motivational systems into bipolar one-dimensional behavioral expression. Thus a bipolar conceptualization of conception-oriented behaviors seems entirely appropriate. At the same time, it is important to keep in mind the bi dimensional nature of the underlying motivational traits that push individuals toward each of the two behavioral poles. We know, for example, that the desire not to get pregnant is driven primarily by NCM (Miller & Pasta, 2002) and the desire to have a child is driven primarily by PCM (Miller,1994).

2.6.3 Intensity across the TDIB Sequence

An important feature of conception-related behaviors is that the irantecedent intentions are generally stronger, that is to say have greater intensity, than the behavior itself. This is because both proception and contraception require effort which commonly means that some of the motivational intensity gets dissipated between the behavioral intention to act and the act itself. In addition, there are usually disincentives that act to deter the carrying out of intentions. Such disincentives are easies to identify in the case of contraceptive behaviors, which are almost inevitably associated with a variety of method side effects. Further, the need for behavioral consistency in order to achieve the intended goal can itself become a disincentive. This is also true of proceptive behavior, as is commonly reported by sub fertile couples whom us repeatedly try to time sexual intercourse in order to conceive. A complementary feature of conception-related behaviors is that some fact or so perate to strengthen them even in the face of relatively weak intentions. Examples include internal factors such as personality traits that support plan fullness and external fact or such as having a partner with strong intentions.

Desires, in turn, are generally stronger than their corresponding intentions. This is because, unlike intentions, desires do not require a decision and a commitment to act. As a result, they are more expressive of the underlying motivations and less constrained by what is possible and practical. For example, Miller and Pasta (2002) found that respondents from a sample of mostly unmarried, contracepting couples who were attending family planning clinic to request a pregnancy reported that their desires not to

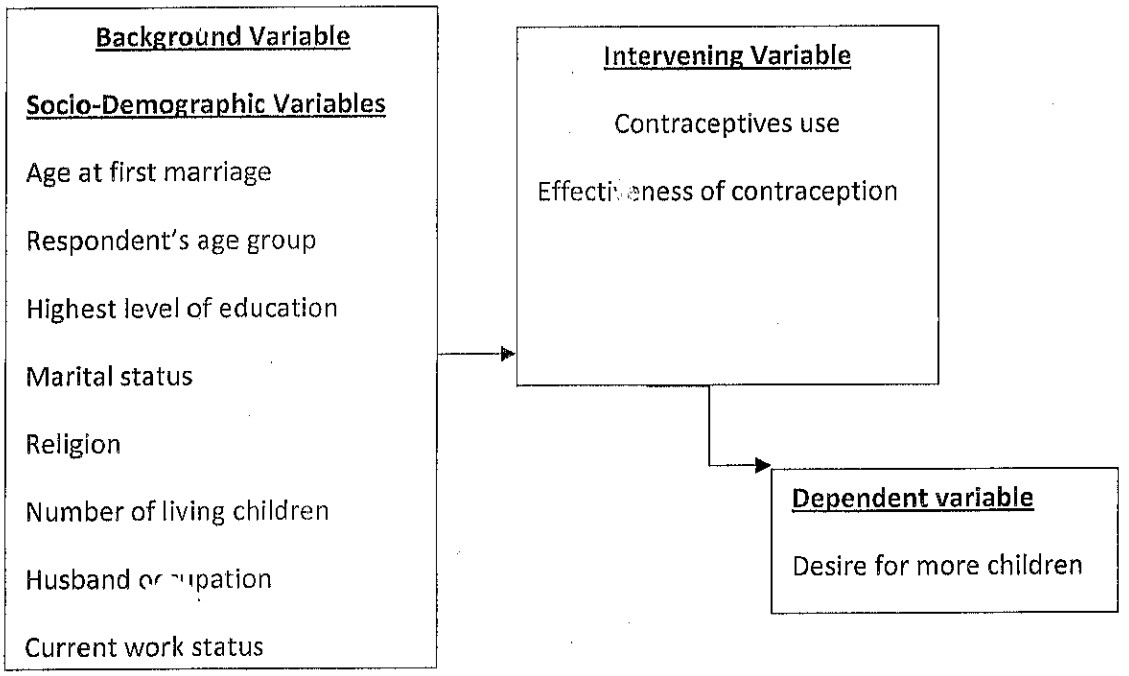
get pregnant were stronger during the previous three months than were their actual intentions not to get pregnant. At the other end of the motivational spectrum, Miller and Pasta (1994) found that respondents from a sample of married couples who were yet to have children wanted their first child sooner than they actually intended to have it.

The intensity of motivational traits may be greater than that of the desires that they generate, especially if one compares positive motivations with the desire to have a child and negative motivations with the desire not to have a child. However, the translation between motivational traits and desires is complicated by a number of factors.

One factor is the stability of motivational traits, which tend to endure across long periods of time. For example, Miller (1995) found that the correlation of PCM with itself across three years was about 0.70 for both husbands and wives who were yet to bear a child at the time of the first measurement. Other research (Miller & Pasta, 1995b) indicates that actual child bearing probably accounted for a sizeable portion of the remaining variance in PCM during the three year interval. Another complicating factor is that implicit motivational traits, which are unconscious and rooted more in the individual's genetic make-up and early life experience (Miller & Pasta, 2000), are much more stable than the self-reported, explicit motivational traits, such as PCM and NCM. A final factor is that motivational traits are relatively general dispositions, whereas desires tend to be closely tied to personal context and influenced by other considerations such as gender role, relationship quality, income, and age. For all of these reasons, the intensity of motivational traits has a less predictable relationship to that of desires.

2.7 Conceptual framework

In line with reviews, is predicted that fertility desire and other selected background variable may be conceptualized as factors that have influence on fertility intention among women in Nigeria. Below is a conceptual frame work adopted for this study by the researcher.



The figure above adopted from the TPB (theory of planned behavior) model. The figure above describes the effect of independent variables on the dependent variable. The independent variable are the socio-demographic characteristics factors (age at first marriage, respondent age, highest level of education and current work status etc.).

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.0 Introduction

This chapter focuses on the various methods, techniques and procedures used in conducting this research. It provides important information on the following data sources, variables and measurement, data analysis and study population.

3.1 Research design

This research was a cross sectional study which made use of secondary data obtained from 2013 Nigeria demographic and health survey (NDHS) individual women recode data set.

The sample of the 2013 NDHS is nationally represented and covers the entire population residing in the country. The sample of the 2013 NDHS was designed to provide population and health indicator estimates in the country. The sample designed allowed for specific indicators, such as Nigeria women and information about their fertility intention.

Nigeria is divided into states, and each states is subdivided into local government areas (LGA), furthermore, during the 2006 population census, each locality was divided into convenient areas called census enumeration (EAs). The primary sampling unit (PSU) referred to as a cluster for the 2013 NDHS, is defined on the basis of EA's from the 2006 EA's census frame.

3.2Study location

The study location is Nigeria, were by the fertility intention of women in Nigeria will be focused on using the 2013 NDHS data. Nigeria came into existence as a geographic or political entity in 1914 following the amalgamation of the northern and southern protectorates by the British colonial authorities. The country obtained independence from the British colonial rule in 1960 and has since passed through various political and economic metamorphoses. The Nigeria federation presently comprises 36 states and the

federal capital territory, the states are in turn grouped into six zones namely the North East, North West, North Central, South East and South South.

3.3 Study population

The population is drawn from 2013 NDHS, it comprises of women in union, married or living together in the reproductive ages 15-49 years interviewed from the 2013 Nigeria demographic and health survey.

3.4 Sampling size and Sampling techniques

The sampling size used for this study, drawing from the 2013 NDHS was 1,551 women of ages 15-49, who are in union or married residing in Nigeria at the time of the survey. The 2013 NDHS national sample was selected using a stratified three stage cluster design consisting of 5,874 women with 4,323 in urban areas and 1,551 in rural areas. In each state, the number of households distributed proportionately among the urban and rural areas. A complete listing of households and a mapping exercise were carried out for each cluster from December 2012 to January 2013 with the resulting list of household serving as the sampling frame for the selection of households in the second stage. All regular households were listed. The national population commission were trained to use the global positioning (GPS) receiver to take the coordinate of the 2013 NDHS sample cluster.

3.5 Data collection methods

The population census of 1973 was not acceptable and was therefore cancelled. Since then, there have been considerable improvement in data collection process NDHS (2013). The women's questionnaire was administered to all women aged 15-49 in every second household in 2013 NDHS sample. All aspects of the NDHS data collection were pretested in November 2012. In addition to, collection of such sensitive information requires the establishment of good communication between the interviewer and the respondent. In due process, interviewers were provided with specialized training on how to obtain information on fertility intention of Nigeria women to enable the field agents to collect data in a secure confidential and ethical manner.

3.6 Methods of data analysis

Stata 12 will be employed for the analysis. This study conducted analysis at three levels. The first level is uni-variate analysis followed by bivariate analysis and multivariate analysis. This three levels of analysis are:

- Univarite descriptive analysis will be done to show the frequency distribution of the selected characteristics of the study population and their fertility intention and background characteristics such as, highest level of education, current work status, age at first marriage, religion etc.
- The chi-square test will be carried out to examine the association between the fertility intention and the selected characteristics of the respondent.
- Binomial logistic regression will be conducted to examine the determinant of fertility intention among women of reproductive age in Nigeria.

MEASUREMENT OF VARIABLES

VARIABLES	DESCRIPTION	MEASUREMENT
Desire for more children	Nigeria women whether pregnant or not were asked about their intentions to have another child. V605 was used to code for desired for more children and was categorized as follows 1- Wants within 2 years 2- Want after 2+ years 3- Wants, unsure timing 4- Undecided 5- Wants no more	For this study, desire for more children was categorized into 4 categories: 1- Wants within 2years 2- Wants after 2+years 3- (wants, unsure timing and undecided) are recoded as undecided 4- Wants no more

Other selected background variables		
Highest educational level	Education categories refer to the highest level of education attained by women in Nigeria. NDHS used v106 to code for the highest education level and was categorized as follow: 0- No education 2- Primary 3- Secondary 4- Higher	For the purpose of this study, highest educational level was therefore categorized into three category: 0- no education 1- primary 3- post-primary education (secondary and higher education)
Religion	Religion of respondent was coded as v130 by DHS and was categorized into 4: 1-catholic 2-other Christian 3-Islam 4-Traditionalist 5-no response	With respect to this study, religion of respondent was categorized into 3: 1-Islam 2-Christian (catholic and other Christian) 3-Traditional
Age of women	Respondent information on age was nominal variable and was obtained by asking all ever married women or in union their current age as at the time the survey was conducted. However the DHS use v103 to measure age of Nigerian women categorized from age group	The DHS categorization was used for this study

	of 15-49, 20-24, 25-29, 30-34, 35-39, 40-44, and 45-49.	
Age at first marriage	Age at first marriage is defined as the age at which the respondent began living with her first spouse. DHS used v511 and categorized it in single age 10-37 years of Nigeria women	This study thus recode and categorized age at first marriage into two categories; 1-<_20years 2-20 years plus
Marital status	Marriage is a primary indication of women's exposure to the risk of pregnancy; therefore, is important for an understanding of fertility. Marital status was coded with v501 and categorized into 6: 0-Never in union 1-married 2-living with partner 3-widowed 4-Divorced 5-No longer living together or separated.	This study only considered married and living with partner, following the drop of other categories. 1-Married 2-living with partner
Household wealth index	Information on household assets is used to create the wealth index, an indicator of household economic status, v190 was coded for wealth index by DHS and was	Wealth index was re-coded and re-categorized into 3; 1-poor(poorest and poorer) 2-middle 3-rich(richer and richest)

	categorized into 5; 1-poorest 2-poorer 3-middle 4-richer 5-richest	
Number of living children	The number of living children includes the current pregnancy for women, it provide information on variations in the potential demand for fertility control. DHS used v218 to code and was categorized into 17 categories; Starting from 0-16 children born by each respondent.	With regards to DHS coding, this study therefore re-categorized number of living children into 3; 1-Had 0-2 children 2-Had 3-4 children 3-Had 5+ children
Current work status	Information on current work status of Nigeria women was categorized into 3, v714 was used to code for the variable 0-Not working 1-Yes working 9-missing value	This study therefore categorized work status into 2; 0-unemployed 1-employed

CHAPTER FOUR

DATA PRESENTATION AND INTERPRETATION

4.0 Introduction

This section presents the basic characteristics of the respondents in the NDHS 2013 data set. This is necessary because the information derived assist in explaining the fertility intention among women in Nigeria. Additionally the description aids in the analysis of other variables of this study. Variables considered in this section are age, education, religion, occupation, marital status, and wealth index. Chi-square test was used to test for the association between some selected predictors and fertility preference among women in Nigeria.

4.1: social- demographic characteristics of the respondents

Table 1. Socio-demographic characteristics of respondents		
Variables	**Frequency**	**Percent**
Age		
15– 24	13542	36.5
25 – 34	12019	32.4
35+	11570	31.1
Marital Status		
Single	8862	23.9
Married	26485	71.3
Widowed/Divorced/Separated	1784	4.8
Place of residence		
Urban	14914	40.2
Rural	22217	59.8
Religion		
Christian	18823	51.9
Islam	17801	48.1
Traditional	35	1.0

Level of Education		
No formal education	13,227	35.6
Primary	6,764	18.2
Secondary	13,579	36.6
Tertiary	3,561	9.6
Employment Status		
Not Working	13,322	35.9
Working	23,809	64.1
Wealth status		
Poor	13516	36.4
Average	7,542	20.3
Rich	16,073	43.3
Decision		
Wife	696	2.6
Husband	13,349	50.5
Joint decision	12,387	46.9
Contraceptive Use		
No	31,348	83.9
Yes	60,230	16.1
Children Ever Born		
0	10497	28.3
1-4	15382	41.4
5+	11252	30.3
Number of Living Children		
0	10903	29.4
1-2	9301	25.0
3-4	8394	22.6
5+	8533	23.0

Source: NDHS, Female, 2013.

Socio-demographic and Economic Characteristics of the Respondents

A total of 37131 women were considered in this study. Table 1 showed the socio-demographic and economic characteristics of the respondents in the study. The age of the respondents revealed that 36.5% were within the ages of 15-24, 32.4% of the respondents were within the ages of 25-34, while 31.1 % of the respondents were 35years and above. The majority of the respondents are married with 71.3%, 23.9% of the respondents were single, while 4.8% of the respondents were widowed/divorced as at the time of study. The respondents who resided in the urban areas were 40.2% while those who resides in rural areas were 59.8%.

Also, the religion of the respondents revealed that more than half of the respondents practiced Christianity with 51.9%, 48.1% of the respondents practiced Islam, less than 1.0% of the respondents were traditionalist. The level of education of the respondents revealed that majority of the respondent's 36.6% had secondary education, 18.2% of the respondents have primary education, 35.6% of the respondent's spouses have no education, while 9.6% of the respondent's spouses have higher education. Furthermore, the employment status of the respondents revealed that 35.9% were not currently working, while those that are currently working 64.1% were about two times more that those not currently working.

On the basis of wealth status, most of the respondents 43.3% were rich, compared to 36.4% and 20.3% of the respondents who were poor and rich respectively. From the table, it revealed that 50.5% of the household decision is from the husband followed by the joint decision with 46.9% while 2.6% of the decision is from the wife. As regards the respondent's contraceptive use, 16.1% of the respondents use contraceptive, while those who does not use contraceptive 83.9% were four times more than those who use contraceptive.

Furthermore, the larger proportion of the respondent had 1 - 4 children ever born with 41.4%, followed by 5+ the 30.3% while 28.3% of the respondent had never had life birth. Also, the table revealed that 29.4% of the respondent no living children followed by

25.0% with 1-2, 23.0% with 5+ and 22.6% with 3- 4 number of living children respectively.

4.2 Fertility Intention among the Respondents

The table below revealed the fertility behaviour among the respondents. From the table the fertility intention among women which was measured in terms of their fertility preference. 27.5% of the respondents desired not to have more children while 72.5% of the respondent desired to have more.

Table 2. Showing fertility intention among the Respondents		
Fertility Intention		
	Frequency	**Percent**
No	10196	27.5
Yes	26935	72.5

Source: NDHS, female, 2013.

4.3 Bivariate Analysis

Table 3: Pearson Chi-Square test of association between some selected predictors and Fertility intention among women in Nigeria				
	Fertility Intention			
Variables	**No**	**Yes**	**χ^2 Value**	**P value**
Age				
15–24	11.1	46.1	0.000**	9.6e+03
25 – 34	19.9	37.1		
35+	69.0	16.8		
Marital Status				
Single	9.3	29.4	0.000**	2.4e+03
Married	80.0	68.0		
Widowed/Divorced/Separated	10.7	2.6		

Religion				
Christian	56.4	48.8	0.000**	221.8456
Islam	42.2	50.4		
Traditional	1.4	0.8		
Level of Education				
No formal education	36.5	35.2	0.000**	630.4149
Primary	25.4	15.5		
Secondary	28.9	39.5		
Tertiary	9.1	9.8		
Employment Status				
Not Working	20.5	41.7	0.000**	1.4e+03
Working	79.5	58.3		
Wealth status				
Poor	33.5	37.5	0.000**	50.3067
Average	21.2	20.0		
Rich	45.3	42.5		
Place of residence				
Urban	41.80	39.6	0.000**	15.6306
Rural	58.2	60.4		
Decision				
Wife	4.7	1.7	0.000**	475.7802
Husband	41.8	54.4		
Joint decision	53.8	43.9		
Contraceptive Use				
No	77.3	86.5	0.000**	468.9192
Yes	22.7	13.5		
Children Ever Born				
0	10.5	35.0	0.000**	6.5e+03
1-4	28.7	46.2		
5+	60.8	18.8		

Number of Living Children				
0	10.8	36.4	0.000**	7.9e+03
1-2	9.4	31.0		
3-4	29.2	20.1		
5+	50.4	12.5		

Source: NDHS female, 2013.

** denotes p-value<0.01, * denotes p-value<0.05, No symbol refers to no significant association.

Table 3 above shows the relationship and the statistical extent to which women's socio-economic and demographic characteristics influences their fertility intention in Nigeria. Showing the characteristics of women by educational level, age, place residence, marriage type, wealth status, religion, marital status, contraceptive use, employment status, children ever born and number of living children. Study revealed that educational level of the respondents is positively correlated with fertility behaviour since the p-value was less than 0.01 also, age, religion, level of education, employment status, wealth status, place of residence, contraceptives use, children ever born and number of living children of the respondents all displayed a p-value less than 0.01 thus denoting significant correlates with fertility intention.

Table 4: Binary Logistic Regression showing the strength of association between Fertility Intention and selected demographic and economic characteristics.

Variables	**Odd ratio**	**95% CI**	
		Lower	**Upper**
Age			
15– 24(RC)	1.0000	--	--
25 – 34	0.7654**	0.6652	0.8806
35+	0.1638**	0.1420	0.1888

Level of Education			
No formal education(RC)	1.0000	--	--
Primary	1.0133	.9167	1.1200
Secondary	1.1343*	1.0108	1.2729
Tertiary	1.1406	0.9752	1.3342
Religion			
Christianity (RC)	1.0000	--	--
Islam	1.8183**	1.6697	1.9799
Traditionalist	1.1238	0.8342	1.5140
Employment Status			
Not Working (RC)	1.0000	--	--
Working	0.9263	0.8522	1.0068
Wealth status			
Poor (RC)	1.0000	--	--
Average	0.8570**	0.7782	0.9439
Rich	0.7156**	0.6429	0.7967
Place of Residence			
Urban (RC)	1.0000	--	--
Rural	1.0524	.9695	1.1425
Decision			
Wife (RC)	1.0000	--	--
Husband	1.7935**	1.4748	2.1814
Joint decision	1.6992**	1.4042	2.0561
Contraceptive Use			
No (RC)	1.0000	--	--
Yes	0.4687**	.4270	0.5144
Children Ever Born			
0 (RC)	1.0000	--	--
1-4	0.8215	0.5318	1.269071
5+	0.5672*	0.3616	8896594

No of Living Children			
0 (RC)	1.0000	--	--
1-2	1.2079	0.8050	1.8123
3-4	0.3856**	0.2576	0.5772
5+	0.2358**	0.1557	0.3571

*Source: NDHS female, 2013.*** denotes p-value<0.01, * denotes p-value<0.05 No symbol refers to no significant association.

The binary logistic table above revealed the extent of association between the dependent variable and selected demographic and economic variables such as age level of education, religion, employment status, wealth status, place of residence, decision, use of contraceptive, children ever born and number of living children. However, marital status of the women was removed from the model due to the presence of collinearity. The logistic regression analysis of women fertility intention and selected socio-demographic and economic correlates of fertility preference among women in Nigeria. The odds were 76% lower for women aged 25-34, while the odd were 16% lower for women age 35years and above with their probability value (P<0.01), implying that as age of women increases, they are more likely to increase their fertility desire as they keep growing.Also, The odds of women who had primary education was about 1% higher with probability value (P>0.05), compare to women whose have no education, the odds were about 1% higher with probability value (P<0.05) for women who had Secondary education, while the odds were about 1% lower with probability value (P>0.05) for women who have higher education, compared to women who have no education implying that women who are more educated tends to desire less number of children. However, the odds of women practicing Islam is about 1% higher with probability value (P<0.01), compare to women practicing Christianity; the odds of women who were traditionalist was 1% higher than those in the reference group, this implies that religion tend to influence women desire for more children. Employment status of women is found to be related to fertility intention as the odds of currently working women is about 92% lower with probability value (P>0.05), compare to women not working. The wealth status of women was also strongly related with fertility intention. The odds were 85% lower for women in the average

category with probability value (P<0.01), compared to women in the reference group, while the odds were about 71% lower for women in the rich category implying that as women get richer, there fertility Intention reduces. The residence of the women also suggest that the odds of fertility intention among women living in rural areas is about 1% higher with their probability value (P>0.05) compared to women living in urban areas. the table also revealed that decision making of the respondents is strongly correlated with fertility intention, the odds ratio of women that their husband decide for is about 1% higher compared to wife decision, the odds were 1% higher for women who makes joint decision with their husband with probability value (P<0.01), This implies that family decision tends to influence fertility decision in the family. The odds of fertility intention among women who uses any form of contraceptive is 46% lower compared to those in the reference group which implies that uses of contraceptives tend to influence fertility behaviour.

Furthermore, the table also revealed that decision making of the respondents is strongly correlated with fertility intention, the odds ratio of women that their husband decide for is about 1% higher compared to wife decision, the odds were 1% higher for women who makes joint decision with their husband with probability value (P<0.01), This implies that family decision tends to influence fertility decision in the family. The odds of fertility intention among women who uses any form of contraceptive is 46% lower compared to those in the reference group which implies that uses of contraceptives tend to influence fertility behaviour. The odds ratio women who ever had 1 to 4 number of live birth is about 82% lower with probability value (P>0.05), compared to women with 0 number of live birth, while the odds of women who had 5 and above number of live birth is about 56% lower compared to women at the reference category with probability value (P<0.05), in the reference group. This implies that number of children ever had can influence the desire for more children.

Finally, from the model, number of living children was also related to fertility intention of women, the odds ratio women who have 1 to 2 number of living children is about 1% higher with probability value (P>0.05), compared to women with 0 number of living children, the odd ration of women with 3-4 number of living children is about 38%

lower with probability value (P<0.01) compared with the reference category. While the odds of women 5 and above number of living children is about 23% lower compared to women with probability value (P<0.01), in the reference group. This implies that number of living children influences the desire for more children.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This study provides how to establish and understand the factors associated with fertility intention among women in Nigeria. This chapter provides the summary of the findings, discussion of the findings, conclusion of the findings from the research and references.

5.1 Summary of the findings

The first objective of this study was to ascertain the number of women who are in their reproductive ages. A total of 37131 women where considered in this study, majority of the respondent are married with 71.3%, 23.9% of the respondent were single, while 4.8% of the respondent were widowed or divorced at this time of study.

Respondent who resided in the urban area as at the time of this study were 40.2%, while those who resides in rural areas were 59.8%.

The second specific objective of this study was to examine the determinants of fertility intention in Nigeria. The findings indicated religion, employment and wealth status determines fertility in Nigeria.

Furthermore, the findings also indicated that 72.5% of the respondent desired to have more, 8.0% of the respondent fertility intention are undecided while 19.5% desired not to have more.

5.2 Conclusion

The main purpose of the study was to access the factors associated with fertility intention among women in Nigeria. The research therefore conclude that religion, employment status and wealth status are major factors associated with fertility intention.

5.3 Recommendations

To increase the rate of fertility transition in Nigeria there is need to intensify governmental and non-governmental family planning programs targeted at women who want more children. Doing this will guarantee increased uptake and continued usage of family planning with respect of reducing women's fertility intention. Findings in this study call for further research which should preferably include a large proportion of qualitative based study to fully understand other factors associated with fertility intention among women in Nigeria.

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