

## **CHAPTER ONE**

### **INTRODUCTION**

#### **1.1 Background Information**

The world's escalating growth rate is such that the fulcrum slants disproportionately towards the less developed countries. The dramatic increase in the population of the World from 2.5 billion people in 1950, to 4.1 billion in 1990; 4.9 billion in 2000; and 6.3 billion in 2003 (United Nations, Population Reference Bureau PRB) is widely believed to contribute significantly to the poverty and deprivation experienced by many countries. This is connected with the fact that it has diluted and dissipated the potentially salutary effects of national and international efforts to promote economic development and alleviate poverty. On the African scene, the general demographic profile of the continent indicates that the population of Africa has been growing at a faster rate than that of any other continent in the world.

Currently, the region's average annual rate of natural increase is 2.4% (PRB, 2010) and with a population growth rate of 2.4 % per annum (PRB 2010), Nigeria is one of the fastest growing countries in the world and the most populous in Africa and; therefore, is at the centre of Africa's population crisis. The 1991 Population Census results of the Nigerian federation, published by the National Population Commission in April 1998, gave the country's numerical strength as 88.99 million (National Population Commission; 1998) and by 2005 the population of Nigeria had grown to 141 million. As at 2008, Nigeria's population was estimated to be 148 million, and was placed 10th in the record of the world's largest countries for the same year. Recently 158.3 million as at mid 2010 and placed 8th in the record of the world's largest countries, Nigeria would be the 6th largest country in the world by the year 2050 with predicted population of 289 million (United Nations, PRB 2010). If nothing were urgently done to reverse this trend. This phenomenon does not augur

well for the region and particularly Nigeria because, for example, its output does not increase that fast (Chuks 2002).

It is universally accepted that unchecked population growth exacerbates and accentuates social and economic problems and that; it will be extremely difficult, if not impossible, to solve any of the social, economic, political, and cultural problems if population growth is not stabilized (World Bank, 1994; USAID, 2004).

An encouraging trend however has been the strengthening of political commitment to population-related policies and family planning programmes by many governments (UNFPA, 2004). The awareness of the socio-economic consequences of rapid population growth has led some of the African countries to formulate and implement several programmes and policies designed to influence undesirable population trends. For example, the Nigerian government's recognition of the negative effects of rapid population growth culminated in the promulgation of the 1988 Population Policy (Federal Government of Nigeria, 1988) and subsequent reviews in 2004 (Federal Government of Nigeria 2004). One major component of the 1988 policy document is the specification of a set of targets, which demonstrates a strong interest of the government to fundamentally change the reproductive behaviour of Nigerians. In particular, a vital aspect of the targets is to *"reduce the number of children a woman is likely to have in her lifetime, then over six, to four per woman..."* (Federal Government of Nigeria 1988:14).

Unfortunately, over the years, emerging issues such as HIV/AIDS, poverty, gender inequality, among others, gained wider recognition. This necessitated a review of the 1988 National Population Policy, giving way to the National Policy on Population for Sustainable Development launched in February 2005. This policy recognizes that population factors, social and economic development, and environmental issues are irrevocably interconnected and critical to the achievement of sustainable development in Nigeria. However, it has no ceiling on the number of children per couple; but places onus on Nigerians to decide on the number of children they would love to have based on their ability to cater for their needs. Its strategies do not sufficiently recognize the role of men in influencing Nigeria's population

growth rates. Concerns are that the provisions made by this policy might not be sufficient to significantly reverse the present population trend in the country (Mba 2002).

Desire for large family size, as well as, poor utilization of various modern methods of contraception and family planning options in developing countries is mainly responsible for the rapid population growth experienced (Konje and Ladipo 1999). The general profile of contraceptive technology in Nigeria shows that in 2006 only 6 % of married women within reproductive age group in the country were using any contraceptive method and; by 2008, 14.6 % were using any form of contraceptive (NDHS 2006, 2008). Even though this indicates some level of increase in contraceptive uptake, it still points to the fact that uptake is still relatively low.

Observations show that men in Africa and indeed Nigeria play significant roles in decisions relating to family size and family planning. Husband's approvals are major determinants of family planning uptake among couples (Moronkola, Ojediran, and Amosu, 2006). However, in many developing countries, men are little involved in their partners' health care during pregnancy and infant and child care is almost exclusively a woman's realm in virtually every culture (Linda, Richter and Robert; 2003). Rouw (2002) reported that traditionally, in many low and middle-income countries, men do not participate in Reproductive or Maternal and Child Health care with their partners. Fathers do less parenting and housework than their wives (Coltrane, 2000). The inadequate male participation witnessed has been cited as one of the reasons for poor family planning service uptake (Rouw, 2002).

It is in recognition of these that the programme of action adopted by the International Conference on Population and Development (ICPD) held in Cairo 1994 notes thus:

Special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behavior, including family planning; pre-natal, maternal and child health; prevention of Sexually Transmitted Diseases (STDs); and prevention of unwanted and high-risk pregnancies'.

-Findings from previous studies suggest that childcare is associated with increased financial, psychological, work and time related cost. This, beyond being considered by many a major cause of parental stress and worry, influences the likelihood for smaller family size ( Parker and Alexander 2004; Hossain and Roopnarine 2004).

The aim of this study is therefore to test the assumption that men's active involvement in early child care influences their fertility-related decisions and behaviours; specifically in the areas of their desired family size, and contraceptive intentions and behaviors.

### **1.2 Statement of Problem**

Nigeria is one of the fastest growing countries in the world and the most populous in Africa and; therefore, is at the centre of Africa's population crisis. If population growth is not urgently stabilized, Nigeria's population (which yields 15% of the African region's total) will translate to mean that out of every 6 or 7 Africans, one would be a Nigerian. It will therefore be extremely difficult, if not impossible, to solve any of its social, economic, political, and cultural problems (World Bank, 1994; USAID, 2004).

In Nigeria today, the Total Fertility Rate (TFR) lies in the neighborhood of 6 children per woman for the country (National Demographic and Health Survey (NDHS) 2008). This shows that Nigerians have relatively large family sizes which are also a reflection of the current status of low contraceptive use in the country as evidenced from the 2008 NDHS. This therefore emphasizes the need for increased utilization in the coming years.

The aims, targets and strategies as outlined in the 2004 National Policy for Population and Sustainable Development does not sufficiently emphasize and provide for men's active involvement and shared responsibility in ensuring a decline in family sizes and overall national population growth rate. This seems absurd not only because men's ideal family size is larger than that of women's but also because men are strong decision makers on reproductive health issues including couple-desired family size and family planning uptake.

A central issue in gender theory is work (paid and unpaid work, and household work), and scholars have repeatedly pointed out that despite an increase in female labor force participation during the last decades, household labor apportionments including childcare

have remained relatively stable and lopsided ( Presser 1994). Men are less involved in their partners' health care during pregnancy and; infant and childcare is almost exclusively a woman's realm in virtually every culture (Linda, Richter and Robert; 2003). There is evidence that gender inequality in the family affects marital stability and the well being of women including their career development (Blair 1993, Glass and Fujimoto 1994).

### **1.3 Justification and Rationale for the Study**

The currently high levels of fertility in Nigeria are, to a large extent, caused by the tendency of couple to continue childbearing even after the birth of a fourth child (NDHS 2008). Since the present Nigerian Population Policy does not have a ceiling for couple family size, nor does it sufficiently emphasize and provide for men's active involvement and shared responsibility in ensuring a decline in family sizes and overall national population, it may not be sufficiently able to influence a reduction in the TFR of Nigerians (Adegbola 1987, Obit 2004) if left as it is. There is need to have evidence-based information that will demonstrate the need for its review. This study therefore has potentials for informing the need to review the present Nigerian Population Policy with the aim of making sufficient provisions that will ensure men's active involvement in the achievement of the so much desired Nigeria population decline. Findings from this study will also contribute to the body of existing knowledge in the areas childbearing and contraceptive intensions among men.

Furthermore, scholars of family life have recently turned their attention to fatherhood in an effort to determine how men's involvement in childcare bears on child well-being, gender equality, marital quality, service uptake and childbearing intensions among women (Booth & Crouter, 1998; Coltrane, 1996; Lamb, 1997). But Up till now, very little is known about the mechanism of potential interplay between the divisions of childcare tasks among partners on the one hand; and further childbearing and contraceptive plans of men on the other hand. There is therefore need for more research in this area. This study has potentials for giving insight into the interrelationship between the division of childcare tasks between partners and men's desired family size, contraceptive intensions and behaviours. It can also yield evidence-based information needed for designing interventions aimed at promoting and

enhancing men's participation in childcare and family life as a whole thereby enhancing the well-being of women and reducing the burden of care on them.

Finally, men's responsibilities in childcare are culturally defined. Hence there are debates relating to the generalizability of existing definitions of the expectations of father in relation to carrying out certain child-care tasks. There are also cultural variations in relation to childcare patterns and practices. Previous studies that have provided bases for existing definition of activities that constitute responsible fatherhood roles during pregnancy, delivery and post delivery periods have mostly been carried out in developed countries where cultural beliefs and practices tend to differ significantly from those obtainable in the African society. There is therefore need to document the contextual perceptions and practices of responsible fatherhood as it could be applicable in the Nigerian society. In addition, information about perceived fatherhood roles and practices in childcare will serve as added literature for future researchers interested in taking up further studies around fatherhood especially within the Nigerian as well as African context.

#### **1.4 Research Questions**

The study will provide answers to the following questions:

1. What early child-care tasks are men expected to participate in?
2. What early childcare task are men usually involved in?
3. How does male involvement in early childcare influence their desired family size?
4. How does male involvement in early childcare influence the contraceptive behaviours of their spouses and themselves?
5. What are the intentions and practices of men in relation to contraceptive use?

#### **1.5 Broad Objective**

The broad objective of this study was to determine the influence of spousal distribution of early childcare tasks on men's Fertility Desires in Ibadan North Local Government Area of Oyo state in Nigeria.

### **1.5.1 Specific Objectives of the Study**

The specific objectives of the study were to:

1. Document expectations about men's participation in early child-care,
2. Determine the levels of male involvement in early child-care,
3. Determine how male involvement in early childcare influences their desired family size,
4. Determine how male involvement in early childcare influences the contraceptive behaviour of their spouses and themselves,
5. Assess men's contraceptive intentions and practices

### **1.6 Hypothesis**

There is no significant relationship between:

1. couple income and men's fertility desires
2. spousal religion and men's fertility desires
3. spousal educational status and men's fertility desires
4. spousal expectations about male involvement in early childcare and actual male involvement early childcare
5. male involvement in early childcare and men's (desired family size)
6. male involvement in early childcare and the contraceptive behavior of their spouses and themselves

## CHAPTER TWO

### LITERATURE REVIEW

#### 2.1 Introduction

Formal and Informal surveys around the World on reproductive health are increasingly focusing on male involvement in reproductive health programmes. This increase in surveys reflects the widening recognition of men's importance in sexual and reproductive health. This section reviews literatures in specific aspects of fatherhood, childcare and fertility in line with the focus of this study. A review in these areas will attempt to examine the interrelationship between spousal distribution of childcare task, male involvement in child care, male desired family size and their contraceptive behaviours

#### 2.2 Male Involvement in Childcare: An Historical Overview

Fatherhood defines a biological and social relationship between a male parent and his offspring. *To father* means to impregnate a woman and beget a child, thus describing a kinship connection that facilitates the intergenerational transfer of wealth and authority. Fatherhood also reflects ideals about the rights, duties, and activities of men in families and in society. It reflects a normative set of social practices that are institutionalized within religion, politics, law and culture (Coltrane, 2004). *Fathering* or *father involvement* (in contrast to fatherhood) refers more directly to what men do with and for children. Although folk beliefs suggest that fathering entails behaviours fixed by reproductive biology, humans must learn how to parent as they learn other social behaviours (Coltrane & Collins, 2001).

##### I. Pre-industrial Fatherhood

Historically, fathers have been viewed as having specific roles and expectations. Throughout pre-industrial America, the father's role was as teacher and moral leader (Waller, 2002). During this time, fathers assumed many responsibilities and were the religious and moral educators of their children (Coltrane, 1998; Waller, 2002) as well as the masters of their



families (Coltrane, 1998; Coontz, 2004). As moral teachers and family heads, fathers were thought to have a greater responsibility and influence on their children than mothers (Coltrane, 1998). Fathers were the directors of most of the household work at the time, both inside and outside the home, reinforcing their authority in the family (Coltrane, 1998). Because women were viewed as less rational and more vulnerable to emotional urges than men, they were assigned the responsibility of caring for children while fathers were encouraged to impose moral standards and promote children's rational development (Waller, 2002). After schooling for all children became mandatory, however, fathers were no longer seen as the moral and practical teacher of their offspring as previously assigned (Stearns, 1991).

## **II. Post-industrial Fatherhood**

As a result of the industrial revolution, work removed fathers from the home and rural farms, which in turn left the majority of childrearing and discipline to mothers (Bowen & Orthner, 1991; Stearns, 1991; Coltrane, 1998; Cabrera et al., 2000; Coontz, 2001; Waller, 2002). Men became known as breadwinners for the first time in history (Coontz, 2004). Male gender roles began to revolve around the importance of breadwinning, while female gender roles focused on domestic life in the private, nuclear family (Bowen & Orthner, 1991; Waller, 2002). Men spent less time interacting with their families, which in turn, led to the decline of their direct authority over other family members (Coltrane, 1998). The status of men as breadwinner instead of moral leader and teacher was seen as justification for the privileged position of the man in the home (Waller, 2002). The emergence of a "cult of domesticity" which glorified motherhood and supported the division of men's and women's family roles emerged during this time (Waller, 2002). Because fathers worked outside the home, the father-child relationship was thought to have little influence on child development (Cabrera, et al., 2000). As large corporations emerged in the twentieth century, so did the "masculine ethic" which emphasized rational and unemotional decision-making (Bowen & Orthner, 1991). Since rationality was viewed as a masculine characteristic, the "masculine ethic" began the exclusion of women as managers, simply limiting their work opportunities to supporting roles (Bowen & Orthner, 1991). At the same time, the "masculine ethic" became

the basis for excluding men from being actively involved participants in child care and child rearing (Bowen & Orthner, 1991).

The overall economic shift of married men working outside the home, with married women remaining in the home, created the expectation of “separate spheres” between women and men; and their place of work (Coltrane, 1998). As Coltrane (1998:62) explained, “A woman’s place is the home, and her true calling is to serve a husband and raise children”. Other barriers historically have prevented fathers from being considered involved parents. Seward (1991) suggested several issues that have influenced how fathers were viewed as parents. First, societal expectations emphasized the husband’s role as the primary breadwinner and wife’s role as homemaker/mother, which, in turn, hindered fathers’ ability to be seen as an important asset in the parenting role. Second, developmental theorists and professionals focused exclusively on the mother-child relationship and failed to acknowledge any “direct caring role for fathers with infants and young children” (Seward 1991:229). The marital dyad of mother and father was largely ignored and focus was put solely upon mothers. Fathers also were delegated to the periphery of parenthood. Due to the absence of parenting advice for fathers, they were given little guidance. Fourth, scholarly research and thought focused on mothers’ experiences. Methods to complete studies, even when examining fathers or fatherhood, did not gather information from fathers themselves but rather from wives or children. Most research neglected fatherhood until recent decades (DeFrain et al., 1991). Finally, professionals and scholars viewed infants and very young children as having the capability to interact and bond with no more than one person, emphasizing mothers as the important and constant caretaker of children (Seward, 1991).

Although recent studies have suggested that men are becoming less traditional in their father roles, current gendered expectations for fathers and mothers typically follow a traditional family model with fathers viewed as disciplinarians (Bowen & Orthner, 1991). In addition, fathers are viewed as contributing to the socialization of gendered roles among children especially in reinforcing ideals of manhood for sons and expectations of their roles in families as sons mature (Stearns, 1991). The meaning of gender is reflected in and reproduced through family values and practices (Coltrane & Parke, 1998). In the early and

mid-twentieth century, the emphasis on fathers as sex role teachers came to a forefront as more fathers were away from home due to World War II (Waller, 2002). Concerns emerged regarding the consequences of mothers' influence on children with no father figure present to balance these parenting roles (Waller, 2002).

### **III. Fathers as Breadwinners**

The central role typically assigned to fathers in industrialized society has been as the breadwinner of the family (Bowen & Orthner, 1991; Cabrera et al., 2000; Doherty et al., 1998; Parke et al., 2005; Seward, 1991; Stearns, 1991; Waller, 2002; Yeung et al., 2000; Yeung et al., 2001). Men were expected to provide economic support for their families (Waller, 2002) and fathers cared for their children by devoting time and energy to paid work (Townsend, 2002) and succeeding in their occupation and work roles (Seward, 1991). As a consequence, children became the motivation for dedication to paid work roles among men (Townsend, 2002). Success as a breadwinner emerged as the accepted standard for measuring a good father (Bowen & Orthner, 1991; Stearns, 1991). "Good" fathers expressed care for their children specifically by providing allowances and opportunities for education, and by supporting them to start their own successful adult careers. With fathers' increased absence from households and decreased daily care of their children, the emphasis on "bad" fathers increased (Stearns, 1991). Work tensions influenced father-child interactions as fathers exhibited harsher parenting practices due to work-induced strain and fatigue. Delinquency and abusiveness, pressures from work, inadequacies in lower-class housing, and behaviors such as alcohol consumption or other non-family involvement after work and on weekends also increased (Stearns, 1991).

Conclusively, four major contributions men make to family life are: taking economic responsibility for children, building a caring relationship with children, reducing the chances of 'unpartnered fertility' and ensuring gender equality in the family (Family Impact Seminar, 1995; Richardson, 1995).

### **2.2.1 Measuring/Assessing Male Involvement In Childcare**

Although the structural aspects of fatherhood (marriage, paternity, and co-residence) are sometimes correlated with various child and family outcomes, most contemporary researchers suggest that fathers' involvement be studied directly by focusing on its three primary components:

1. Engagement
2. Accessibility
3. Responsibility

Engagement activities are those in which the father interacts with the child on a one-on-one basis, including a father's direct contact with his child through care-giving and shared activities e.g. feeding, playing with and instructing the child. These types of activity require a high degree of interaction with and direct proximity to child. Accessibility activities require less intensive interaction with or physical proximity and, include activities that can be carried out in same room or otherwise within a supervisory hearing range of the child, whether or not direct interaction is occurring. For example, accessibility activities can be carried out when the father is cooking, cleaning, typing on the computer, watching TV etc. Responsibility refers to the role the father takes in ascertaining that the child is taken care of and in arranging for resources to be available for the child. These include many diverse activities that while taking directly on behalf of the child, may or may not require the actual presence of the child, that is, setting doctor appointment, taking part in baby-sitting arrangements, selecting the child's wardrobe, providing financial needs of the child, accompanying the child and its mother to the hospital etc (Lamb, Pleck, Charnov, & Levine, 1987).

From available literatures, one thing comes out clearly; engagement, accessibility and responsibility as components of paternal involvement are influenced by indigenous perceptions about childcare practices, patterns and beliefs. Previous studies on this will be discussed briefly in the next section.

### **2.2.2 Indigenous Child Care Practices Patterns and Beliefs**

Understanding childcare practices patterns and beliefs is necessary to understanding the components of paternal childcare. Historically, fathers' involvement in childcare has varied considerably across regions, time periods, and ethnic or cultural groups, with economic, political, legal, and cultural practices structuring privileges and obligations within families and shaping fathers' ideal and actual behaviours (Griswold, 1993; LaRossa, 1997; Mintz, 1998; Pleck & Pleck, 1997).

Research studies have provided several examples of cultural variation in childrearing behaviour. For example, the extent to which parents take into account the wishes and feelings of the child and encourage expression of feelings differs according to the extent to which the culture values individuality or ability to function as a group member (Kagan 1984; Lee 1959). Parental discipline styles (for example, use of reasoning, showing disapproval, redirecting behaviours, using time out or physical punishment) vary according to whether or not a culture believes external controls lead to self-discipline (Gonzalez-Mena 1997; Julian, McKenry and McKelvey 1994). There is also considerable variation in the ways that adults organize children's learning, ranging from deliberately arranging learning opportunities to relying on child-managed imitation and modeling (Sigel and Kim 1996; Gonzalez-Mena 1997). Further, there is a great deal of variation in basic care giving practices across cultures, including ways of managing eating and sleeping patterns; and toilet training. Interacting with these culturally based differences are differences in developmental level, temperament and gender. It should also be noted that there is considerable variation among families within a culture, and that any generalizations about care giving practices within a particular culture need to be made with care.

The differences in cultural systems of beliefs, values and behaviours already discussed open up the possibility that parents from different cultural groups will have different goals for their children, interpret quality of care in terms of how well child care meets these goals, and thus prefer child care arrangements that are likely to have the desired effects on their child's development (Rosenthal 2000; Sigel 1992; Moss and Pence 1994). As Farquhar (1990: 80)

notes: 'What might be quality for one cultural group, or in one country, may not necessarily be so for other cultures or in other countries.'

Attitudes and behaviours towards childcare are likely to vary according to parents' beliefs about what experiences are most important to children; their views about who should be responsible for raising young children; and their attitudes towards work and family roles. As one begins to explore the considerable variation in child rearing beliefs and behaviours cross-culturally, however, it becomes clear that there is not a universal standard for child rearing. In view of this, this study will explore indigenous beliefs and practices about paternal child care.

### **2.2.3 Levels of Male Involvement in Childcare and Related Household Tasks**

Pregnancy and infant childcare necessitate increased involvement of fathers in household labour. Across the world, there are evidences which show that husbands have important roles to play both in sharing childcare responsibilities and in providing crucial support to the vulnerable mother-child dyad in the early weeks, months and years of life (Hossain and Roopnarine 2004).

Several studies across the world also show that as compared to women, men are little involved in their partners' health care during pregnancy and; infant and child care is almost exclusively a woman's realm in virtually every culture (Linda, Richter and Robert; 2003). Furthermore, one clear finding from most other studies (Derow, 1977; Niemi et al, 1981; Matsuhima, 1982; Vanek, 1984; Nordenstam, 1984; Michelson, 1985; Scarr et al, 1989; etc.) is that women, even if employed and regardless of social class, still do the greatest share of household and childcare activities. While the time they devote to these activities is diminished, it still is much more than the time anyone else gives. In general, traditional household sex roles appear to have stayed the same in the great majority of families (Cooke 2004).

Many researchers across the world in the 1980s reported that many fathers resisted assuming responsibility for daily housework or child care (Thompson & Walker, 1989). Some suggested that men, on the whole, were less committed to families than they had been in the

past (Ehrenreich, 1984) and other researchers claimed that popular images far exceeded men's actual behaviors (LaRossa, 1997). Japanese fathers' limited participation in childcare and housework has been reported in previous studies and in media reports (Ishii-Kuntz, 1994, 2003). An Analysis of Jamaican couples in common-law unions also revealed that there was a markedly gender-differentiated pattern of involvement in child care and household tasks by parents and that they held very traditional conceptions of the roles of mothers and fathers. (Roopnarine, Brown and Snell-White 2002). Even in the United States of America mothers participated in childrearing activities at a significantly higher rate than fathers. This pattern held true in both dual-earner and single-earner families. Cross-cultural studies in Africa reveal that African fathers spend much less time with their children than do fathers in such Western countries as the United States, France, and Sweden (National Women's Education Center, NWECC, 2005). In Nigeria, Traditionally men do not participate in domestic work including child rearing – such tasks are considered to be the exclusive domain of women. Males are classed as having the following qualities: strength, vigor, virile/powerful courage, self-confidence and the ability to meet the outside world i.e. animal and human intruders head on and deal with it effectively. These qualities were reflected in the kinds of work that men engaged in (Bernard 1981; Aweda 1984; Carrigan et al, 1987; Stock 1995; Silberschmidt, 1999.).

With respect to the distribution of child caring tasks between spouses, a study among Jamaican couples revealed that both mothers and fathers were more likely to spend time playing with rather than feeding or cleaning their babies ( J Roopnarine, Brown and Snell-White 2002). In the United States of America, mothers spent a significantly higher proportion of their interaction time in functional and work-related activities whereas fathers spent a significantly greater proportion of their interaction time in play activities with their children (McBride and Mills 1993). In Nigeria, men are responsible for much of what was thought of as “heavy” labour. Men in short provided for their families (Bernard 1981; Aweda 1984; Carrigan et al, 1987; Stock 1995; Silberschmidt, 1999). Women oversee the domestic chores. They keep houses, process and cook all foods. They also help in the planting and harvesting of food crops and cash crops. They are primarily responsible for the bearing and

rearing of children from birth on; men are only called upon to assist when extraordinary discipline is considered necessary especially for the boys (Aweda, 1984:184).

Summarily, based on data collected between 1960 and 1980, paternal involvement has increased (Yeung et al., 2001). According to cross-cultural studies, fathers' participation in child rearing has varied from virtually no direct involvement to active participation in all aspects of children's routine care (Coltrane, 1996). Research on fathering in two-parent households across the world also shows a noticeable and statistically significant increase in men's parenting, both in absolute terms and in relation to mothers, although fathers' levels of interaction with, availability to, and responsibility for children lag well behind those of mothers (Marsiglio, Amato, Day, & Lamb, 2000; Parke, 1996; Pleck & Masciadrelli, 2003).

On the average, in the 1960s to early-1980s, fathers interacted with their children about a third as much as mothers and were available about half as much as mothers (Lamb et al., 1987). During the mid-1980s to early-1990s, the average co-resident father interacted about two fifths as much as mothers and was available to his children almost two thirds as much (Pleck, 1997). In the late 1990s, he was available to his children about three fourths as much as mothers, interacting on weekdays about two thirds as often, but over four fifths as much on weekends. In an estimated 20% of two-parent families, men are now about as involved as mothers interacting with and being available to their children (Bianchi, 2000; Pleck & Masciadrelli, 2003; Yueng, Sandberg, Davis-Kean, & Hofferth, 2001). At the same time, in most families, fathers and mothers share much less of the responsibility for the planning, scheduling, emotional management, housework, and other maintenance activities associated with raising children (Coltrane, 1996; Deutsch, 1999; Hochschild, 1989). In this study, levels of paternal involvement in childcare will be assessed based on expected childcare practices as identified by indigenous communities.

#### **2.2.4 Predictors of Male involvement in childcare**

As demonstrated in comprehensive reviews (Pleck, 1997; Pleck & Masciadrelli, 2003; Marsiglio et. al., 2000), fathers' involvement is determined by several factors with no single factor responsible for the different types and levels of involvement. For fathers to become



actively involved with children, they required four facilitating factors: (a) motivation, (b) skills and self-confidence, (c) social approval, and (d) institutional support (Lamb et al., 1987; Pleck, 1997).

Researchers have begun to isolate the effects of income, marriage, employment, work schedules, and other factors on fathers' involvement, though results are often incomplete or contradictory. For example, the relation between socioeconomic status and father's involvement is complex. Income is often found to be positively correlated with father's involvement among various ethnic groups (Fagan, 1998; Parke, 1996). Relative income contributions by wives are also associated with higher proportionate levels of father's involvement in housework and child care (Coltrane, 2000; Yeung et al., 2001), though some studies still find that financially dependent husbands do less domestic work than others (Brines, 1994). Wealthier men do little routine family work, but the amount their wives do varies dramatically, with higher-earning wives more likely to purchase domestic services (e.g., child care, house cleaning, laundry) (Cohen, 1998; Coltrane, 2004; Oropesa, 1993).

When financial stability is hard to achieve, fathers only minimally involved with their children may nevertheless see themselves as "good fathers" because they work hard to provide financially. Because of inequities in the labour market, men of colour are disproportionately likely to face difficulties being adequate providers (Bowman & Sanders, 1998; Hamer & Marchioro, 2002). Comparisons between white, African-American, and Latino fathers suggest similar levels of involvement with children after controlling for family type, though Latino fathers may be more involved in family rituals than non-Latino fathers and nonresident African-American fathers may contribute more to children than nonresident white fathers (Coltrane, Parke, & Adams, 2004; Wilson, Tolson, Hinton, & Kiernan, 1990; Yeung, 2001).

Institutional supports can include factors such as fewer work hours and more flexible work schedules (Pleck, 1993). Most researches show that a father's availability (as determined by work hours) is a strong predictor of his involvement in child care. When mothers of preschool children are employed, a father's time availability predicts whether he will serve as

a primary caregiver (Brayfield, 1995; Casper & O'Connell, 1998). Fathers and mothers with non overlapping work shifts are the most likely to share child care (Presser, 1995). When mothers of school-age children are employed more hours, their husbands tend to do a greater portion of the child care and housework, and fathers tend to be more involved to the extent that they view their wives' career prospects more positively (Pleck, 1997). Whereas men formerly interpreted long work hours to relieve them responsibility to perform child care at home, there are indications that things are changing. Brewster (2000) found that fathers in the late 1970s and early 1980s tended to use nonworking discretionary hours for personal leisure activities, whereas in the late 1980s and 1990s, they were likely to use those hours for child care (Coltrane, 2004).

Prior research supports the claim that maternal beliefs influence father's involvement (Bouchard, Lee, Asgary, & Pelletier, 2007; McBride, Brown, Bost, Shin, Vaughn, & Korth, 2005). Beitel and Parke (1998) found that wives' perceptions of their husbands' skill at child care was related to husbands' involvement with their infants. Wives who believed their husbands were more skilled at child care tasks had husbands who were more involved (Beitel & Parke, 1998). In addition, several studies have demonstrated that men who see themselves as more skilled at child care report higher levels of involvement (e.g., Jacobs & Kelley, 2006; Sanderson & Thompson, 2002).

### **2.3 Fertility**

Fertility studies in Nigeria date back to decades and have examined a wide range of topics on fertility though mostly at local geographical areas. These include trends,, determinants and differentials, adolescents' reproductive health (Otoide, Oronsaye & Okonofua, 2001; Adeboyejo & Onyeonuru, 2003), family planning (Renne, 1996; Lacey, Adeyemi & Adewuyi, 1997; Odimegwu, 1999), abortion (Makinwa-Adebusoye, Singh & Andaru, 1997), poverty and fertility dynamics (Oduola, 2002); the relationship between child labour and fertility preferences of parents (Togunde and Newman, 2005) and a host of others.

### **2.3.1 Fertility Trend in Nigeria**

Fertility trend studies have shown estimates of total fertility rate (TFR) in Nigeria for the years 1965, 1970, 1971-73 and 1975 to be 6.6, 6.5, 7.3 and 7.0 respectively. This generally implies a rise between 1965 and 1975. The 1981/82 Nigeria Fertility Survey put the TFR at 5.94 while the 1990, 1999, 2003 and 2008 NDHS put the estimates at 6.01, 5.2, 5.7 and 5.7 respectively (NDHS, 2008; Feyisetan & Bankole, 2002). It is evident that the TFR has followed a downward trend after the 1970s if one ignores the figure given by the 1999 NDHS, which was reported to have been affected by underreporting of births (NDHS, 2003). Some favorable indicators for future fertility decline in Nigeria have also been alluded to. These include decline in wanted fertility; increase in age at marriage; increase in contraceptive use, increase in the rate of abortion (even though this is illegal); erosion of social values placed on child bearing; increase in female enrolment at all levels of education as well as increasing participation of women in the labour force (Oladosu, 2001; Feyisetan & Bankole, 2002).

### **2.3.2 Fertility Preferences ↗**

Fertility preference studies have looked at peoples' preferences using different terminologies and definitions. Desired family size, ideal number of children, fertility preference, desire for additional children and fertility intentions are some of the measures that have been used to describe and/or estimate the number of children that people actually want to have. For example, Monnier (1979) used intended additional births to refer to fertility intention; McCarthy and Oni (1987) used non-numeric responses while Nii-Amoo Doodoo (2001) used preference for no more kids.

The meaning and validity of these measures have been a source of controversy for quite sometime (Coombs, 1974, 1979; Bongaarts, 1990). For example, desired family size refers to the number of children the respondent would have liked to have in his/her whole life irrespective of the number he/she already has. This is said to be prone to rationalization (upward adjustment in stated desired family size so that it is close or equal to actual number of children) and non-numeric bias (underreporting of average family size because some

women are unable or unwilling to respond to the question on desired family size) (Bongaarts, 1990).

Questions on wanted status of recent births as a measure of wanted fertility have also being queried on account of non-uniformity in its phrasing in the different surveys and for being equally subject to rationalization (Rasul, 1993; Bongaarts, 1990; Eggleston, 1999; Adetunji, 2001). Responses to questions about desire for additional children also referred to as fertility or reproductive intention and dubbed fertility preference in the demographic and health surveys (DHS) are generally considered to be relatively unbiased, though not completely free of error (Bongaarts, 1990). Some queries have been raised about the predictive value of these fertility measures. For example, Coombs (1979) used the National Survey of Family Growth (NSFG) data of the United States to show that individual's response to the question on intended family size is a point on a continuum, which conventional survey questions do not capture. In the survey, after the respondents had stated their preference, they were asked to give a second (third, fourth and so on) choice regarding family size. The responses were then scaled taking into consideration the direction of the choices of the women (lower or higher than the original stated number). The results show that identical statements about desired family size do not have the same meaning for all people. This finding casts doubt on the reliance of a single response to fertility intention questions.

Despite these misgivings, these preference measures continue to be very relevant because of their importance in the estimation of actual fertility. Fertility preference in this study refers to the desired number of children, which is a response to the question "If you could choose the number of children to have in your whole life, how many would that be?"

#### **2.3.2.1 Spousal Fertility Preference**

In most of Africa, questions on fertility preferences are often responded to with non-numeric answers: many are hesitant to give specific numbers when asked about their desired family size. This is rooted in cultural and religious beliefs as people are expected to leave their destiny wholly in the hands of their creator. However, fertility preference studies in the Sub-Saharan region have shown high rate of disagreement among couples (Westoff & Bankole, 2002). While about 58% of wives in Kenya wanted no more children after the birth of a

fourth child, only 49% of their husbands did not want more. The corresponding figures for Ghana are 29% and 19% respectively (Bankole & Olaleye, 1993). The story is the same among the *Yoruba* of Nigeria where 24% of the wives compared to 18% of the husbands wanted no more births (Kritz, Gurak & Fapohunda, 1992). In a study of seven Sub-Saharan African countries, the ideal number of children (wanted fertility rate) was 6.7 for all females, 8.6 and 10.6 for all males, unmarried and Married respectively generally larger than that of women and the Total Fertility Rate was averagely 5.7 (rural 6.1 vs. urban 4.9) (NDHS 2003).

#### **2.3.2.2. Fertility Preference and Contraceptive Intentions and Practices**

Feyisetan & Casterline (2000) found that the indicators of fertility preferences revealed increases in the desire to limit childbearing and that these contributed substantially to the increase in prevalence of contraceptive use when the latter is decomposed into the explanatory variables. For example, controlling for demographic and socio-economic variables, the contribution of changing preferences to increase in contraceptive prevalence exceeded one-third in Ghana (37%).

Across the globe, fertility rates have fallen largely due to the widespread and increasing use of modern methods of contraception. However, in some developing countries the uptake of contraception remains low due to cultural, economical and political barriers (Konge & Oladipo, 1999). Today, sub-Saharan Africa is the region with the lowest levels of contraceptive use and the high levels of fertility rates. A study of six ethnic groups in Nigeria (*Yoruba, Hausa, Fulani, Ibo, Ka-nuri, Efik and Ibibio*) found that all placed a high premium on large family size (Nigeria's population profile, Population Reference Bureau, info by country; Nigeria statistics UNICEF 2009).

One study by Sheryl Thorburn (2007) examined men's attitudes towards seven contraceptive methods among a national sample of African-American men and women aged 15–44. All significant gender differences in attitudes were in the direction of men having more negative attitudes than women. Furthermore, there was some evidence of concern about a potential link between contraceptive use and infertility among them. Community suspicion, and in

many cases, rejection of family planning, particularly in the northern region of Nigeria, has impacted on the health of women and children (Akinfeleye, Charlse, Omideyi 2009).

There are considerable variations in contraceptive usage from country to country and region to region. One-third of developing countries have a skewed method mix, in which a single method accounts for more than half of all contraceptive use. In many cases, this is an indication that knowledge or access to a broad range of contraceptive methods is limited (Sullivan et al 2006). In places where a wider variety of methods have become available, contraceptive uptake has often been observed to rise (Doucouré , Djeneba , Touré , et al 1998). Genuine access to a broad method mix involves many factors – the availability and affordability of a variety of contraceptive methods, community members' awareness and understanding about these methods, and their ability to overcome the various barriers to obtain the method of their choice. Personal preferences, social norms, gender preferences, women's education, rural or urban residence and perceived acceptability of family planning have all been shown to impact contraceptive usage (Jejeebhoy 1992; Castro 1995).

Contraceptive use, particularly of modern methods, has increased in Nigeria since the early eighties. At the time of the 1981/82 WFS, 6.2 per cent of women exposed to the risk of child bearing were using contraception and of these only 0.7 per cent were using modern (efficient) methods. By 1990, 7.5 per cent of all women and 6 per cent of currently married women were using contraception. Of these 3.8 per cent of all women and 3.5 per cent of currently married women were using modern methods. By 1999, use of contraception had increased substantially: 15.7 per cent of all women were using any method and about 9 per cent were using modern methods. Among married women, use of contraception increased between 1990 and 1999 by 155 per cent, from 6 per cent to 15.3 per cent. Also, by 1999 about 9 per cent of married women were using modern methods. Contraception use among married women however decreased to 6 percent in 2006 but increased to 14.8 percent from 2006 to 2008 (NDHS). However, the national contraceptive prevalence rate (CPR) for modern methods in Nigeria is 11%.

Twenty-nine percent (29%) of women reported in the Nigerian Demographic and Health Survey (NDHS 2006) that they wanted to have another child soon and 32 % would prefer to have their next child in 2 or more years. Contraceptive use has generally been higher in the South (especially South-West), in urban areas and among more educated women. But an increase in contraceptive use has been experienced by most sub-groups between 1990 and 1999. For example, use of contraceptives increased by 233 per cent in the rural areas and by 76.6 per cent in urban areas. Similarly an increase of 55-167 per cent was recorded in the various regions (NDHS 2008). In northern Nigeria, researchers found that the mean number of pregnancies was 6.7 and the mean number of live births was 5.7 (NDHS, 2008). On the average, northern Nigerian women have given birth to one child by the age of 19 and more than 50% have eight or more children by the time they are in their late forties (Galadanci, Ejembi, Iliyasu, Alagh , and Umar 2008).

In Maiduguri, injectables were found to be the most commonly used and female sterilization the least commonly used method (Mairiga, Kyari, Audu, Lawuwa; 2007). Ameh et al (2007) also found injectables to be the most commonly used method (50.7% of users) in Zaria . In contrast, Mutahir and Pam (2008) reported that in Jos, the IUCD was the most commonly used method by 26.1% of users

### **2.3.3. Fertility Preference and Preference Implementation**

Significant differences exist between fertility preference and preference implementation (Cho, 1978; Monnier, 1979). Using the world fertility survey (WFS) data from five Asian countries, Cho found that the actual number of living children is often greater than the number the women say they want in all the countries. Monnier used a longitudinal study to assess whether it was possible to forecast fertility behaviour from statements about intentions. Results show significant differences between intentions and behaviour especially among women who intended a second or third birth (predictive value of intentions was 0.637 and 0.357 respectively).

The Bongaarts' (1993) framework posits that fertility (F) as measured by total fertility rate is an outcome of the interaction of supply of births (natural fertility), demand for births (wanted fertility) and degree of fertility preference implementation. Wanted fertility and the degree of preference implementation are, in turn, dependent on the extent of male influence on couple fertility preference stress (cost) of fertility regulation; and that of childbearing, as well as the household division of childcare and other social determinants.

Decomposition of changes in fertility into its determinants shows that, while on the average the level of implementation index is a more important determinant of fertility decline for all the developing countries examined; the demand for children (wanted fertility) is the dominant factor in Sub-Saharan Africa (Bongaarts, 1993; Ibisomi, 2002; Ibisomi, Odimegwu, Otieno & Kimani, 2005).

Bongaarts went further to explain how to identify the causes of fertility declines in specific populations and operationalise the framework by estimating the levels of preference implementation for 18 DHS countries. He also used 12 of the 18 countries with WFS and DHS data sets to decompose changes in fertility into its determinants. Ibisomi (2002) and Ibisomi et al (2005) adopted the same framework in the analysis of changes in fertility across 60 developing countries.

The results of the two studies show that the level of implementation index is lowest in Sub-Saharan Africa and that; on the average; the value of the index has been increasing for countries with trend data. This decomposition procedure shows that preference implementation is a more important determinant of fertility decline than wanted fertility. It is however noted that the formulation is only relevant in a situation where observed fertility exceeds wanted fertility (an excess supply situation hence its relevance and adoption for this study since this is the case in Nigeria) and for macro level analysis where averages of the determinants are used in the calculations.



### **2.32.3.1. Determinants of Fertility Preference and Preference Implementation**

As earlier stated, wanted fertility preference and the degree of preference implementation are dependent on the level of male influence on couple's fertility preference; the stress (cost) of fertility regulation and that of childbearing; household division of childcare; and other social determinants. These variables are too generic and their component parts need to be examined more closely for a better understanding of the background characteristics that work through them to result into couple fertility desires and the ability of couples to implement their fertility preferences. This examination is attempted below.

#### **I. Male influence**

It is noted that all the variables factored into the derivation of the index of preference implementation are woman-based although; the index is touted to be measuring the ability of couples and individuals in achieving their fertility preferences. It is important to note that the fact that a woman does not want a pregnancy does not necessarily imply that the husband does not want the pregnancy. Studies have shown that fertility intentions of their husbands or partners do matter and have a great influence on actual fertility outcome (Beckman, Aizenberg, Forsythe & Day, 1983; Thomson, McDonald & Bumpass, 1990; Ezeh, 1992; Isiugo-Abanihe, 1994; Bankole, 1995; Thomson, 1997; Odimegwu, Okemgbo & Pallikadavath, 2005a; Odimegwu, Okemgbo & Pallikadavath, 2005b).

An examination of spousal influences over each other's reproductive motivations and behaviour in Ghana and elsewhere shows that husbands have greater control over couple's reproductive decision-making and behaviour than their wives (Ezeh, 1993; Bankole and Singh, 1998; DeRose, Nii-Amoo Dodoo and Patil, 2002; DeRose, 2003). Lower fertility seems to be associated more with men's declining fertility desires than with women's increasing reproductive autonomy (DeRose and Ezeh 2005). Bankole 's (1995) study in Nigeria brought forth the strong influence of men on fertility decisions, which cannot be ignored or captured by proxy information. He found that fertility desires of both marriage partners are important predictors of the couple's fertility and that the desires of both spouses have equal effects on fertility behaviour. The husband's desire is however dominant in

predicting couple's behaviour when the number of living children is small while the wife's desires become more important during the later stages of marriage.

Husband's approvals are major determinants of family planning uptake among couples, even though communication between husbands and wives about family planning uptake is strongly associated with couple's fertility desires' (Moronkola, Ojediran, and Amosu, 2006). Other Studies have also shown that disagreement among couples regarding the number of children wanted reduces the likelihood that either spouse will achieve individual preferred fertility (Beckman, Aizenberg, Forsythe & Day, 1983; Thomson, McDonald & Bumpass, 1990; Thomson, 1997; Bankole, 1995).

## **II. Financial and Work-Related Cost of Childbearing**

Over time, material living standards have increased in modern societies, with many of yesterday's perceived luxuries becoming today's perceived necessities – thus highlighting the importance of values in shaping considerations about whether or not a couple can afford to have children. Indeed, divergent views about the material necessities in life and associated expenditure patterns may partly explain the fact that the people who can least afford it are having the largest families ( de Vaus 2004).

In addition to the *direct* financial costs of having and raising children (for example, food, clothing, housing, education and possibly child care), the *indirect* costs such as reduced earnings and potentially curtailed careers when caring for children takes precedence over paid work. While it appears that the foregone earnings of women who have children have diminished somewhat since the 1980s, when cohorts with the same level of education are compared (Gray and Chapman 2001), women's improved career opportunities mean that increasing numbers have a great deal to lose should they decide to relinquish full-time work to raise a family. Such losses are emphasized by McDonald (2000b, 2001a) as a central reason for the fall in fertility. The deprivations are not only monetary, but can also be felt in relinquishment of work-related prestige and diminished opportunities for social relationships, job skill development, and mental stimulation and challenge ( Barnes 2000; Perry-Jenkins, Repeti and Crouter 2000). Thus, while the labour market and economic context may

encourage the accumulation of educational and career-based accomplishments, the benefits of this pathway may compete with having children as alternative avenues for self-fulfillment (Quesnel-Valee and Morgan 2002).

Parents may, of course, use non-parental child care to enable each partner to remain in full-time work, but this introduces other monetary and time costs, with women typically carrying most of the child care and other domestic responsibilities (Bittman and Pixley 1997; Bittman and Matheson 1996; Moen and Yu 2000). These costs, along with potential difficulties in accessing high quality child care and worries about the suitability of child care for very young children, may contribute to couples' decisions to have few if any children, or to continue to defer decision-making.

The above issues relate to the "gender equity" explanation for low fertility (which will be discussed further below). Basically, McDonald (2000c, 2001b) argues that gender equity has progressed well in those institutions that are oriented to the individual, such as education and employment, but family-oriented institutions have lagged behind by continuing to assume a male breadwinner model of family life. Under these circumstances, women's opportunities are seriously diminished if they have children, thereby discouraging them from having the number of children many would like to have. The potential for indirect discrimination around pregnancy and family commitments is also work-related costs that may influence fertility decisions.

The stress of childbearing and childrearing can be better conceptualized when taken as avoiding cost of additional child(ren). The cost of a child involves cost in resources required to rear the child to adulthood. These resources include food, shelter, and clothing, costs of education and health care among others as well as the time-labour cost of providing childcare (Easterlin, 1975; Beaujot, Krotki & Krishnan, 1978; McCarthy & Oni, 1987; Warren, 1997).

The microeconomics approach to the study of fertility determinants focuses more on the economic dimension of fertility choice. The conventional theory of consumer behaviour views the individual as trying to maximize satisfaction, given a range of goods, their prices, and his/her own tastes and income (Becker, 1960; Easterlin, 1975; Beaujot, Krotki &

Krishnan, 1978; Montgomery, 1987; Bongaarts, 1993; Shapiro, 1997; Robinson, 1997). Basic to the theory is the proposition that children are a special kind of capital goods and fertility is seen as a response to the consumer's demand for children relative to other goods. The model presumes that couples would have as many children as they could if doing so were costless in terms of money, time and foregone opportunities. Some studies suggest that due to increased uncertainty and hardship characterizing life in Africa, most African couples may not base their fertility motivations on prior long-term considerations that their fertility desires may be influenced more by a mix of short-term, often unstable factors connected with the quest to survive the economic, cultural and social pressures (Johnson-Hanks 2007, 2005; Agadjanian 2001, 2005). Better prospects of the household economic situation, personal health, etc. would lead to reluctance to stop childbearing, all else equal; because as literature suggests, in sub-Saharan Africa, people want to stop childbearing when times are hard (Eloundou-Enyegue, Parfait, Shannon C. Stokes, and Gretchen T. Cornwell. 2000; Lindstrom and Berhanu 1999; Shapiro 1996; Rutenber and Diamond 1993). However, fertility fell as income increases in the course of demographic transition led to the inclusion of the concept of child quality by Becker (1965) in the economic model.

A more comprehensive treatment of the production of children to the microeconomic theory of fertility was introduced by Easterlin (1975). This model incorporated Becker's earlier work, which focused on the demand for children. At the same time, Easterlin (1975) sought to develop a model that would be compatible with the approaches to fertility used in other disciplines (Shapiro, 1997). Thus, a sociological variable (the subset of 'proximate determinants' relating to deliberate fertility control) was added. He proposed that the determinants of fertility are seen as working through one or more of the following: the demand for children, the potential output of children and the costs of fertility regulation, including both subjective (psychic) and objective (time and money required to learn about and use of specific techniques) costs. The dependent variable is measured by the total number of surviving children couples will have at the end of the reproductive span of the wife. Demand is measured as the number of surviving children parents would want if fertility regulation were costless while potential output was the number of surviving children parents would have if they did not deliberately limit fertility. The framework was used to show how

modernization leads to a shift from high to low fertility as described by the demographic transition theory (Easterlin, 1975).

The costs of childbearing certainly differ across strata. They are also multi dimensional and difficult to measure. The amount of education parent's hope their children will achieve and, willingness to support children in postsecondary education have also been used as indicators of cost of a child (Beaujot, Krotki & Krishnan, 1978; McCarthy & Oni, 1987). For example, McCarthy & Oni (1987) in a household survey carried out in Ilorin, South-West, Nigeria used aspiration for son and daughter's education up to secondary and post secondary levels as one of the independent variables in the examination of the differences between respondents who expressed numerical fertility desires and those who did not. They found that women with relatively low aspirations for the education of their sons and daughters are more likely to give non numerical responses.

Measuring cost using the level of education parents wish their children to attain can also be problematic. This is because parents' aspiration cannot be equated with affordability. They may also hope for assistance through scholarships and other means such as child fostering. A parent's response to the question can also be limited to his/her exposure or knowledge of what he/she thinks is the ultimate educational level and not necessarily because he/she does not want the best for the child. Costing a child in general appears to be an uphill task especially its quantification. Attaching appropriate weights to the identified proxies of these two determinants of levels of fertility preference implementation and offsetting them is practically impossible and unrealistic. For example, fertility regulation costs are likely to be no more than a tiny fraction of the net return or the net cost anticipated from having a child (Pritchett, 1994; McNicoll, 2003). Even if one is able to quantify these costs appropriately, at present, there appears to be no established quantitative method of estimating the degree of fertility preference implementation for individual women because of the difficulty involved in calculating natural fertility for individual women. This thus makes it difficult to link the index to its determinants quantitatively.

Also, although children come with positive (benefits) and negative (costs) values, marriage and having children are two events that are universal in Nigeria and are embedded in the people's way of life. The special and coveted high status, which children bestow on both mothers and fathers together with other social and psychological benefits of children are much more important determinants of fertility than the economic benefits derived from having them. For example, children validate marriages and bring about stronger emotional ties to social groups and the partner (Makinwa-Adebusoye, Kohlmann, 2002). Thus, due to the fact that having children in the Nigerian context goes beyond the arithmetic of costs and benefits and the difficulty of quantifying the costs of unwanted childbearing and that of fertility regulation, qualitative data will be used to look at the context within which the two costs influence couple's decision to control or not to control fertility thereby influencing the level at which they achieve their fertility preferences. The exploration will cover the costs in terms of resources (which is affected by prevailing socio-economic conditions in the country), time-labour, emotional and the psychological requirements of bearing as well as rearing a child during the first 2 years of the child's life.

### **III. Division of Childcare and Related Domestic Task**

Evidence is emerging that the division of domestic labour, not just the division of paid labour, is implicated in intra-household fertility decisions. Cooke (2004) analyzed German data to find that husbands' relative domestic contribution increased the likelihood of a second birth, and Torr and Short (2004), using US data, found a relationship between gender equity, fertility and gender ideology, which suggested that both the most modern and the most traditional housework arrangements are positively associated with second births. Torr and Short argue that their findings underscore the need to incorporate family context, including gender equity, into explanations for fertility change. Both men and women's understandings and wishes are of importance to household fertility decisions (Cannold 2005).

A study carried out in Italy, a country characterized by very low fertility reveals that fathers' participation in childcare and domestic activities significantly increased the intention to have a second child for working women, while fathers' participation had no influence on the intentions to have a third child or on fertility intentions of non-working women (Pinnelli,

Antonella, Flori, Francesca, 2008). However, nothing was reported about the intensions of fathers to have a second and a third child, following father's participation in childcare and domestic activities.

A study by Lehrer and Kawasaki (1985) suggests that the availability of care by relatives increases US parents' desire to have another child. Mason and Kuhltau (1992) found evidence for child care constraints on women's employment and fertility in a sample of Detroit-area mothers. Affordable prices and a sufficient availability of child-care centres facilitate greater participation of mothers in the labour market (Anderson and Levine 2000; Gustafsson and Stafford 1991; Stolzenberg and Waite 1984).

For Norway, Kravdal (1996) reports a stimulating effect of an increasing supply of public day care for children aged 0 to 3 on women's probability to advance to parity three. However, this effect only appears at very low levels of day-care coverage. There is no increase in birth probabilities at coverage levels above 10 percent, and the day-care-effect becomes insignificant when aggregated female employment is accounted for in the model.

More recently, Del Boca (2002) detected a positive influence of the availability of public child care on childbearing in the Italian lowest-low fertility setting. Hank and Kreyenfeld (2003), on the other hand, do not find such an effect in their analysis of western Germany . They argue that the institutional set-up of the western German day-care regime is inappropriate to foster fertility and the employment of mothers. Access to informal care arrangements (namely the grandparents), however, increases a woman's probability of entering motherhood. Hank and Kreyenfeld (2003) point out that those empirical studies usually face severe limitations with regard to their measurement of child care. In most cases, only a single indicator is used to account for a truly 'multidimensional' commodity.

In Nigeria, there is dearth of knowledge about the mechanism of potential interplay between the divisions of childcare task between spouses on the one hand and childbearing plans of men on the other hand. This study will therefore explore the extent to which the division of childcare task between spouses influences men's childbearing desires.

#### **IV. Cost of Fertility Regulation.**

Cost of fertility regulation is the subjective (psychological, health) and objective (time and money) costs of learning about and using specific fertility regulation techniques (Easterlin, 1975). A comprehensive means of fertility control includes regulating access to or frequency of heterosexual intercourse; employing some temporary device which allows intercourse without resulting into pregnancy; employing permanent means of breaking the link between intercourse and pregnancy and ending a pregnancy after it has occurred. These can be achieved through celibacy, abstinence within marriage, contraception, sterilization and abortion (Warren, 1997). Most authors agree that there are three main types of stress involved in adopting and using contraception. These are psychic, social and market stress or cost. Psychic stress includes attitude or displeasure towards use as a result of fears, anxieties and risks about health and the threat of a loss of sexual pleasure because known methods of contraception are considered to be unacceptable. The psychic stress also includes knowledge of fertility control methods. The market stress relates basically to the fund and time required to learn and use the techniques while social stress is defined as the perceived risk of incurring societal, familial or spousal disapproval for fertility regulating practice(s) (Easterlin, 1975; Warren, 1997; Shapiro, 1997).

#### **V. Social determinants (Social Interaction, Ethnicity, Religion and Education)**

In line with the social networks literature, positive social interaction (such as encouragement to adopt birth control) would increase the likelihood of fertility limitation, while negative influence would reduce the likelihood of desiring to stop. According to the theory of reasoned action and planned behaviour (Ajzen and Fishbien 1980), a person's intentions or desire to perform an action is determined by her beliefs about the consequences of the action, the perception of value of the consequences, the beliefs about what significant others think he or she should do, and the motivation to comply with those expectations.

In all societies, there are social norms prescribing what the acceptable family size should be. People experience social pressure to have children at parities below the normative family size threshold. Likewise, there is pressure to limit births at or above the normative family size. Apart from family size norms, there are other norms prescribing when to stop childbearing



(Bledsoe 2002; Page and Lesthaeghe 1981). As individuals consider childbearing options, they are sometimes influenced by people around them – relatives, friends, health workers etc. There is much empirical evidence suggesting that the influence of individuals or groups has a bearing on reproductive behaviour, particularly contraceptive behaviour (Madhavan, Sangeetha., Alayne Adams, Dominique Simon. 2003; Arends-Kuenning, Mary, Hossain Mian Bazle, and Barkat-e-Khuda 2002; Barber et al. 2002; Godley 2001; Casterline et al. 2000; Arends- Kuenning et al. 1999; Kohler 1997; Rutenberg and Watkins 1997; Montgomery and Casterline 1996). Studies show that men are more likely to adopt the reproductive behaviour of other men in their social network.

However, the influence of other individuals in fertility decision making is difficult to substantiate through survey interviews. Social influence or pressures may simply be internalized and expressed as personal motivations or preferences for normative expectations. It is possible that individuals may be reluctant to disclose such social influence, especially familial pressure to have children or opposition to fertility limitation. In addition, those who have already decided to stop childbearing could be the ones who proactively seek information from friends, relatives and health workers regarding reproductive issues. Such information seeking could create potential selectivity bias. One way of disentangling the effect of social interaction is by ascertaining whether conversations relating to having additional children occurred within respondents' support networks before the survey and whether such conversations had a positive or negative impact in the choice to limit births at a later time.

Finally, the Isiugo-Abanihe (1994) study however shows that although preference for large families is very strong among Nigerian men (who generally decide and dictate what happens within and around the family) there are considerable ethnic and religious variations. For example, average number of children desired is 4.90 among the Yoruba and the Igbo while it is 6.09 and 7.34 among the Hausa/Fulani and the Ishan respectively. Similarly, average number of children desired is 6.20 for the Muslims, 5.45 for the Catholics, 4.97 for the Protestants and 6.04 among the people who hold indigenous belief. Some studies have compared the likelihood of a second birth in various policy settings. Köppen ( 2006) found

that educated women were more likely to have a second child in France, where policies specifically aim to reconcile work and family, than in Germany, where they do not.

## **2.4.3 Conclusion**

Literatures available and studies carried out indicate an increased interest on male participation in reproductive health and family planning. Several studies have established that men's ideal family sizes are generally larger than women's and they (men) have largely influenced spousal fertility preference and preference implementation. Some studies note that low fertility preference and implementation is better explained in terms of the combined forces of costs, uncertainty, and the difficulties spouses face in attempting to combine paid work and family life. Many studies have provided several examples of cultural variations in childcare practices with attitudes and behaviours varying according to their views about family roles and who should be responsible for raising children. Other studies suggest that gender equity at both national and family level may influence fertility. In this regard, many studies demonstrate a positive influence, though in more developed countries with a record of low fertility trends. This paper contributes to this emerging body of research as it attempts to address the question: does the division of household labour (specifically those resulting from pre and post natal conditions in the home) between spouses affect the number of children husbands would like to have in their life time?

It will explore the cultural expectations for men in relation to their involvement in pre and post natal childcare from women and men's perspectives. It will also explore the division of childcare tasks among couples as well as men's perceptions about the cost of childcare as influenced by their childcare experiences. Overall, this study will attempt to determine the existence of a relationship between childcare-related stress experienced by men and their contraceptive decisions.

## 2.54 Conceptual Framework (Theory of Planned Behaviour)

The Theory of planned behaviour was adopted for this study. This theory was postulated by Ajzen (1985); Ajzen (1991). Theory of planned behaviour posits that individual behaviour is driven by the individual's intentions to perform that behaviour; where behavioral intentions are functions of:

1. An individual's attitude towards the behaviour (i.e. beliefs about the outcome of the behaviour and the value of these outcomes),
2. The subjective norms surrounding the performance of the behaviour (the influence of the person's social environment – beliefs about what other people think the person should do as well as the person's motivation to comply with the opinions of others), and
3. The individual's perception of the ease with which the behaviour can be performed (behavioral control).

In other words, to predict whether a person intends to carry out an action, we need to know:

- I. Whether the person is in favour of doing it ('attitude')
- II. How much the person feels socially pressured to doing it ('subjective norm') and
- III. Whether the person feels in control of the action in question ('perceived behavioral control')

By changing any or all of these three 'predictors', w chances that a person will intend to carry out a desired action might be increasedand thus increase the chance of the person actually carrying out that action. In relation to this study, to predict whether a man intends (will decide) to have a small family size and use or encourage his partner to use contraceptives, there isneed to know:

1. Whether he favours having a small family size and using contraceptives (attitude). This will be determined through an assessment of a man's beliefs regarding the consequences of having a large family size and not using or encouraging the use of contraceptives in their home, and an evaluation of the desirability of these consequences.

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2. How much he feels pressured (socially, economically, religiously e.t.c) by his involvement in early childcare to have small family sizes and use contraceptives (subjective norms). This study postulates that maternal and societal early childcare expectations could exert additional pressure on men. It therefore proposes that such pressure can increase the chances that many more men will decide to have fewer children, decide to use or encourage their partners to use contraceptives; so that they are able to satisfy existing expectations. This could in-turn increase the chances that they will actually use or encourage their partners to use contraceptives to prevent having large family sizes.
3. Whether he feels in control of the action in question (Behavioral control). This is defined as one's perception of the difficulty of performing behaviour. TPB views the controls that people have over their behaviour as lying on a continuum from behaviours that are easily performed to those requiring considerable effort, resources, etc. A man's fertility desires and contraceptive decisions could therefore be influenced by considerations of the resource implications (financial, time, social etc.) of having more children if he does not utilize contraceptives, as well as his ability to respond to these demands.

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## CHAPTER THREE

### METHODOLOGY

#### 3.1 Introduction

This chapter comprises of the design and scope of the study, and description of the study area. It also describes the study population, study variables, the methods and instruments for data collection and data analysis. Finally, it explains the limitation of the study.

#### 3.2 Research Design and Scope of Study

A cross-sectional descriptive study design was used for this study. The study assessed the influence of spousal involvement in early childcare on men's fertility related descisions and behaviours. It was designed to assess respondents' expectations in relation to male involvement in early childcare, levels of men's involvement in early childcare, spousal knowledge, intensions and behaviours with respect to contraceptives as well as men's childcare stress experiences and fertility desires. The outcome variables are men's fertility desires and men's contraceptive intensions and behaviours.

#### 3.3 Description of Study Area

As study area is the physical location and conditions in which data collection takes place in a study (Polit and Hungler, 1977), Ibadan North Local Government Area (IBNLGA) was selected for this study. It was selected after careful consideration of the actual number of annual child delivery and the number of children per unit population of the five Local Government Areas within Ibadan metropolis. See tables 3.1 and 3.2 .

**Table 3.1: Actual Number of Child delivery per year and estimated number of children per unit Population in Ibadan metropolis**

<b>Name of Local Government (LG)</b>	<b>2006 Local Government Census Result</b>	<b>2008 Actual No. of Child delivery per year</b>	<b>2008 No. of Children per unit population</b>	<b>2009 Actual No. of Child delivery per year</b>	<b>2009 No. of Children per unit population</b>
Ibadan North	308,119	6,244	0.0202649	10,036	0.0325718
Ibadan North East	331,444	2,270	0.0068488	3,998	0.0120624
Ibadan North West	154,029	1,050	0.0068169	1,429	0.0092775
Ibadan South East	266, 457	3,055	0.0114653	4,876	0.0182994
Ibadan South West	283,098	1600	0.0056518	2,456	0.0086754

Source: Oyo State Ministry of Health (Oyo State Health Management Information & Statistics Unit) 2010

**Table 3.2: Estimated Number of Children and Per-unit Population by age in Ibadan Metropolis**

<b>Name of Local Government (LG)</b>	<b>2007 Estimated No. of Child &lt; 1 year</b>	<b>2007 Estimated No. of Child &lt; 5 year</b>	<b>2006 Local Government Census Result</b>	<b>Estimated No. of &lt;1year Children per unit Population.</b>	<b>Estimated No. of &lt;5year Children per unit Population.</b>
Ibadan North	12,664	63,322	308,119	0.041101	0.2055115
Ibadan North East	13,638	68,194	331,444	0.0411472	0.2057482
Ibadan North West	6,309	31,545	154,029	0.0409598	0.2047991
Ibadan South East	10,982	54,912	266, 457	0.0412149	0.2060820
Ibadan South West	11,665	58,326	283,098	0.0412048	0.2060276

Source: Oyo State Ministry of Health (2008); Oyo State Health Facility Directory 2007.Pg13.

Ibadan North LGA is situated in Ibadan metropolis and it was carved out of the defunct Ibadan Municipal Government by the Federal Military Government of Nigeria on 27th September, 1991. In the North, the LGA is bounded by Akinyele Local Government. It is bounded by Ibadan North-East and Lagelu Local Governments in the East. In the West, it is bounded by Ido Local Government, Ibadan South-West and Ibadan South-East Local Government Area (Abiola, 2001).

Ibadan North LGA covers a large expanse of land with an area of about 132.5 square meters. It is multi-ethnic and is dominated by the Yoruba. The Igbo, the Edo, the Urobo, the Itsekiri, the Ijaw, the Hausa, the Fulani and some foreigners who are from Europe, America, Asia and other parts of the world are also resident in the LGA (Oyo State Ministry of Health (2008). The Local Government Area has a population of 308, 119 people. This comprises of 152, 608 males and 155, 511 females (Federal Republic of Nigeria Printers, 2009; Table 3.3 shows the population of local governments in Ibadan metropolis.

**Table 3.3: Population of the Local Governments in Ibadan Metropolis (2006 Census Result).**

<b>Name of Local Government (LG)</b>	<b>Male Population</b>	<b>Female Population</b>	<b>Total Population</b>
Ibadan North East	163,844	167,600	331,444
Ibadan North	152,608	155,511	308,119
Ibadan North West	75,410	78,619	154,029
Ibadan South East	130,334	136,123	266,457
Ibadan South West	139,622	143,476	283,098

Source: Federal Republic of Nigeria Printers, (2009). Report on the census 2006 final results. Federal Republic of Nigeria, *Official gazette*. 96.2. 2nd February, 2009.



Most people who live in the Local Government Area are in the private sector (self-employed). They are mainly traders and artisans. A good number of workers in the LGA are civil servants who live predominantly around Bodija Estate, Agbowo, Sango, Mokola, the University of Ibadan and the Polytechnic Ibadan. The notable tertiary institutions in the Local Government Area are the University of Ibadan, the Polytechnic, Ibadan, and University College Hospital Ibadan (Abiola, 2001).

Ibadan North Local Government has 12 geo-political wards with 6 State-owned health facilities, 11 Primary Health Centres/Maternity Centres and 157 registered private health institutions. Its health manpower includes 1 Medical Doctor, 15 Nurses/Midwives, 3 Pharmacist, 12 Community Health Assistants and 48 Community Health Extension Workers (Oyo State Ministry of Health, 2008). It has been stratified into 3 developmental zones – Inner core, Transitional and Peripheral - based on the characteristics, pattern of evolution and socio-economic status (Osundare, 990). Table 3.4 below shows the strata's' wards and communities in Ibadan North LGA .

**Table 3.4: Strata's Zones and Wards in Ibadan North Local Government Area**

ZONES	WARDS	COMMUNITIES
Inner core	1	Beere Kenike, Agbadagbudu, Oke Are, Odo Oye
	2	Ode-Oolo, Inalende, Oniyanrin, Oke Oloro
	3	Adeoyo, Yemetu, Oke Aremo, Isale Alfa
	4	Itutaba, Idi Omo, Oje-Igosun, Kube, Oke Apon, Abenla, Aliwo/Total Garden and NTA Area
Transitional	6	Sabo Area
	7	Oke Itunu, Cocacola and Oremeji Areas
	8	Sango, Ijokodo
	12	Agbowo, Bodija Market, Oju Irin, Barika, iso Patako, Lagos Ibadan Express
Peripheral	5	Bashorun, Oluwo, Ashi, Akingbola, Ikolaba and Gate
	9	Mokola, Ago Tapa and Premier hotel Areas
	10	Bodija, Secretariat, Awolowo, Obasa, Sanusi
	11	Samonda, Polytechnic, University of Ibadan

### 3.4 Description of Target Population and Inclusion Criteria

The target population for this study was men and women in spousal relationships and living together in Ibadan North LGA Oyo State. Eligible respondents were men within the ages of 15 to 49 and women within the ages of 15-49 who had two children and had had a child within the two previous years. They (couples) must have been living together since the birth of their last child. This study was limited to couples living in 20 communities from all three developmental zones in the Local Government Area. This represents about 40% of the total number of communities in Ibadan North LGA of Oyo State.

### 3.5. Sampling Procedure

#### I. Sample size Calculation

The total sample size was determined using the EPI INFO Statistical package which calculates sample size for determining the frequency of a factor in a population (random sample) and uses the following formula and variables:

Sample size  $n = [DEFF * Np(1-p)] / [(d^2 / Z^2_{1-\alpha/2} * (N-1) + p(1-p)]$  (Results from Epi Info, Version 2)

Where;

**N:** Population Size (No of Men in the LGA): 152,608 (see table 3.3)

**p:** Hypothesized frequency of outcome factor in a population or reasonable estimate of key proportion 68% +/-5

(In this study, key proportion refers to the proportion of men who desired more children after four living children)

**d:** confidence limit as % of 100 (absolute +/- %): 95%

Design effect (for cluster surveys-*DEFF*): 1

N = 384 at 95% confidence level

The calculated sample was however increased to **400** in order to address any possible cases of incomplete response.

## **II. Sampling Technique**

The multi-stage sampling technique was used in selecting couples that participated in the household survey. There are three development zones with a total of about 52 communities in Ibadan North Local Government area, each consisting of a number of compounds/households. Table 3.5 shows the distribution of respondents by their communities.

**Table 3.5 Community distribution of respondents**

Zone	Communities	Total Population (Male & Female- 2006 – NPC)	Number of Questionnaires Administered	No of Couples Interviewed
INNER CORE	Yemetu	5,667	20	10
	Inalende	7,666	28	14
	Oniyarin	1,880	6	3
	Isale Alfa	3,815	14	7
	Ikolaba	3,174	12	6
	Oje Igosun	5,200	16	8
	Ogbadagbudu	742	4	2
	Aliwo/Total Garden &NTA Area	2,664	10	5
<b>Sub Total</b>	<b>8 communities</b>	<b>30,818</b>	<b>110</b>	<b>55</b>
TRANSITIONAL	Cocacola Area	2,839	8	4
	Agbowo	28,419	82	41
	Sango	25,592	72	36
	Ijokodu	1,717	6	3
	Bodija market	15,377	42	21
<b>Sub Total</b>	<b>5 Communities</b>	<b>73,944</b>	<b>210</b>	<b>105</b>
PERIPHERAL	Bashorun	1,702	8	4
	Ashi	2,322	12	6
	Agodi Gate	1,482	8	4
	Ago Tapa	8,962	30	15
	Premier Hotel Area	2,212	12	6
	Samonda	1,195	6	3
	Polytechnic	611	4	2
<b>Sub total</b>	<b>7 communities</b>	<b>18,486</b>	<b>80</b>	<b>40</b>

Procedures for the selection of respondents are highlighted below:

**Step 1: Stratification of the wards and communities:** The wards and communities in the LGA were stratified into three developmental zones based on the characteristics, pattern of evolution and socio-economic status in accordance with the modified stratification model adapted by Osundare, (1990). See table 3.4 above-

**Step 2: Development of Sampling Frame:** A sampling Frame consisting of a list of all the communities under the 3 developmental zones in the area was made.

**Step 3: Selection of the communities:** The names of the communities were written on different sheets of papers of equal size and colour and divided first into three groups based on the development zone under which they belong. Still left in these bowls, these papers were squeezed and 40% of the total number of communities (squeezed papers) was randomly selected by balloting from each of the three developmental zones (three bowls).

**Step 4: Determining zonal and community sample size:** Based on the individual population and total population of selected communities in each zone, a proportionate sampling technique was used to determine the sample size (No. of couples/respondents) for each zone and subsequently each community. ( table 3.4. Above).

**Step 5: Selection of Houses:** Each community selected was divided into 4 clusters from a reference point which was —the centre of the community. Households were then systematically selected using a class interval of three from each of the community. Households where questionnaire was administered were those who met the inclusion criteria. For the households selected within the interval who did not meet the inclusion criteria, replacement selection was done.

**Step 6: Selection of respondents:** Each selected household was required to produce a couple meeting the eligibility criteria who would participate in the research. In a household with more than one married woman, balloting was done to produce the married woman in the household who was interviewed alongside the husband. Table 3.5 shows the sample distribution of respondents by their communities.

### **3.6 Study Variables**

There were four major variables from the conceptual framework that are relevant to this study. These include levels of male involvement in pre-natal and early child care, childcare-related stress experience, contraceptive behavior and desired family size.

### **3.7 Instruments for Data Collection**

**I. Semi-Structured Questionnaire** – Information from literatures guided the development of a researcher-administered semi-structured questionnaire. The questionnaire employed both open ended and closed ended question items. It was divided into five sections: The first section elicited information on the social-demographic and economic characteristics of respondents. In this section, respondents were expected to respond to 24 question items. These included those relating to their age, average monthly income, educational status, occupation, and religion among others. The second section elicited information on respondent's expectations and actual involvement in early childcare. In this section, spouses were expected to independently respond to specific question items relating to their childcare expectations and involvement in listed childcare tasks. The third section contained question items assessed respondent's early childcare stress experiences. Under this section, assessments of stress levels resulting from husband's involvement in early childcare hinged on three indicators: experience (feelings) of pressure, financial related childcare demands and time-related childcare demands. Finally, the fifth section elicited information on respondent's fertility desires, and contraceptive intentions and practice.

In this section, spouses were expected to independently respond to question items relating to the number of biological children they would love to have in their life time; as well as their

contraceptive intentions and practices. Questionnaires were written in English but were translated to *Yoruba* for participants that were from *Yorubaland* and were not educated for better understanding.

**II. Focus Group Discussion (FGD) Guide** - An FGD guide was developed to further elicit more in-depth information from respondents. It had three sections: Discussion starter, Main discussion points and Conclusion. Main discussion points probed for indigenous perceptions of men's involvement in early child-care, level of men's involvement in early child-care, influence of men's involvement in early childcare on their fertility desires and contraceptive intentions and practice.

### **3.8 Reliability of Instruments**

The reliability of an instrument is the degree to which it yields constant results on repeated trials. Several measures were taken to ensure the reliability of the instruments. The test-retested method was used to test the reliability of the research instruments. Prior to its use, the semi-structured questionnaire and FGD guide were pretested among 40 couples and 4 FGD groups (10% of the total sample size) who met the inclusion criteria described above in Ibadan North-West Local Government Area (IBNWLGA). The population of this LGA has similar characteristics with the actual study population but did not consist of those who participated in the real study. The ethical review committee of the State Ministry of Health, Ibadan, made some adjustments to the instruments. These corrections were incorporated before the instruments were administered.

The findings from the pretest were used to further scrutinize and reset the items in the instruments for necessary adjustments in the main study. The instruments also went through measures of internal consistency with the use of Cronbach Alpha coefficient analysis to confirm its reliability. This is a model of internal consistency, based on its average inter-item correlation. Results that show correlation coefficient greater than 0.05, are said to be reliable. In this study, the result was 0.625, which is greater than 0.05, thereby confirming its highest degree of reliability.



### **3.9 Validity of Instruments**

Validity is the degree to which an instrument measures what it is supposed to measure. The instrument was developed in simple English with its validity ensured through extensive literature search on spousal involvement in early childcare, spousal fertility desires and contraceptive behaviours. The draft of instruments was developed with assistance from the researcher's supervisor and lecturers in the field of reproductive health in Health Promotion and Education, College of Medicine to ensure face and content validity. All necessary corrections made by the experts were adapted to improve the instrument. Filter questions were strategically placed within the questionnaire to ensure that respondents were not faking responses.

Approaches to the validity of tests and measures include content and construct validity. To ensure validity of data collected, several steps were taken. Groups of items which were representative of content of trait to be measured were obtained. These included indigenous perceptions and practice with respect to the distribution of childcare task in the home; male pre-natal and early childcare related stress experience; contraceptive knowledge intentions and practice and; demographic and socio-economic information. Both the qualitative and quantitative tools were written in simple English and translated into *Yoruba* Language. This was designed to aid the comprehension of the respondents. The validity of content of the questionnaire was strengthened through an extensive review of literatures and supportive information obtained during the FGD. Furthermore, review of the instrument by the researcher's supervisor and other senior colleagues was extensively undertaken to provide face validity.

### **3.10 Ethical Considerations**

A number of steps were taken to address ethical issues inherent in the study. Prior to commencement of the study, the researcher got permission to carry out the study from Oyo State Ministry of Health Ethical Review Committee, Oyo State Secretariat, and Ibadan. In addition, informed consent by all participants was the basis for participation in the research. Participation was voluntary and there were no victimization of participants who refused to participate or withdrew midway. An assurance of confidentiality of participants' responses

was maintained during and after the conduct of FGDs and administration of questionnaire. In order to ensure anonymity of responses, names of participants were not written on any copy of the questionnaire, neither was names mentioned on record during any of the FGDs.

### **3.11: Method of Data Collection**

Prior to data collection, seven research assistants were recruited and adequately trained to ensure that they had good understanding of the instruments prior to commencement of data collection. Their training focused on objectives and importance of the study, sampling processes, how to secure respondents' informed consent, detailed review of the questions to ensure familiarity and interviewing techniques. The research assistants were also involved in pretesting of the questionnaire and FGD guide which created opportunities for them to acquire practical interviewing skills.

After pre-testing, and prior to the administration of the questionnaire, the researcher and research assistants facilitated six FGDs in three communities. Three (3) FGDs were carried out among husbands, while the other three were carried out among wives. After the protocol of obtaining permission from and meeting with the leaders of the communities including the *Baale*, women leaders and women of the community in general (separate meetings were held for men and women), appropriate date and time was fixed for the focus group discussions in selected communities. We ensured that one pair of FGD was conducted in each of the socio-economic cluster. Communities where we had the FGDs were randomly selected to include those represented in the table below:

**Table 3.6: FGD Zones and communities**

<b>ZONE</b>	<b>Communities</b>	<b>FGD</b>
Inner	Yemetu,	Men
Inner	Oje-Igosun	Women
Transitional	Cocacola Area	Women
Transitional	Sango	Men
Peripheral	Ashi	Women
Peripheral	Ago Tapa	Men

After a general meeting with the community, participants for the FGDs were selected. Only individuals who met the inclusion criteria were selected to participate in the FGD, each of which was made up of 8-10 persons. A moderator, a recorder and an observer conducted each FGD. The Principal Investigator served as an observer and the role of the observer was to note the non-verbal expressions of the discussants. With the permission of discussants in each FGD session, the whole conversation from the beginning to the end was tape-recorded. Following completion of the FGDs, the researcher and seven research assistants administered the questionnaire and this lasted a period of three weeks including the weekends. Households were visited daily from 9:00am to 6:00pm for the period. On the average, 20 questionnaire copies were administered daily.

### **3.132 Data Processing and Analysis**

Data from the FGD were processed and analyzed as follows: At the end of each FGD session, there was a brief meeting of researcher and research assistants in which observations during the discussions were raised and discussed. The recorder and the moderator later transcribed each tape from *Yoruba* to English while the researcher rechecked them to eliminate errors. Responses were organized and summarized, content analysis of discussions were done. Analysis looked for trends and patterns that reappeared within either a group

FGD or among various focus groups. Points of agreement and disagreements among discussants in various groups were identified. Trends and patterns as well as frequently mentioned and strongly held opinions were noted. Comparisons were made between different responses from various locations against one another. Similar responses were put together and then compared with contrasting one. Findings from the FGDs were used to refute or support findings from the quantitative survey results.

All questionnaire copies were edited by researcher for completeness. Processing of data included sifting, sorting, collation and coding of the administered questionnaire copies. A coding guide was developed after carefully reviewing the responses; responses were appropriately grouped and categorized.

Data were then entered using Statistical Package for Social Sciences (SPSS) software. Double data entry was checked and analysis was done using descriptive (mode mean and media) and inferential (i.e. Chi-square and Logistic regression) statistics. Frequency tables were generated and presented appropriately.

### **3.103 Limitation of Study**

Interpretations of results were done with the following limitations in mind: Preliminary investigations revealed that many child birth records were not efficiently collated by the relevant officers generally. The tertiary institutions such as University College Hospital and *Adeoyo* General Hospital have most of their patients from all over Ibadan. Therefore, the numbers of children allotted to the wards in these areas are an extension of deliveries from other wards. Besides, a good number of the citizens had their child deliveries at home without any record with the government. This observation was said to be more prevalent with the residents in the inner core. Although the sample was ethnically and socio-economically diverse, generalization of result beyond the target population and areas should be done with caution. In addition, since data collected was limited to self-report, possibilities of measurement errors no matter how small cannot be ruled out. The issue of funding was also a major limitation and this resulted in the fact that only six FGDs were conducted. It would have been more objective and helpful for the purpose of generalizability if more FGDs were conducted in each of the zone.

**CHAPTER FOUR**

**RESULTS**

**4.1 Social Demographic and Economic Characteristic of Respondents:**

A summary of respondents social demographic and economic characteristics are presented in table 4.1

#### **Respondents Age Group, Religion, Sex distribution, Ethnicity and Marital Status**

In this study, four hundred respondents were interviewed(200 husbands and their spouses(200). It recorded a response rate of 95% with 180( 50%) male respondents and 180(50%) female respondents. The overall mean age of respondents was  $30.9\pm 5.97$ . The mean age of male respondents was  $33.5\pm 6.03$  while that of the female respondents was  $28.6\pm 5.07$ . Majority of respondents 175(49.0%) fell within the 29-38 year age group followed by the 19 -28 year age group 139(38.9%). The distribution of respondents by their religious affiliations indicates that Islam was the dominant religion for respondents 190 (53.7%), while 164(46.3%) were Christians. Most respondent 336(94.1%) were Yoruba's, 1(0.3%) were Hausa's and 11(3.1) Igbo's. Majority of couples 309(86.6%) were married and few 48(13.4%) were co-habiting.

#### **Respondents Level of Education, Occupation and monthly income**

While 57(16.1%) respondents had no form of education; 71(20.0%) had primary school education, 159(44.8%) had secondary school and 68(19%) had at least one form of tertiary education. Most respondents were predominantly artisans 161(45.2%) Others 104(29.2%) were professionals like accountants and engineers. Traders/business men and women make up 23.3 %( 83) of respondents. The overall average monthly income of respondents was  $20991\pm 17278$ . Individual reports of the mean monthly income for male and female respondents were slightly different from spousal reports of monthly incomes. The Mean monthly income for male respondents as reported by men themselves was  $24828\pm 20485$ , while the mean monthly income for male respondents as reported by their spouses was  $13399.18\pm 21135.14$ . Similarly, the mean monthly income of female respondents as reported by women themselves was  $16920\pm 11797$  while the mean monthly income for female respondents as reported by their spouses was  $18147\pm 16175$ . The total monthly income for most 153(46.9%) respondents was in the range of 10,000 – 20,000 naira. Few 22(6.7%) respondents earned above 40,000 naira monthly.

**Table 4.1: Socio-Demographic & Economic Characteristics of Respondents.**

<i>Variables</i>	<i>Categories</i>	<i>Sex</i>	<i>Total</i>
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		<b>Men(N=195)</b> <b>n(%)</b>	<b>Women(N=195)</b> <b>n(%)</b>	<b>(N=390)</b> <b>n(%)</b>
<b>Age Group</b> <i>n= 357</i>	19-28	42(23.5)	97(54.5)	139(38.9)
	29-38	97(54.2)	78(43.8)	175(49.0)
	39-48	39(21.8)	3(7.1)	42(11.8)
	49 and above	1(0.6)	0(0.0)	0(0.6)
<b>Marital Status</b> <i>n=357</i>	Married	157(87.7)	152(85.4)	309(86.6)
	Cohabiting	22(12.30)	26(14.6)	48(13.4)
<b>Ethnic Origin</b> <i>n=357</i>	Yoruba	170(95.5)	166(93.2%)	336(94.1)
	Igbo	4(2.2)	7(3.9)	11(3.1)
	Hausa	1(0.6)	0(0.0)	1(0.3)
	Others	3(1.7)	5(2.8)	8(2.2)
<b>Religion</b> <i>n=354</i>	Christianity	77(43.3)	87(49.4)	164(46.3)
	Islam	101(56.7)	89(50.6)	190(53.7)
<b>Educational Status</b> <i>n=355</i>	No Formal	30(17.0)	27(15.1)	57(16.1)
	Primary	30(17.0)	41(22.9)	71(20.0)
	Secondary	76(43.2)	83(46.4)	159(44.8)
	Tertiary	40(43.2)	28(15.6)	68(19.2)
<b>Occupation</b> <i>n=356</i>	Professional	57(32.2)	47(26.3)	104(29.2)
	Artisan	98(55.4)	63(35.2)	161(45.2)
	Trader/Business	20(11.3)	63(35.2)	83(23.3)
	Student	2(1.1)	2(1.1)	4(1.1)
	Unemployed	0(0.0)	4(2.2)	4(1.1)
<b>Monthly Income</b> <i>n=326</i>	Less than 10,000	19(11.3)	42(26.6)	61(18.7)
	10,001 - 20,000	75(44.6)	78(49.4)	153(46.9)
	20,001 - 30,000	38(22.6)	19(12.0)	57(17.5)
	30,001 - 40,000	21(12.5)	12(7.6)	33(10.1)
	Above 40,000	15(8.9)	7(4.4)	<b>22(6.7)</b>

**4.2 Spousal Perception about Men's Responsibilities in Early Childcare** A large number of respondents (both male and female) felt that Husbands/fathers should be responsible for

financial related childcare responsibilities more than women. For example, 314(88.7%), 309(87.0%) and 271(76.3%) respondents believed that men should be more responsible for paying childcare related hospital bills and providing monies for the purchase of mother and child's food and clothings respectively. Comparatively, more men were positively poised towards this feeling than women. See table 4.2

**Table 4.2 Spousal Perceptions about Men's Responsibilities in Selected Childcare Tasks (N=354)**

Variable	Categories	Sex		Total n(%)
		Male (n=176) n(%)	Female(n= 178) n(%)	
<b>Who should pay for the family hospital bills</b>	More the husband	164(52.2)	150(47.8)	<b>314 (88.7)</b>
	More the wife	7(4.0)	11(6.2)	<b>18(5.1)</b>
	Both equally	5(2.8)	17(9.6)	<b>22 (6.2)</b>
<b>Who should always pay family feeding bills</b>	More the husband	166(93.8)	143(80.3)	<b>309 (87.0)</b>
	More the wife	5(2.8)	9(5.1)	<b>14(3.9)</b>
	Both equally	5(3.4)	26(14.6)	<b>31(8.7)</b>
<b>Who should always pay clothing purchase bills</b>	More the Husband	156(88.7)	114(42.0)	<b>271(76.3)</b>
	More the wife	10(5.6)	30(16.9)	<b>40(11.3)</b>
	<b>Both equally</b>	<b>10(5.6)</b>	<b>34(19.1)</b>	<b>44(12.4)</b>

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### 4.3 Spousal Expectations About Male Involvement in Early Childcare

Table 4.3 shows spousal expectations about male Involvement in early childcare. Spousal expectations were generally low during pregnancy, delivery and two years post delivery. Overall only few 72 (20.1%), respondents had very high expectations in relation to ~~male participation in pre-natal and early childcare. 168(46.9%) respondents and 118(33.0%) had~~ male participation in pre-natal and early childcare. 168(46.9%) respondents and 118(33.0%) had fairly high and Low expectations relating to male involvement in prenatal and early childcare. ~~fairly high and Low expectations relating to male involvement in prenatal and early childcare.~~

Spousal expectations were highest during delivery compared to during pregnancy and two years post delivery. 57(15.9%), 113(31.6%), 44(12.3%) had very high expectations during pregnancy, delivery and 2 years post delivery respectively. When disaggregated by gender, women's expectations about their spouse's involvement in childcare though slightly higher was similar to men's assessments of their spouse's expectations. During pregnancy many women 93(52.0%), had low expectations, some 56(31.3%) had fairly high expectations and few 30(16.8%) had very high expectations about men's involvement in prenatal childcare, Similarly, some men 57(31.8%) felt that their spouses had low expectations, many 95(53.1%) felt that their spouses had fairly high expectations while others 27(15.1%) felt that their spouses had very high expectations.. During delivery and within two years post delivery, Women's expectations also varied with men's assessments of their spouses' expectations.

**Table 4.3: Spousal expectations about Male Involvement in Early Childcare**

Expectations	Sex		Total (N=358)		
	Male(N=179) n (%)	Female(N=179) n (%)	n(%)	Percent (%)	
<b>Overall</b>	Low	63(35.2)	55(30.7)	118(33.0)	33.0
	Fairly high	83(46.4)	85(47.5)	168(46.9)	46.9
	Very high	33(18.4)	39(21.8)	72(20.1)	20.1
	Total			358	100.0
<b>During Pregnancy</b>	Low	57(31.8)	93(52.0)	188(52.5)	52.5
	Fairly high	95(53.1)	56(31.3)	113(31.6)	31.6
	Very high	27(15.1)	30(16.8)	57(15.9)	15.9
	Total			358	52.5
<b>at Child Delivery</b>	Low	125(69.8)	120(67.0)	245(68.4)	68.4
	High	54(30.2)	59(33.0)	113(31.6)	31.6
	Total				100.0
<b>Within 2-years AfterDelivery</b>	Low	64(35.8)	60(33.5)	124(34.6)	34.6
	Fairly high	94(52.5)	96(53.6)	190(53.1)	53.1
	Very high	21(11.7)	23(12.8)	44(12.3)	12.3
	Total			358	100.0

#### 4.4 Specific childcare related tasks men are expected to perform

Most respondents in the survey expect men to be actively involved in performing five key childcare and related task or responsibilities during the period of pregnancy. Table 4.4 shows the frequency of early childcare task wives expected their spouses to perform and husbands felt their wives expected them to perform during their last pregnancy. Two hundred and ninety-two (91.3%) respondents expected that husbands would buy wife's medications, 273(85.3%) expected that husbands would pay for their wives antenatal clinics, 216(67.5%) expected that husbands' would spend more time with their pregnant wives. A hundred and fifty-eight (49.3%) respondents expected that husbands would fetch water for the family and 130(40.6%) expected that Husbands would clean the house -(table 4.4)

**Table 4.4 Spousal Response to the Specific Childcare Related Task Men are Expected to Perform During Pregnancy. N=320**

Childcare Task Expected	Sex		Total n (%)
	Male	Female	
Clean the House	68(52.3)	62(47.7)	130(40.6)
Sweep the House	43(47.3)	48(52.7)	91(28.4)
Accompany wife to antenatal visits	44(50.6)	42(49.4)	86(26.8)
Wash wife's cloths	23(48.9)	24(51.1)	47(15.20)
Wash the older children's cloths if any	26(46.3)	31(53.7)	57(17.7)
Prepare meals for the family	34(48.6)	36(51.4)	70(21.8)

Take the older children to school if applicable	60(46.5)	69(53.5)	129(40.3)
Fetch water for the family	76(48.1)	82(51.9)	158(49.3)
Go to the market and shop for the family	37(46.8)	42(53.2)	79(24.7)
Pay for antenatal bills	128(46.9)	145(53.1)	273(85.3)
Buy wives medications	139(47.6)	153(52.4)	292(91.3)
Spend more time with wife	105(48.6)	111(51.4)	216(67.5)

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Similarly, respondents' childcare expectations within the first 2 years after childbirth rested on five key tasks/responsibilities: provide money to pay Child's hospital bills 309(96.6%); provide money to buy clothes for the baby 309(96.6%); provide money to buy food for the children 302(94.4%); buy wives' medications and that of the child 284(88.8%), and spend more time with mother -212(66.3%) see table 4.5.

**Table 4.5 Spousal Response to the Specific Childcare Related Task Men are Expected to Perform During The First Two Years After Childbirth.**

Expected Childcare Task Within 2-years After Childbirth	Sex		Total(N=320)
	Male	Female	n (%)
Clean the House	56(47.9)	61(52.1)	117(36.6)
Sweep the House	39(55.7)	31(44.3)	70(21.8)
Put child to sleep	81(48.2)	87(51.8)	168(52.5)
Take the older children to school if applicable	25(47.2)	28(52.8)	53(16.6)
Prepare meals for the child	33(48.5)	35(51.5)	68(21.3)
Fetch water for the family	70(49.6)	71(50.4)	141(44.0)
Go to the market and shop for the family	35(48.6)	37(51.4)	72(22.5)
Take the child to the doctor when sick	74(46.5)	85(53.5)	159(49.7)
Buy your medications and that of the child	139(48.9)	145(51.1)	284(88.8)

<b>Spend more time playing with the child</b>	88(50.6)	86(49.4)	<b>174(54.3)</b>
<b>Spend more time with you</b>	104(49.1)	108(50.9)	<b>212(66.3)</b>
<b>Accompany the child for immunization</b>	45(46.4)	52(53.6)	<b>97(30.3)</b>
<b>Prepare meals for you and the other children</b>	37(49.3)	38(50.7)	<b>75(23.4)</b>
<b>Take the other children to school and bring them back</b>	65(47.1)	73(52.9)	<b>138(43.1)</b>
<b>Fetch water for the house</b>	83(45.4)	100(54.6)	<b>183(57.1)</b>
<b>Provide Money to pay hospital bills</b>	141(48.3)	151(51.7)	<b>292(91.3)</b>
<b>Provide Money to buy food for the children:</b>	143(47.4)	159(52.5)	<b>302(94.4)</b>
<b>Provide Money to buy cloths for the baby</b>	149(48.2)	160(51.8)	<b>309(96.6)</b>
<b>Provide Money to pay the child's hospital bills</b>	<b>147(47.6)</b>	<b>162(52.4)</b>	<b>309(96.6)</b>

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Just like findings from the survey, majority of FGD discussants felt that husbands/fathers should be responsible for all financial-related needs of the mother and child, like paying hospital bills, providing monies for food and purchase of clothes, medications, shelter etc. In addition to these, husbands/fathers should also provide spiritual needs of their wives and children during this period, express love to their children and instill discipline in them. According to one female discussant, *'Since we don't use to have enough strength during pregnancy, men ought to be helping us in household chores, carry heavy loads till we put to bed. Apart from household chores, they need to show more love, it is not time to look out for other women.'*

Another male discussant added that:

*'A Father must be responsible for the care of the mother and children in providing money, food clothes and school fees. He must also take action in discipline the child when wrong.'*

Some male discussants also added that taking on such task is a way of reciprocating the care God provides for them. In one discussant's own words: *'A father is the God of a child in this world'*.



Some male and female discussants believed that a because a man is responsible for his spouses pregnancy he should take up all responsibility and challenges that comes with it and care for the child. Besides taking responsibility for the care of the mother and child during pregnancy and after childbirth is a way of expressing appreciation to the mother for successfully carrying a pregnancy and giving birth: A quote by one of the male discussant goes thus: *“I should buy cloths for her too & show love to her through all means to appreciate her for carrying the pregnancy & giving birth to the baby safely”*.

#### 4.5 Actual Male Involvement In Early Childcare

The average correlation between mother’s assessment of men’s involvement and men’s reports of their involvement in this study was .68 for the child-care tasks. One hundred and sixty (44.7%) respondents’ reported that men’s involvement in early childcare was low, 129 (36.0%) respondents reported that male involvement in early childcare was fairly high, and only 69(19.3%) respondents reported that male involvement was very high. See table 4.6.

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**Table 4.6: Spousal Report of Actual Male Involvement in Early Childcare**

Gender	Male Involvement			Total(N=358) n (%)
	Low n (%)	Fairly High n (%)	High n (%)	
Men	79(44.1)	62(34.6)	38(21.2)	179(50.0)

<b>Women</b>	81(45.3)	67(37.4)	31(17.3)	179(50.0)
<b>Total</b>	160(44.7)	129(36.0)	69(19.3)	358(100)

These findings were similar to observations related by majority of the FGD discussants who noted that although few husbands supported their wives financially and in performing some household task like cleaning, fetching water and caring for the older children, during pregnancy through 2-years post delivery: most husbands spend relatively insignificant time in providing support to their wives' during pregnancy, delivery and early years after a child is born:

*“Most men in this community don’t help their wives; some don’t even have the knowledge of the importance of helping their wives in pregnancy. We even see many pregnant women in this community carrying heavy load or hawking and they continue to hawk until they give birth – this shows that they are sustaining themselves in their homes with what they sell”.* One female FGD discussants noted.

Another female discussant also mentioned thus: *“In my own case, my own husband neglects me anytime I am pregnant till I deliver, he will not even talk to me sometimes not to talk of helping me or supplying my needs”*

A male discussant had this to say: *“It is not common at all for husbands to help their wives during delivery; most of them will just leave their wives in the hospital and go their way expecting the baby. Some of them may not even bother to know the sex of their baby when he/she is born”*

#### **4.6 Expectations versus Actual Male involvement in Childcare (Performance)**

Out of 188(52.5..%) respondents who had low expectations about men’s involvement in childcare, 126(67.0%) reported low levels of male involvement (low performance), 41(21.8%) reported fairly high levels and only 21(11.2%) reported very high levels of involvement. Similarly, out of the 57(15.9%) who had very high expectations, only 6(10.5%) reported low levels of male involvement, while 24(42.1%) reported very high levels of male involvement in child caring task. (Table 4.20)

Many men performed some five childcare tasks women expected them to perform (, 98.6%, 97.4%, 89.2%, 76.4% and 68.5% respectively). Similarly husbands performed same five identified areas of expectations within 2 years after delivery (98.7%, 94.3%, 98.8%, 99.0% and 96.8.0% respectively). Table’s 4.78, and 4.89: Overall, Reports of male involvement in these top five childcare tasks were higher after childbirth than they were before childbirth. In addition, the relationship between women’s expectations and men’s involvement in childcare tasks was significant, ( $p<0.05$ ) even though there were little variations between women’s report of men’s involvement and men’s report of their involvement. While about seventy-two

percent (72.7%) of men said they usually participate in childcare task, 67.3% of women also reported their husbands usually participated in childcare related task.

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**Table 4.78: Spousal Expectations and Male Involvement in Five Top Prenatal Childcare Tasks. N=320)**

<b>Childcare Tasks</b>	<b>Spousal Expectations n (%)</b>	<b>Male Involvement n (%)</b>
Clean House	130(40.6)	89(68.5)
Fetch Water	158(49.3)	141(89.2)
Pay Antenatal Bills	273(85.3)	266(97.4)
Buy Wive’s Medications	292(91.3)	288(98.6)
Spend more time with pregnant wife	216(67.5)	165(76.4)

**Table 4.98: Spousal Expectations and Male Involvement in Five Top Postnatal Childcare Tasks. N=320)**

<b>Childcare Tasks</b>	<b>Spousal Expectations n (%)</b>	<b>Male Involvement n (%)</b>
Buy Medication for Mother and Child	284(88.7)	274(96.8)
Provide money for mother’s hospital bills	292(91.3)	287(99.0)
Provide money for child’s food	302(94.4)	297(99.0)
Provide money for child’s cloths	309(96.7)	290(94.3)
Provide moneys for child’s hospital bills	309(96.7)	304(98.7)

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Similarly, Majority of female FGD discussants noted that they would greatly appreciate help from their spouses in the areas of washing their undergarments because there would be enough help from friends and relatives within the first two years after childbirth to handle other household chores. They would greatly appreciate support from their spouses in taking the child for all its immunization sessions and caring for the older children were they exist as external help will be limited or non-existent for these tasks., Most of them will also appreciate expressions of understanding from their spouses in relation the challenges of nursing a growing child. One of them said: *'It is not the time for the husband to be shouting that the baby has claimed something or mess his body'*

Majority of male discussants recognized that they should always spend time with the child to allow the mother time to attend to other household chores like washing or cooking in the kitchen. Only few felt that they should wake up at night and support their wives to nurse the child, ensure that they are well fed to help with quick recovery from delivery and facilitate the provision of help in the house either a relative or paid labor to help with caring for the mother and child.

#### **4.7 Spousal Early Childcare Stress Experience**

Most respondents 230(65.2%) felt that men experience increased stress from the period of pregnancy through the first two years after childbirth. Most husbands 125(54.3%) and wives 105(45.7%) reported increased early childcare stress levels for men, table 4.109

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**Table 4.109: Men’s Early Childcare Stress Experience**  
N(358)

<b>Stress Experience</b>	<b>Husbands n (%)</b>	<b>Wife n (%)</b>	<b>Total n (%)</b>
No Difference in Stress Experience	50(40.7)	73(59.3)	123(34.8)
Increased Stress Experience	125(54.3)	105(45.7)	230(65.2)
Total	175(100)	178(100)	358(100)

However, few FGD discussants majority of who were women felt that the period of pregnancy, delivery and pre-school years of their last child was a period of increased stress on their husbands. For most male discussants, women experience most of the stress, because they carry the pregnancy, deliver the baby and spend more time with the child after he/she is born; they do not consider early childcare an issue of stress. According to one male discussant: *“The stress may not affect the man directly because they are often out of the house and are not around to participate in household chores that arise from childcare”*

Majority of FGD discussants however noted that childcare related stress during pregnancy, delivery and two years post delivery could be a determinant of intra-household fertility decisions. Many female FGD discussants said that husband’s relative domestic contribution reduces the likelihood of having more children: One of them commented thus: *‘I know a woman that when she is pregnant, she is unable to do anything, so the whole stress is on the husband and this in-turn influenced his decisions about the number of children he decided to have after the birth of his first child’*.

Another female discussant had this to say: *‘For women that usually deliver through cesarean section (CS), it may influence the number of children the husband will decide to have due to the stress he does pass through’*

Few men agreed that stress and pressure associated with pregnancy and childcare influences the number of biological children they would like to have in a life time, *‘Yes, pressure associated with my wives’ last pregnancy and childcare significantly influenced the number*

of children we decided to have' one of them noted. Some however felt that men's fertility desires were self determined and had no relationship with any external factor. They felt that since pregnancy and childcare were not time demanding for them it does not influence on their fertility desires. One male discussant stated thus:

A male discussant had this to say:

*'Demand on time does not really have effects on the number of children I choose to have because I don't spend extra time with the mother or child except a few times at night when the child needs some attention besides a friend of mine's wife gave birth to 2 children through caesarian section and did not stop because of the stress or cost of child care, he stopped because he initially determined to have only 2 children'*

Others added that men could experience stress caused by the pressure to meet the increasing financial demand that arises from pregnancy and childbirth. This may also not influence their fertility desires. One male discussant explained thus: *'The stress of time and direct care may not affect the man especially if the nature of his work does not give room to helping his wife in domestic work during pregnancy and childbirth. These periods will only have effect on his finance and that may not reduce number of children if there is enough money'*

Most respondents from the survey also believed that men's stress experience could be higher at some stages of childcare than the others. For example, while 300 (85%) felt that men experience increased stress during pregnancy, 304(84%) felt that men experience increased stress during delivery and 231(64.5%) felt that men experience increased stress within the first 2 years after the child is born..

#### **4.8 Spousal Desired Family Size**

Spousal desired family size was generally large – more than half (61.5%) of respondents would like to have more than four biological children in their live time. Husbands desired family size was generally higher than those of their wives. The mean desired family size for Husbands was  $4.7 \pm 1.6$  and those for wives were  $4.1 \pm 1.3$ . Out of 390 respondents, 275(70.6) indicated their desired family size in exact numbers while others 115(29.4%) felt



that their family sizes will determined by their creator. Out of the 275 male and female respondents who indicated their desired family size in exact numbers, Most(69.5%) husband’s desired more than four children while only 43(30.5%) wanted less then four children. Wive’s report of their desired family size were such that 71(53.0%) would love to have above four biological children in their life time while only 63(47.0%) will want to have at most four children in their life time.. See table 4.10.1.

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**Table 4.10.1: Spousal Desired Family Size.**

N=390

Desired Family Size	Gender		
	Male n (%)	Female n (%)	Total – n(%)
Not more than four Children	43(40.5)	63(59.4)	106(27.1.)
Above four children	98(57..9)	71(42.0)	169(43.3).
As God Pleases	70(61.4)	45(39.1)	115(29.4)
<b>Total</b>	<b>211(54.1)</b>	<b>179(45.9)</b>	<b>390(100)</b>

**4.9 Spousal awareness about contraceptives, intentions and Practices**

Most 333(93.5%) respondents have heard of contraceptives. See Table 4.12.1. One Hundred and sixty-six(93.8%) were men while 167(93.3%) were women.

**Table 4.12.1: Spousal awareness of contraceptives**

Sex	Ever Heard of Contraceptives		Total (N=356) n(%)
	Yes n(%)	No n(%)	
Male	166(93.8)	11(6.2)	177(49.7)
Female	167(93.3)	12(6.7)	179(50.2)

Total	333(93.5)	23(6.5)	356(100)
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The most commonly identified method of traditional contraceptives were the withdrawal method, the most commonly known type of modern contraceptives were condoms, injectibles, IUCD and Pills. For Husbands, condoms(31.0%), injectibles (15.0% ) and pills (10.5%) were most commonly identified, while for women, injectibles(17.3%) pills(14.5%) and condoms(9.3%) were the most commonly identified. See table 4.123.

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**Table: 4.123: Commonly Identified methods of contraceptives. N=358**

Method	Men n(%)	Women n(%)	Total(N=358) n(%)
Condom	108(41.5)	133(55.1)	241(67.3)
Injectibles	51(42.5)	69(57.5)	120(33.5)
IUCD	7(41.1)	10(58.8)	17(4.7)
Pills	38(43.1)	50(56.1)	88(24.5)
Traditional (Withdrawal)	17(51.5)	16(49.5)	33(9.2)

### Spousal Contraceptive Intentions

Overall, respondents had relatively negative intentions towards contraceptives. Most 250(64%) respondents wanted more children. Among those who wanted more children, nearly half 116(46.4%) wanted at most two more children, others 134(53.6%) wanted at least two more children. see Table 4.134.

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**Table 4.134: Spousal Intentions for further childbearing. N=390**

<b>Desired Additional No. of Children s</b>	<b>Husbands n(%)</b>	<b>Wives n(%)</b>	<b>Total – n (%)</b>
2 more children	55(47.5)	61(52.6)	116(29.7)
More than 2 children	72(53.7)	62(46.3)	134(34.3)
No Response	65(46.4)	75(53.6)	140(35.8)
<b>Total</b>	<b>192(50.8)</b>	<b>198(49.2)</b>	<b>390(100)</b>

Very few men' 44(25.6%) expressed their intentions to use or encourage their spouses to use contraceptives when they were pregnant for their last child. However, more men 105 (59.3%) expressed their intentions to use or encourage their spouses to use contraceptives within two years of their last childbirth. See table 4.145.

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**Table 4.145 Men's Expressed Intentions towards Contraceptive use. N=354**

<b>Expressed Intention for Contraceptives Use</b>	<b>Categories</b>	<b>Men n(%)</b>	<b>Women n(%)</b>	<b>Total- N (%)</b>
During the last pregnancy	Yes	44(25.6)	37(21.3)	81(23.4)
	No	128(74.4)	137(78.7)	265(76.6)
	Total	172(49.7)	174(50.3)	346(100)
within 2 years after the birth of	Yes	105(59.3)	106(59.9)	211(59.6)
	No	72(40.7)	71(40.1)	143(40.4)

your last child	Total	177(50.0)	177(50.0)	354(100)
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Most female FGD discussants had more positive attitudes towards contraceptive use as compared to husbands. Most men –believed that modern contraceptives had a number of harmful disadvantages for women: ‘contraceptives *could encourage promiscuity among women and can result to STD and delay in pregnancy*’ says one male respondent. Majority of women believed that the advantages of contraceptives outweigh the disadvantages. Both male and female discussants however felt that contraceptives are more beneficial to women especially in the areas of enhancing maternal health and preventing unwanted pregnancy. One female discussant noted thus: “*Contraceptives help mothers to rest from pregnancy because pregnancy is not a joke and childbirth to ensure proper recovery of lost blood and water. Also, if there is enough gap between the children, the older one can assist the mother in some household chores*”

A male respondent also agreed thus: “*contraceptives reduces unwanted sudden death among women due to unwanted pregnancy which can lead to abortion or the pre-mature child*”

Few male respondents however noted that contraceptives also benefits men but indirectly. According to one of them, “*contraceptives help women plan how to give birth since most men cannot control their sexual urge. Infact, it prevents violence associated with sex among couples*”

### **-Spousal Contraceptive Behavior**

Men and women’s report of their contraceptive behavior and their spouse’s contraceptive behavior were highly coherent even though there were slight variations in men’s report of their contraceptive behavior and women’s report of their spouse’s contraceptive behaviours and vice versa. For example, 65(36.7%) female respondents reported that they had used any form of contraceptives in the last two years but 58(33.5%) men reported that their spouses had used contraceptives in the last two years. Similar reports were gotten for male respondents. Men and women’s report of their contraceptive behavior showed poor contraceptive uptake among both male and female respondents. Out of the 174(100%) male respondents, only 63(36.2%) reported using any form of contraceptive within the last two years with their spouse, others 111(63.8%) reported never using any form of contraceptive. These results were similar with those reported by their spouses where 65(36.7%) out of 178(100%) wives reported that they had used any form of contraceptives within the last two years with their spouse (Table 4.165). There was no significant difference between men and women’s report of their contraceptive behaviours ( $P>0.05$ )

**Table 4.165: Spousal Contraceptive Behavior**

Gender	Used Contraceptives Within Last Two Years			Spouse Used Contraceptives Within Last Two Years		
	Yes	No	Total	Yes	No	Total
Men	63(36.2)	111(63.8)	<b>174(49.6)</b>	58(33.5)	115(66.5)	<b>173(49.3)</b>
Women	65(36.7)	112(63.3)	<b>177(50.4)</b>	69(38.8)	109(61.2)	<b>178(50.7)</b>
<b>Total</b>	<b>128(36.5)</b>	<b>223(63.5)</b>	<b>351(100)</b>	<b>127(36.2)</b>	<b>224(63.8)</b>	<b>351(100)</b>

Majority of husbands on contraceptives used condoms (14.3%) and withdrawal method (8%). While the most commonly used contraceptive method for women were pills (12%) and injectable (6.8%) For both men and women, reasons for using contraceptives were based on decisions to stop childbirth or space children, and reasons for not using contraceptive were spouse on use (12.3%), dislike (8.0%) and side effects (5.8%).

#### 4.10 Test of Hypothesis

##### 4.10.1 Hypothesis 1 - There is no significant relationship between couple income and Men's' desired family size.

Table 4.167 shows that there is a significant relationship between couple income and men's desired family size ( $X^2=10.376$ ,  $df=4$ ,  $p=0.03$ ). It was observed that majority 48(80%) out of 60 respondents with monthly earnings of 10,000 -20,000 desired to have more than 4 children compared to 41(56.9%) out of 72 who had average monthly earnings of over 40,000 naira and desired to have between 1-4 children in their life time.

**Table 4.176 Relationship between Couple Income and Men's Desired Family Size**

		Desired Family Size		
		1-4 children n(%)	Above 4 children n(%)	Total n(%)
<b>Monthly Income (Naira)</b>	Less than 10,000	10(50%)	10(50%)	20(100)
	10,001 -19,999	12(20.0%)	48(80.0%)	60(100)
	20,001 – 30,000	21(37.5)	35(62.5)	56(100)
	30,001 – 40,000	11(42.3)	13(57.1)	26(100)
	Above 40,000	31(43.1)	41(56.9)	72(100)
	Total	85(36.3)	149(63.7)	234(100)

Chi square  $X^2=10.376$

$df=4$ ,

$p<0.05$

**4.10.2 Hypothesis 2 - There is no significant relationship between religion and men's desired family size**

Table 4.178 shows that there is a significant relationship between religion and men's desired family size ( $X^2 = 36.496$ ,  $df = 1$ ,  $p = 0.00$ ). More than half 70(58.8%) Christians wanted to have between 1 and 4 children in their life time while 105(38.6%) Muslims said they would want to have between 1 and 4 children. However, 49(41.25) Christians and 118(77.1%) Muslims said they would love to have more than four children in their life time.

**Table 4.178 Relationship between religion and men's desired family size**

Religion	Desired Family Size		Total (N=272)
	1-4 Children n (%)	Above 4 Children n (%)	n(%)
Christianity	70(58.8)	49(41.2)	119(100)
Islam	35(22.9)	118(77.1)	153(100)
Total	105(38.6)	167(61.4)	272(100)

Chi square  $X^2 = 36.496$ ,  
 $df = 1$   
 $p < 0.05$



**4.10.3 Hypothesis 3 There is no significant relationship between educational status and men’s desired family size**

Table 4.198 shows that there is a significant relationship between Men’s educational status and their desired family size ( $X^2 = 15.707$ ,  $df = 3$ ,  $p = 0.04$ ). Only 4(21%) respondents with tertiary educational status, wanted more than four children, compared with 7(38%) and 24(68%) of those with no formal education and only primary education respectively.

**Table 4.189 Relationship between educational status and men’s desired family size**

Educational Status	Desired Family Size		Total(N=134)
	1-4 children	Above 4 children	
No formal	11(61.1)	7(38.9)	18(100)
Primary	11(31.4)	24(68.6)	35(100)
Secondary	26(41.9)	36(58.1)	62(100)
Tertiary	15(78.9)	4(21.1)	19(100)
Total	63(47.0)	71(53.0)	134(100)

Chi square  $X^2 = 15.707$

$df = 3$

$p = 0.004$

**4.6.4 Hypothesis 4 - There is no significant relationship between spousal expectations about male involvement in early childcare and actual male involvement early childcare.**

Table 4.2190 shows the results of the chi-square test used to determine the relationship between spousal expectations about male involvement in early childcare and actual male involvement in early childcare. It was observed that the relationship was statistically significant ( $X^2 = 90.627$ ,  $df=4$ ,  $p=0.000$ ). Out of 188(52.5.%) respondents who had low expectations about men’s involvement in childcare, more than half 126(67.0%) reported low levels of male involvement (low performance), and only 21(11.2%) reported very high levels of involvement. similarly, out of the 57(15.9%) who had very high expectations, only 6(10.5%) reported low levels of male involvement, while 24(42.1%) reported very high levels of male involvement in child caring task. (Table 4.20)

**Table 4.2190 Relationship between spousal expectations about Male involvement in early childcare and actual male involvement in early childcare**

Expectations	Actual Performance								Total	
	Low	Males Report			Total	Low	Females Report			Total
		Fairly High	Very High	Very High			Fairly High	Very High		
Low	63(66.3)	21(22.1)	11(11.6)	95(50.5)	63(66.3)	20(21.5)	10(10.8)	93(49.6)	<b>188(52.5)</b>	
Fairly High	13(22.8)	29(50.9)	29(50.9)	57(50.4)	15(26.8)	32(57.1)	9(16.1)	56(49.5)	<b>113(31.6)</b>	
Very High	3(11.1)	12(44.4)	12(44.4)	27(47.3)	3(10.0)	15(50.0)	12(40.0)	30(52.6)	<b>57(15.9)</b>	
<b>Total</b>	<b>79(44.1)</b>	<b>62(34.6)</b>	<b>52(29.0)</b>	<b>179(50.0)</b>	<b>78(43.5)</b>	<b>67(37.4)</b>	<b>31(17.3)</b>	<b>179(50.0)</b>	<b>358(100)</b>	

Chi square  $X^2 = 90.627$

$df = 4$

$P = 0.000$

**4.10.5 Hypothesis 5 - There is no significant relationship between actual male involvement in early childcare and Men’s desired family size.**

Table 4.204 shows that the relationship between actual male involvement in early childcare and Men’s fertility desires was significant ( $X^2 = 8.998$ ,  $df = 2$ ,  $p = 0.01$ ). It was observed that majority 49(79.9%) of male respondents with low levels of involvement in childcare desired to have more than four biological children in their life time.

**4.204 Relationship between Actual Male Involvement In Childcare and Men’s Desired Family Size**

Actual Male involvement in early childcare	Desired Family Size		Total n (%)
	1-4 children n(%)	Above 4 children n (%)	
Low	12(20.3)	47(79.7)	59(100)
Fairly High	23(25.0)	27(54.0)	50(100)
Very High	8(25.0)	24(75.0)	32(100)
Total (N)	43(30.5)	98(69.5)	141(100)

Chi Square  $X^2 = 8.998$

$df = 2$

$P = 0.01$

**4.10.6 Hypothesis 6 – There is no significant relationship between actual male involvement in early childcare and the contraceptive behavior of their spouses and themselves.**

Table 4.22<sup>1</sup> shows that there is no significant relationship (Men:  $X^2 = 3.481$ ,  $df = 2$ ,  $p = 0.175$ ; Women:  $X^2 = 1.399$ ,  $df = 2$ ,  $p = 0.495$ ) between actual male involvement in early childcare and the contraceptive behavior of their spouses and themselves. 23(62.2%) out of 37(100%) male respondents with high levels of involvement in early childcare never used any form of contraceptive in the last two years prior to the time of data collection. Similarly, 109(61.2%) out of 178(100%) female respondents whose assessments of their spouses involvement in early childcare was high, had not used any form of contraceptive in the last two years.

**Table 4.22<sup>1</sup> Relationship Between actual male involvement in early childcare and the contraceptive behavior of their spouses and themselves**

Actual Male Involvement in Early Childcare	Used Contraceptives					
	Male Response			Female Response		
	Yes n (%)	No n (%)	Total- n (%)	Yes n (%)	No n (%)	Total n (%)
Low	23(30.3)	53(69.7)	76(100)	30(37.0)	51(63.0)	81(100)
Fairly high	26(42.6)	35(57.4)	61(100)	29(43.9)	37(56.1)	66(100)
Very high	14(37.8)	23(62.2)	37(100)	10(32.3)	21(67.7)	31(100)
Total	63(36.2)	111(63.8)	174(100)	69(38.8)	109(61.2)	178(100)

**Men:**  $X^2 = 3.481$ ,  $df = 2$ ,  $p = 0.175$ ;

**Women:**  $X^2 = 1.399$ ,  $df = 2$ ,  $p = 0.495$

**4.10.7 Hypothesis 7 - There is no significant relationship between men’s early childcare stress experience and their desired family size**

Table 4.232 shows that the relationship between men’s early childcare stress experience and their fertility desires is significant ( $X^2 = 7.437$ ,  $df = 1$ ,  $p = 0.006$ ). Thirty-six (85.7%) male respondents who felt there was no difference in their stress experiences during the period of their most recent pregnancy, delivery and two years post delivery p, said they would like to have more than four biological children in their life time. Contrastingly, more than half 60 (62.5%) male respondents who experience increased stress experience during their most recent pregnancy, delivery and two years post delivery periods, said they would want to have less than four biological children in their life time.

**Table 4.232 Relationship between men’s early childcare stress experience and their fertility desires**

Men’s Early Childcare Stress Experience	Men’s Desired Family Size		Total n(%)
	1-4 children n(%)	Above 4 children n(%)	
No difference in stress experience	6(14.3)	36(85.7)	42(100)
Increased stress experience	36(37.50)	60(62.5)	96(100)
Total	42(30.4)	96(69.6)	138(100)

Chi square  $X^2 = 7.437$ ,  
 $df = 1$ ,  
 $p = 0.006$

#### **4.10.8 Other Predictors of Men's Fertility Desires**

Given that actual male involvement in early childcare, couple monthly income, men's educational status and religion were found to be significantly associated with men's fertility desires, logistic regression analysis was used to explore the strength of significance for each of these contributing factors to men's desired family size. Table 4.24<sup>3</sup> demonstrates that Men with tertiary education are 1.7 times more likely to desire less than four children (OR=1.743, C.I =0.671-4.524) compared to those with no formal education; while those with secondary education are 2.4 times more likely to desire less than four children than men with no formal education. (OR =2.429 C.I =0.755-7.821). Couples whose average monthly income is above 40,000 naira are 1.4 times more likely to desire less than four children than those with average monthly income of less than 10,000 naira. However, those with average monthly income in the range of 20,000 -30,000 naira are 2.0 times more likely to desire less than four children (OR=2.01, C.I: 0.806 -5.052). It was also observed that men who are fairly involved in early childcare were 1.3 times more likely (OR=1.397, C.I =1.157 -3.418) to desire less than four children than those who were poorly involved in childcare while men who were highly involved in childcare were 2.5 times less likely to desire more than four children than those who were poorly involved (OR=2.43, C.I:1.91-6.44) Couples with Islam religious orientation were 5 times less likely to desire less than 4 children than those with Christian religious orientation. Only male involvement in early childcare tasks and spousal religion were found to be predictors of men's desired family size as they were statistically significant at  $p < 0.05$ .

**Table 4.243 Predictors of Men's Fertility Desires (Test of Significance -Logistic Regression Test)**

Variable		Odds Ratio(OR)	Sig(P)	95% Confidence Interval(C.I) for OR	
				Lower	Upper
Educational Status	No formal education (Ref.)	1	0.488		
	Primary	2.036	0.238	0.625	6.647
	Secondary	2.429	0.137	0.755	7.821
	Tertiary	1.743	0.254	0.671	4.524
Couple Monthly Income(Naira)	Less than 10,000 (Ref.)	1	0.070		
	10,001 - 20,000	0.447	1.760	0.140	1.433
	20,001 -30,000	2.018	0.134	0.806	5.052
	30,001 - 40,000	0.663	0.343	0.283	1.551
	Above 40,000	1.449	0.507	0.485	4.329
Male Involvement in Early Childcare	Low (Ref)	1	0.026		
	Fairly High	1.397	0.0464	1.157	3.418
	Very High	2.433	0.012	1.918	6.44
Religion	Christianity(Ref)	1			
	Islam	0.278	0.000	0.142	0.547

## CHAPTER FIVE

### DISCUSSION

#### **5.1 Socio-Demographic and Economic Characteristics of Respondents**

Nearly all respondents were married and about three –quarter was within the ages of 19-38 years. While most male respondents were within the ages of 29-38 years, most female respondents were within the ages of 19-28. This should be expected since in most cultures within Africa, childbearing is considered acceptable within the confines of marriage. This finding is in line with the 2008 Nigerian Demographic and Health survey results which shows that 78% of women were married and had had at least 2 children by age 29 while 88.1% of men were married and had had at least 2 children by age 39 (NDHS 2008).

Majority of respondents were artisans and belonged to the lower socio-economic level, earned an average of 10,000 to 20,000 naira monthly. This might have been as a result of the relatively low literacy level reported by most respondents.

#### **5.2. Male Involvement in Early Childcare: Spousal Perceptions, Expectations and Practices**

A major finding from this study with respect to spousal perceptions about male involvement in early childcare was that fathers should be breadwinners; more responsible for financial related childcare responsibilities in the home than women. However, more men were positively poised towards this feeling than their female counterparts who perceived that in addition to this, fathers should provide spiritual and psychological needs of both the mother and child while significantly participating in handling daily household chores and providing parental discipline. These perceptions probably stems from believes that women are more



domesticated in nature than men on one hand; and because a father is considered the god of a child (as testified by some respondents) He should be responsible for ensuring that the child and its mother are provided with everything necessary for health living and survival just as God provides for them. This is inline with generally accepted cultural perceptions from literatures that men are breadwinners hence they should be restricted to only financial-related duties in the home. Similar findings has been reported by Waller (2002) who found out that historically fathers had been viewed as having specific roles in relation to childcare. Traditionally men did not participate in domestic works including child rearing as such these tasks are considered the exclusive domain of women. According to these studies, males are classed as having the following qualities: strength, vigor, virile/powerful courage, self-confidence and the ability to meet the outside world, that is, animal and human intruders head on and deal with it effectively (Bernard, 1981; Aweda, 1984; Carrigan et al, 1987; Stock, 1995; Silberschmidt, 1999). Waller (2002); Yeung (2000) and Parke (2005) observed that men were known as bread winners, expected to provide economic support for their families rather than teachers and moral leaders; and mothers in turn had been left with the majority of child rearing and discipline.

These perceptions were expressed in respondents' expectations during their last pregnancy, delivery and 2-years post delivery experience. In concurrence with observations from pre-industrial fatherhood studies (Coltrane, 1998; Waller, 2002; Coontz, 2004), many women expressed their desire to have their spouses being masters of their families, teachers, moral and religious leaders, directors of household work, providing for psychological, emotional and physical support. However, most male and female respondents' rating of their expectations was very low. Only 20% of respondents had high expectations in relation to male involvement in early childcare. This might have been because listed childcare tasks were not only financial related, but required direct contact with the child and increased emotional and psychological support to mother and child, which are not culturally accepted.

From this study, men's involvement in early childcare was low and relatively insignificant as reported by most respondents. Only about 20% couples reported high levels of male involvement in early childcare. One reason for this could be that spousal expectations were

low and mothers preferred to perform majority of childcare tasks as also observed by Peterson et al. (2004). Many spouses culturally do not expect men to be involved in domestic related childcare activities except for providing financial support. Another reason may have been that other childcare tasks are performed by friends, social groups, family members or neighbors. These findings concur with previous findings from studies in Nigeria where in an estimated 20% of two-parent families, men are now about as involved as mothers interacting with and being available to their children (Bianchi, 2000; Yueng, Sandberg, Davis-Kean, & Hofferth, 2001; Pleck & Masciadrelli, 2003;). Furthermore, findings from cross-cultural studies in sub-saharan Africa affirm that compared to women, men are little involved in the early childcare practices during pregnancy and the infancy period of a child.. Linda, Richter and Robert, 2003; Derow, 1977; Niemi et al., 1981; Matsuhima, 1982; Vanek, 1984; Nordenstam, 1984; Michelson, 1985; and Scarr et al., 1989 also found that women, even if employed and regardless of social class, still do the greatest share of household and childcare activities.

Furthermore, in this study, women's expectations were major determinants of men's assessments of their spouses' expectations in relation to their involvement in child care, and were, in turn, major determinants of men's involvement in childcare. Men performed mostly the child care tasks their spouses expected them to perform. One reason for this could be that women are able to share their childcare expectations with their spouses who in-turn in most cases meet these expectations.. In line with these findings was an emerging literature by Allen and Hawkins (1999) that showed that mothers play an important role in recruiting men into family work as well as restricting their participation.

### **5.3 Spousal Desired Family Size**

Most respondents had large fertility desires. Although not significantly, men's desired family size were larger than that of their spouses. The mean desired family size for men was 4.7 +/- 1.6 and 4.1 +/- 1.3 for women. similar fertility desires were recorded in the 2008 Nigerian Demographic and Health Survey which showed the national ideal number of children (wanted fertility rate) was 6.7 for all females, 8.6 and 10.6 for all males, unmarried and married respectively and; about 3 children per women for the South-West geo-political zone.

Fertility preference studies in the Sub-Saharan region showed high rate of disagreement among couples and larger desired family sizes among men when compared to women (Westoff & Bankole, 2002; Bankole & Olaleye, 1993; Kritz, Gurak & Fapohunda, 1992). Findings from a study of six ethnic groups in Nigeria (*Yoruba, Hausa, Fulani, Ibo, Kanuri, Efik and Ibibio*) also found that all placed a high premium on large family size (Nigeria's Population Profile, Population Reference Bureau, info by country; Nigeria statistics UNICEF 2009).

#### **5.4 Contraceptive Awareness Intentions and Practices**

Also, In this study, awareness about contraceptive was high both among male and female respondents. However, women appeared to be more aware about contraceptives than their male counterparts as more women could mention at least one method of contraception than men. This finding could be associated with observed perceptions among respondents that relative to men, women should utilize contraceptives when necessary because contraceptive are more beneficial to women than men. Besides, as observed from findings in this study, more women are known to be part of peer social groups and circles where information is usually shared than their male counterparts. These findings are similar to those of the 2008 NDHS which showed that knowledge of any contraceptive method is widespread in Nigeria. It however deviates a little from findings from this study with more men being aware of contraceptive than women (72 percent of all women and 90 percent of all men knowing at least one method of contraception). For both male and female respondents, most commonly identified methods of contraceptives were Condoms, IUCDs and Injectibles with condoms being the most commonly identified for men and IUCDs and Injectable being the most commonly identified for women.

This study found that contraceptive use was low among most male and female respondents. Men and women's report of their contraceptive practices and their spouses' contraceptive practices were highly coherent. The overall low contraceptive use recorded may have been due to the observed relatively large desired family, negative intentions towards contraceptive use and the perceived unpleasant side effects associated with contraceptive use. Also, the relatively lower contraceptive utilization rate among men might be due to a general

perception among both male and female respondents that contraceptives were more beneficial to women than men as observed from comments in the FGD sessions. It may also be an indication of the levels of contraceptive availability and accessibility within the study environ. This observation fall inline with those of the 2008 NDHS that showed that similar low levels of contraceptive utilization. Overall, 29 percent of all women reported ever using a method of contraception at some time;) while 41 percent of all men age 15-49 reported having used a method of contraception at some time Similarly, previous studies by Konge and Oladipo's (1999) revealed that contraceptive use were low in some developing countries including Nigeria. Feyisetan and Casterline (2000) found that the desire to limit childbearing among couples, contributed substantially to the increase in prevalence of contraceptive use. Observations from Jejeebhoy (1992); and Castro (1995), also suggest that perceived acceptability of family planning impacts on contraceptive usage

In this study, traditional methods especially withdrawal methods were mostly used. However, among respondents who used modern methods, condoms were mostly preferred and used for men while for women; injectibles were mostly preferred and used. This finding is in-line with those reported in previous studies where injectibles were found to be the most used among women, and condoms were most used by men (Mairiga, Kyari, Audu, Lawuwa 2007; Ameh, Sule, 2007). Twenty- four 24 percent of women used a modern method and 13 percent used a traditional method. The male condom (12 percent), is the most commonly used modern method, followed by the pill (6 percent), injectables (5percent), and LAM (5 percent. Among traditional methods, withdrawal and the rhythm method are the most commonly used by women (7 percent each), while folk methods are the least used (3 percent) (NDHS 2008) Sulavan et al. (2007) also found that one-third of developing countries had a skewed method matrix in which a single method accounted for more than half of all contraceptive use. This as the author further noted, was an indication that genuine access to a broad range of contraceptive methods were limited.

Most respondents had negative intentions towards contraceptive use. However women were more positively poised towards contraceptives than their male counterparts as most male respondents expressed their intentions not to use or encourage their spouses to use

contraceptives. Respondents' negative intentions towards contraceptive use could be attributed mainly to their large fertility desires, positive intentions for further childbearing and a common perception that contraceptives had unpleasant side effects. This finding is similar to those of Sheryl Thorburn's study (2007) that examined men's attitudes towards seven contraceptive methods among a national sample of African-American men and women aged 15–44. The author found that women were more positively poised towards contraceptive use when compared to their men counterparts. Akinfele et.al (2009) also found some evidence of concern about a potential link between contraceptive use and infertility. According to the theory of reasoned action and planned behaviour (Ajzen and Fishbien 1980), a person's intention or desire to perform an action is determined by her beliefs about the consequences of the action, the perception of value of the consequences, the beliefs about what significant others think he or she should do, and the motivation to comply with those expectations.

### **5.5 Spousal Early Child Care-Related Stress Experience**

Pregnancy and early child care were associated with increased stress for most male and female respondents and Men's reports of parenting stress were significantly lower than their partners' reports. Although men experience increased stress as a result of childcare, women experience more of the stress than men. Men's relatively low levels of stress might have been as a result of their low levels of involvement in child care; while women's relatively high levels of stress was associated with their higher levels of involvement in child care. This finding supports the social-role hypothesis formulated by Barnett and Baruch (1987) regarding the relation between social responsibilities inside and outside the home and stress levels. As they proposed, if men and women share responsibilities both inside and outside of the home, they should report similar stress levels. To the extent that this is not the case, stress levels should be different for men and women.

In this study, male childcare stressors were not exactly childcare stressors of their spouses (female counterparts). Key childcare stressors for men were the increased demand for money and time necessitated by pregnancy, delivery and two years post delivery. In addition, the emphasis on being a provider may be associated with other types of stress not related to

parenting because their contact with their children is limited. Increased pressure to satisfy the increasing financial demands of pregnancy and early childcare might necessitate extended working hours and multiple jobs. Crnic and Acevedo (1995) reported that men's levels of parenting stress were more influenced by situations outside the home, such as their employment. For women, the emphasis on taking care of the family may relate to more parenting stress.

## **5.6 Predictors of Men's Fertility Desires**

### **I. Male involvement in early childcare:**

This study demonstrates that Men's involvement in childcare was significantly associated with their desired family size. Men's involvement in childcare negatively influenced their desires for large family sizes. Men who were more involved in childcare were more likely to desire fewer children compared to men who were less involved in childcare. This may have been due to the increased stress levels men reported to be associated with higher levels of male involvement in early childcare. Previous studies (Pinnelli, Antonella, Flori, Francesca, 2008; Cooke 2004) in Germany showed a positive relationship between men's involvement in childcare and their spouses' intention for further childbearing.

### **II. Male early childcare stress experience:**

In this study, there were inconsistent opinions about the role of stress in men's fertility desires. However, child care-related stress was a major positive determinant of men's desired family size. Men who felt childcare was an issue of stress to them was more likely to desire fewer children than those who felt that child care was not an issue of stress to them. This study also found that childcare-related stress was a major determinant for women's fertility desires than men's fertility desires.

### **III. Socio-Cultural and Economic predictors:**

Educational status, socio-economic status and religion played a significant role in men's fertility desires. Men who were Christians, had higher educational and socioeconomic status are less likely to desire large family sizes. There are possibilities that components of these socio-economic categories could have potentials of creating awareness and consciousness

about the gains of smaller family sizes. This study finding agrees with those of Isiugo-Abanihe (1994) and Köppen (2006) –which showed considerable variations relating to educational status, religion and; spousal income and preference for large family.

### **5.7 Implications for Population Reproductive Health Education**

Enhancing male involvement in childcare is the most realistic strategy for significantly reducing individual family size and achieving concomitant reduction in Nigeria’s population growth rate while enhancing maternal and child health. The incorporation of three strategies is recommended for incorporation into male involvement programmes.

First, interventions must begin with policy makers who are key gatekeepers. Advocacy programmes must be organized for policy makers in the population and health sector to sensitize them on the significant role of men in population growth reduction, sustainability, maternal and child health; such that relevant policies are developed or reviewed to ensure that they adequately reflect the significant role of men in population reduction and sustainable development. Provisions should also be made to ensure institutional support that will enable increased male involvement in their families as well as population and sustainable development programmes.

Second, a structured peer- education/family life programme is recommended for men, especially those whose wives are pregnant because of its proven efficacy in increasing knowledge and fostering behaviour change in different settings. Such approach creates the opportunity for on-going access to informed persons and enhances the credibility of the programme among target populations because the peer educator is one of them.

Finally, an intervention will only have potential for success in changing behaviour if it also addresses the socio-economic conditions of men. Fostering access to formal education, micro credit interventions, and working with religious leaders as partners in change could enable men gain the socio-economic power they need for behaviour change.

## 5.8 Conclusion

- I. Men have clear and specific roles and responsibilities as husbands and fathers in childcare during pregnancy, delivery and the early years of a child's life.
- II. The division of childcare tasks in the home still slants disproportionately towards women even though some women perceive that beyond providing economic support, men should be involved psychologically, emotionally and physically in early childcare.
- III. The discrepancy between perceptions, expectations and actual male involvement in childcare can be attributed to social norms that prescribe men's responsibilities in childcare which is reflected in most women's low childcare expectations.
- IV. Women's expectations with respect to male involvement in early childcare is a major driving force behind men's involvement in childcare.
- V. Couple's ideal family size is large and men's ideal family sizes are larger than those of women.
- VI. Awareness about contraceptives as a means of birth control is high among men and women. However, utilization among spouses is low with negative intentions arising from misconceptions and large desired family size among couples.
- VII. Women are more positively poised towards contraceptives and its use than their male counterparts.
- VIII. Most men and women believe that contraceptives are more beneficial to women than men.
- IX. Couple income, educational status, religious orientation and male involvement in childcare task are major determinants of men's desired family size as demonstrated in findings from this study.
- X. Male involvement in early childcare and their religious orientation are strong predictors of their desired family size. As such they are major driving force behind men's childbearing desires.
- XI. Addressing harmful religious orientations and Increased male involvement in childcare will most likely lead to a reduction in their desired family size with concomitant impact on total fertility rate.



XII. Male involvement of in early childcare task did not impact on men and their spouse's contraceptive intentions and behavior..

### -5.9 Recommendations

To achieve significant reduction in family sizes in Nigeria; Interventions for increased male involvement in childcare should be increasingly carried out; In this regard,

I. There should be a review the current National Population Policy such that it adequately reflects the significant role of men in reducing Nigeria's population growth rates and make provision for paternal leave and other paternal childcare incentives for increased male involvement in childcare;

II. Interventions should work with religious and traditional leaders, educational and health service institutions and providers, as partners to sensitize, create awareness and provide correct knowledge about the negative impact of large family sizes, unchecked population growth and the benefits of male involvement in early childcare.

III. Sensitization and other related programmes that promote men's involvement in family life should incorporate a wide variety of avenues through which men can be involved in childcare during the pregnancy, delivery and infancy period of a child's life. These programs should include education on good and quality paternal childcare components and its implications for family life, women's health, Nigeria's population and its overall development This may be an effective way of increasing male involvement in early childcare.

IV. Health service providers should be trained on strategies to encourage men's participation in pre-natal care.

V. Antenatal clinic classes and other opportunities should be utilized to ensure that educational interventions targeting women and aimed at enhancing women's childcare expectations in relation to male involvement in childcare are increasingly carried out. These should focus on educating women on the psychological, emotional, spiritual and financial support that should be provided by their spouses for better and healthy babies

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and family lives. These interventions should also equip women with skills to communicate their childcare expectations to their spouses.

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V A minimum standard for quality childcare as highlighted in the child rights act should be domesticated and widely disseminated.

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#### **5.10 Suggestions for Further Research**

Similar research in other parts of Nigeria is desirable. This will help for comparism and better generalizability of findings.

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## APPENDIX 1

### RESEARCHER ADMINISTERED SEMI-STRUCTURED QUESTIONNAIRE FOR HUSBANDS: INFLUENCE OF SPOUSAL INVOLVEMENT IN EARLY CHILD CARE ON MEN'S FERTILITY DESIRES IN IBADAN NORTH LGA, IBADAN

#### Introduction

Dear respondent,

My name is EKECHUKWU Esther Chinonso; I am a student of the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan. I am presently carrying out a research to determine the Influence of male involvement in early childcare on their fertility desires in Ibadan North LGA, Oyo State.

Overall, findings from this study will add to the body of existing knowledge in areas of parenting and men's fertility desires. It can provide insight into male involvement in maternal and childcare during pregnancy, delivery and post-delivery period and its possible influence on family planning uptake.

Please kindly assist by responding to the questions asked in this questionnaire, giving sincere and genuine answers. It is not a test. No answer is wrong or right. Your response will be kept confidential and your name will not be necessary for the study.

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**INSTRUCTIONS:** Some questions asked in this questionnaire may be a little personal, please don't be offended. Your answers to the questions will enable me learn from you and better understand and appreciate the issue being investigated. We will appreciate it if you will respond to the questions asked to the best of your ability.

**Reference Number:**-----

**Location** \_\_\_\_\_

**SECTION A: Socio-Demographic and Economic Information**

**Instructions: please tick where appropriate**

1. What is your Age as at last birthday (please specify in years) \_\_\_\_\_
2. What is your Marital status: 1. Single ( ) 2. Cohabiting ( ) 3. Married ( )  
4. Separated ( ) 5. Divorced ( ) 6. Widowed ( )
3. What type of family do you live in? 1. Monogamous ( ) 2. Polygamous ( )
4. How long have you been married? (Please specify in years)\_\_\_\_\_
5. What is your Religion?: 1.Christian ( ) 2. Islam( ) 3. Others (please specify)-----
6. What is your highest level of education?: 1. No formal Education ( )  
\_\_\_\_2. Primary education ( ) 3. .Secondary Education ( ) 4. Bachelor/HND ( )  
~~6.~~ \_\_\_\_5.Postgraduate ( ) 6.Others (please specify) ( ) \_\_\_\_\_

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7. What is your Ethnic group: 1. Yoruba 2. Igbo 3. Hausa  
4. others (please specify).....

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8. What is the type of your family origin? 1. Monogamous ( ) 2. Polygamous ( )

9. How many children do you have? (Please be specific)\_\_\_\_\_

10. How many male children do you have? (Please be specific) \_\_\_\_\_

11. How many female children do you have? (Please be specific)\_\_\_\_\_

12. Do you want to have more children? 1. Yes ( ) 2. No ( )

13. If yes, how many more children do you want to have? Please be specific \_\_\_\_\_

14. What is the age of your last child? (As at last birth day) (Please be specific)\_\_\_\_\_

15. Did you have relatives living with you during your wife's last pregnancy?

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15. 1. Yes ( ) 2. No ( )

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a. If Yes, Who were they? (Please list)

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- I. \_\_\_\_\_
- II. \_\_\_\_\_
- III. \_\_\_\_\_
- IV. \_\_\_\_\_
- V. \_\_\_\_\_

b. If No, Did any neighbor or friend come to help out in the domestic work during your wife's last pregnancy? 1. Yes ( ) 2. No ( )

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b:

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17-16. Did you have relatives living with you during the first two years after your last child was born? 1. Yes ( ) 2. No ( )

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a. If Yes, Who were they? (Please list)

- I. \_\_\_\_\_
- II. \_\_\_\_\_
- III. \_\_\_\_\_
- IV. \_\_\_\_\_
- V. \_\_\_\_\_

b. If No, Did any neighbor or friend come to help out in the domestic work during the first two years after your last child was born? 1. Yes ( ) 2. No ( )

- 18.17. What is your occupation? (Please specify) \_\_\_\_\_
- 19.18. What is your monthly income in Naira? (Please be specific) \_\_\_\_\_
- 20.19. Were you on paid employment during your wife's last pregnancy? 1. Yes ( ) 2 No ( )
- 21.20. What is your wife's occupation?(please specify) \_\_\_\_\_
- 22.21. What is your wife's monthly income in Naira? (please be specific) \_\_\_\_\_
- 23.22. Was your wife on paid employment during her last pregnancy? 1. Yes ( ) 2. No ( )
- 24.23. What is the Name of area where you are living? \_\_\_\_\_
- 25.24. Where you living with any friend or relative during your wife's last pregnancy? 1. Yes ( ) 2. No ( )

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**SECTION B: Childcare Expectations and Practices**

26.25. Do you normally participate in Household task? 1. Yes ( ) 2. No ( )

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25(a) If yes, what are those Household tasks (Please List exhaustively)

- I. \_\_\_\_\_
- II. \_\_\_\_\_
- III. \_\_\_\_\_
- IV. \_\_\_\_\_
- V. \_\_\_\_\_

26. In your household, whose responsibility is it to provide the following (Please tick as appropriate)

- A). Money to pay hospital bills: 1. More the Husband ( ) 2. More the wife ( ) 3. Both Equally ( ) 4. Others ( ) please specify \_\_\_\_\_
- B) Money to buy food for the children: 1. More the Husband ( ) 2. More the wife ( ) 3. Both Equally ( ) 4. Others (Please specify) \_\_\_\_\_
- C). Money to buy cloths for the children: 1. More the Husband ( ) 2. More the wife ( ) 3. Both Equally ( ) 4. Others ( ) Please specify \_\_\_\_\_
- D). Money to pay the children's hospital bills: 1. More the Husband ( ) 2. More the wife ( ) 3. Both Equally ( ) 4. Others ( ) please specify \_\_\_\_\_

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27. Who did the following domestic chores in the house during your wife's last pregnancy?

(Please tick as appropriate)

A). Sweep the house: 1. More the Husband ( ) 2. More the wife ( ) 3. Both Equally ( ) 4.

Others ( ) please specify \_\_\_\_\_

B). Clean the house: 1. More the Husband ( ) 2. More the wife ( ) 3. Both Equally ( ) 4.

Others() please specify \_\_\_\_\_

C). Fetch water for the house: 1. More the Husband ( ) 2. More the wife ( ) 3. Both Equally ( ) 4.

Others (please specify) \_\_\_\_\_

D). Cooked for the family: 1. More the Husband ( ) 2. More the wife ( ) 3. Both Equally ( )

4. Others ( ) please specify \_\_\_\_\_

E). Washing the dirty cloths: 1. More the Husband ( ) 2. More the wife ( ) 3. Both Equally ( ) 4.

Others ( ) please specify \_\_\_\_\_

F). Go to the market: 1. More the Husband( ) 2. More the wife( ) 3. Both Equally( ) 4. Others ( )

28. During your wife's last pregnancy, which of the following did your wife expect you to do for her, which of them did you actually do and what was the frequency?

SN	Household task	Tasks Expected From Husband (Please state Yes or No)	Task actually performed by Husband (Please state Yes or No)	No. of Times Task was performed by Husband(Frequency - Please be specific)
A	Clean the house			
B	Sweep the house			
C	Accompany you to the hospital for antenatal visits			
D	Wash dirty cloths for wife			
E	Wash dirty cloths for the other children			
F	Prepare meals for you and the children			
G	Take the other children to school			
H	Fetch water for you and the other children			
I	Go to the market to buy things needed for the family			
J	Pay for antenatal clinics			
K	Buy your medications			
L	Spend more time with you <b>(please state frequency in min/hours per day)</b>			

29. Did your wife expect you to be present in the hospital at the delivery of your last child? 1.

Yes ( ) 2. No ( )



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30. Were you present at the hospital during the delivery of your last child? 1. Yes ( ) 2. No ( )

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31. During the first 2 years after your last child was born, which of the following did your wife expect you to do for her, which of them did you actually do and what was the frequency? (Please state yes or No as appropriate)

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SN	Household task	Tasks Expected From Husband (Please state Yes or No)	Task actually performed by Husband (Please state Yes or No)	No. of Times Task performed by Husband (Frequency - Please be specific)
A	Clean the house			
B	Sweep the house			
C	Help to put the child to sleep			
D	Wash the child's dirty cloths			
E	Prepare meals for the child			
F	Fetch water for you and the child / children			
G	Go to the market to buy things needed for the family			
H	Take the child to the doctor when he/she is sick			
I	Buy your medications and that of the child			
J	Spend more time with you (please state frequency in hours per day)			
K	Spend more time playing with the child (please state frequency in hours per day)			
L	Accompany the child for immunization			
M	Prepare meals for you and the other children			
O	Take the other children to school and bring them back			
P	Fetch water for the house			
Q	Provide Money to pay hospital bills			

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<b>R</b>	Provide Money to buy food for the children:			
<b>S</b>	Provide Money to buy cloths for the baby			
<b>T</b>	Provide Money to pay the child's hospital bills			

**SECTION C: Early Childcare Related Stress Experience**

32. On a scale of 1 - 10 where 1 is Lowest and 10 is Highest, how will you rate your participation in household task before your wife's last pregnancy (Please circle)  
 Lowest 1 2 3 4 5 6 7 8 9 10 Highest

33. On a scale of 1 - 10 where 1 is lowest and 10 is Highest, how will you rate your participation in household tasks during the period when your wife was pregnant for your last child (Please circle)  
 Lowest 1 2 3 4 5 6 7 8 9 10 Highest

34. On a scale of 1 - 10 where 1 is Lowest and 10 is Highest, how will you rate your participation in household tasks within 2 years after the birth of your last child compared to the period before your wife's last pregnancy? (Please circle)  
 Lowest 1 2 3 4 5 6 7 8 9 10 Highest

35. On a scale of 1 - 10 where 1 is Lowest and 10 is Highest, how will you rank the level of pressure on you associated with the level of your participation in household tasks during the following period? (Please indicate Number)

Period	Scale ( 1- 10; Lowest – Highest)
Your wife's last Pregnancy	
Delivery of your last child	
Two years after your last child was born	

36. On a scale of 1 - 10 where 1 is Lowest and 10 is Highest, how will you rank overall the level of financial demand on you during the following periods?

Period	Scale ( 1- 10; Lowest – Highest)
Your wife's last Pregnancy	

Delivery of your last child	
Two years after your last child was born	

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37. On a scale of 1 - 10 where 1 is Lowest and 10 is Highest, how will you rank the level of demand on your time during the following periods?

Period	Scale ( 1- 10; Lowest – Highest)
Your wife’s Pregnancy	
Delivery of your last child	
Two years after your last child was born	

**SECTION D: Contraceptive Awareness, Intentions and Practices**

38. How many biological children would you like to have in your life time? (Please specify)-

-----

39. Have you heard about contraceptives? Yes ( ) No ( )

39(a). If Yes, What methods do you know? (Please List)

- I. \_\_\_\_\_
- II. \_\_\_\_\_
- III. \_\_\_\_\_
- IV. \_\_\_\_\_
- V. \_\_\_\_\_

40. Have you used any form of contraceptive within the last two years? Yes ( ) No ( ) if 'No' Go to question 40(c)

- 40(a) If yes, why? -----

40 (b) If yes what type of contraceptive did you use?\_\_\_\_\_

40(c) If no, why? -----

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41. Did you ever say that you or your wife needs to delay or prevent having the next baby by using contraceptives?

A. during the last pregnancy?: 1. Yes ( ) 2. No ( )

B. within 2 years after the birth of your last child? 1. Yes 2. No ( )

42 Have your wife used any form of contraceptive during the last two years? 1.-Yes ( ) - 2.-No ( )  
→ if 'No' Go to question 41c

42. (a) If yes why?-----

42. (b) If Yes what kind of contraceptive did she use? -----

42. (c) if No, why? -----

43. When you realized your wife was pregnant for your last child were you surprised?  
(Please tick) 1. Yes ( ) 2.No ( )

43 (a). If yes why were you surprised?

-----

43(b). If No why? -----

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44. How many years interval do u think is ideal to give before having another child after the birth of a child? (Please be specific)\_\_\_\_\_

45. Giving my experience in caring for my wife and child during the last period of pregnancy, delivery and post child birth, I have decided to have a minimum of 3 years child spacing:

Strongly disagree 1 2 3 4 5 6 7 strongly agree

46. Giving my experience in caring for my wife and child during the last period of pregnancy, delivery and post delivery period, I have decided not to have more children:

Strongly disagree 1 2 3 4 5 6 7 strongly agree

47. having many children will negatively impact on the quality of life I am able to give each one of my children

Strongly disagree 1 2 3 4 5 6 7 strongly agree

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**APPENDIX 2**

**RESEARCHER ADMINISTERED SEMI-STRUCTURED QUESTIONNAIRE (FOR WIVES):  
INFLUENCE OF SPOUSAL INVOLVEMENT IN EARLY CHILD CARE ON MEN'S  
FERTILITY DESIRES IN IBADAN NORTH LGA, IBADAN -**

**Introduction**

Dear respondent,

My name is EKECHUKWU Esther Chinonso; I am a student of the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan. I am presently carrying out a research to determine the Influence of male involvement in early childcare on their fertility desires in Ibadan North LGA, Oyo State.

Overall, findings from this study will add to the body of existing knowledge in areas of parenting and men's fertility desires. It can provide insight into male involvement in maternal and child care during pregnancy, delivery and post-delivery period and its possible influence on family planning uptake.

Please kindly assist by responding to the questions asked in this questionnaire, giving sincere and genuine answers. It is not a test. No answer is wrong or right. Your response will be kept confidential and your name will not be necessary for the study.

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**INSTRUCTIONS:** Some questions asked in this questionnaire may be a little personal, please don't be offended. Your answers to the questions will enable me learn from you and better understand and appreciate the issue being investigated. We will appreciate it if you will respond to the questions asked to the best of your ability.

**Reference Number:**-----

**Location** \_\_\_\_\_

**SECTION A – Socio-Demographic and Economic Information**

**Instruction: Please tick as appropriate**

- 1. What is your Age as at last birthday (please specify) \_\_\_\_\_
- 2. What is your Marital status: 1. Single ( ) 2. Cohabiting ( ) 3. Married ( )  
\_\_\_ 4. Separated ( ) 5. Divorced ( ) 6. Widowed ( )
- 3. What type of family do you live in? 1. Monogamous ( ) 2. Polygamous ( )
- 4. How long have you been married? (Please be specific) \_\_\_\_\_
- 5. What is your Religion? (Please Tick): 1.Christian ( ) 2. Islam ( )  
\_\_\_ 3. Others (please specify)-----
- 6. What is your highest level of education?: 1. No formal Education ( ) 2. Primary education ( )  
3. .Secondary Education ( ) 4. Bachelor/HND( ) 5. Postgraduate ( ) 6. Others  
specify\_\_\_\_\_
- 7. What is your Ethnic group (please tick): 1. Yoruba 2 Igbo 3 Hausa  
\_\_\_ 4 others (please specify).....
- 8. What is the type of your family origin? 1. Monogamous ( ) 2. Polygamous ( )
- 9. How many children do you have? (Please be specific) \_\_\_\_\_

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10. How many male children do you have? (Please be specific) \_\_\_\_\_
11. How many female children do you have? (Please be specific) \_\_\_\_\_
12. Do you want to have more children? 1. Yes ( ) 2. No ( )
13. If yes, how many more children do you want to have? Please be specific \_\_\_\_\_
14. What is the age of your last child? (As at last birth day) (Please be specific) \_\_\_\_\_
15. Did you have relatives living with you during your last pregnancy? 1. Yes ( ) 2.No ( )

a. If Yes, Who were they? (Please list)

- I. \_\_\_\_\_
- II. \_\_\_\_\_
- III. \_\_\_\_\_
- IV. \_\_\_\_\_

b. If No, Did any neighbor or friend come to help out in the domestics work during pregnancy? 1. Yes ( ) 2. No ( )

16. Did you have relatives living with you during the first two years after your last child was born? 1. Yes ( ) 2. No ( )

a. If Yes, Who were they? (Please list)

- I. \_\_\_\_\_
- II. \_\_\_\_\_
- III. \_\_\_\_\_
- IV. \_\_\_\_\_
- V. \_\_\_\_\_

b. If No, Did any neighbor or friend come to help out in the domestics work during the first two years after your last child was born? 1. Yes ( ) 2. No ( )

17. What is your Profession/occupation? (Please specify) \_\_\_\_\_
18. What is your monthly income in Naira? (Please be specific) \_\_\_\_\_
19. Were you on paid employment during your last pregnancy? 1. Yes ( ) 2 No ( )
20. What is your husband's profession/occupation?(please specify) \_\_\_\_\_

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- 21. What is your husband's monthly income in Naira? (please be specific)\_\_\_\_\_
- 22. Was your husband on paid employment during your last pregnancy? 1.Yes ( ) 2.No( )
- 23. What is the Name of area where you are living?: \_\_\_\_\_
- 24. Did you have a house of your own as at last pregnancy? 1. Yes ( ) 2. No ( )

**SECTION B: Early Childcare Expectations and Performance**

25. Does your husband normally participate in Household task? 1. Yes ( ) 2. No ( )

25a. If yes, what are those Household tasks **(Please list exhaustively)**

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- I. \_\_\_\_\_
- II. \_\_\_\_\_
- III. \_\_\_\_\_
- IV. \_\_\_\_\_
- V. \_\_\_\_\_

26. In your household, whose responsibility is it to provide the following (Please tick as appropriate)

  A). Money to pay hospital bills: 1. More the Husband ( ) 2. More the wife ( )  
 3. Both Equally ( ) 4. Others ( ) please specify \_\_\_\_\_

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  B). Money to buy food for the children: 1. More the Husband ( ) 2. More the wife ( )  
 3. Both Equally ( ) 4. Others (Please specify) \_\_\_\_\_

  C). Money to buy cloths for the children: 1. More the Husband ( ) 2. More the wife ( ) 3.  
 Both Equally ( ) 4. Others ( ) Please specify \_\_\_\_\_

  D). Money to pay the children's hospital bills: 1. More the Husband ( ) 2. More the wife ( )  
 3. Both Equally ( ) 4. Others ( ) please specify \_\_\_\_\_

27. Who did the following domestic chores in the house during your last pregnancy? (Please tick as appropriate)

A). Sweep the house: 1. More the Husband ( ) 2. More the wife ( ) 3. Both Equally ( ) 4.

Others ( ) please specify \_\_\_\_\_

B). Clean the house: 1. More the Husband ( ) 2. More the wife ( ) 3. Both Equally ( ) 4.

Others ( ) please specify \_\_\_\_\_

C). Fetch water for the house: 1. More the Husband ( ) 2. More the wife ( ) 3. Both Equally ( ) 4.

Others ( ) please specify \_\_\_\_\_

D). Cooking for the family: 1. More the Husband ( ) 2. More the wife ( ) 3. Both Equally ( )

4. Others ( ) please specify \_\_\_\_\_

E). Washing the dirty cloths: 1. More the Husband ( ) 2. More the wife ( ) 3. Both Equally ( ) 4.

Others ( ) please specify \_\_\_\_\_

F). Go to the market: 1. More the Husband ( ) 2. More the wife ( ) 3. Both Equally ( ) 4.

Others ( ) please specify \_\_\_\_\_

28. During your last pregnancy, which of the following did you expect your husband to do for you, which of them did he actually do and what was the frequency?

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SN	Household task	Task Expected (Please state Yes or No)	TASK Performed (Please state Yes or No)	How many times (Frequency) (Please be specific)
A	Clean the house			
B	Sweep the house			
C	Accompany you to the hospital for antenatal visits			
D	Wash dirty cloths for wife			
E	Wash dirty cloths for the other children			
F	Cook for you and the children			
G	Take the other children to school			
H	Fetch water for you and the other children			
I	Go to the market to buy things needed for the family			
J	Pay for antenatal clinics			
K	Buy your medications			
L	Spend more time with you (please state frequency in hours per day)			

29. Did you expect your husband to be present at the delivery of your last child?

\_\_\_\_\_ 1. Yes ( ) 2. No ( )

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30. Was your husband present at the hospital during the delivery of your last child?

\_\_\_\_\_ 1. Yes ( ) 2.No( )

31. During the first 2 years after your last child was born, which of the following did you expect your husband to do for you, which of them did he actually do and what was the

frequency? (Please state yes or No as appropriate)

SN	Household task	Tasks Expected From Husband (Please state Yes or No)	Task actually performed by Husband (Please state Yes or No)	No. of Times Task was performed by Husband(Frequency - Please be specific)
A	Clean the house			
B	Sweep the house			
C	Help to put the child to sleep			
D	Wash the child's dirty cloths			
E	Prepare meals for the child			
F	Fetch water for you and the child / children			
G	Go to the market			
H	Take the child to the doctor when he/she is sick			
I	Buy your medications			
J	Spend more time with you (please state frequency in hours per day)			
K	Spend more time playing with the child (Please state frequency in hours per day)			
L	Accompany the child for immunization			
M	Prepare meals for you and the other children			
N	Take the other children to school and bring them back			
O	Fetch water for the house			
P	Provide Money to pay hospital bills			
Q	Provide Money to buy food for the children:			
R	Provide Money to buy cloths for the baby			
S	Provide Money to pay the child's hospital bills			

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**SECTION C: Early Childcare Related Stress Experience**

32. On a scale of 1 - 10 where 1 is Lowest and 10 is Highest, how will you rate your husband's

participation in household task before your last pregnancy (Please circle)

Lowest 1 2 3 4 5 6 7 8 9 10 Highest

33. On a scale of 1 - 10 where 1 is lowest and 10 is Highest, how will you rate your husband's participation in household tasks within 2 years after the birth of your last child compared to the period of your last pregnancy (Please circle)

Lowest 1 2 3 4 5 6 7 8 9 10 Highest

34. On a scale of 1 - 10 where 1 is Lowest and 10 is Highest, how will you rate your participation in household tasks within 2 years after the birth of your last child compared to the period before your last pregnancy? (Please circle)

Lowest 1 2 3 4 5 6 7 8 9 10 Highest

35. On a scale of 1 - 10 where 1 is Lowest and 10 is Highest, how will you rank the level of pressure on your husband associated with the level of his participation in household tasks during the following period? (Please indicate Number)

Period	Scale ( 1- 10; Lowest – Highest)
Pregnancy	
Delivery	
Two years post delivery	

36. On a scale of 1 - 10 where 1 is Lowest and 10 is Highest, how will you rank overall the level of financial demand on your husband during the following periods?

Period	Ranking ( 1- 10; Lowest – Highest)
Pregnancy	
Delivery	
Two years post delivery	

37. On a scale of 1 - 10 where 1 is Lowest and 10 is Highest, how will you rank the level of demand on your husband's time during the following periods?

Period	Rank ( 1- 10; Lowest – Highest)
Pregnancy	
Delivery	
Two years post delivery	

**SECTION D: Contraceptive Awareness Intentions and Practices**

38. How many biological children would you like to have in your life time? (Please specify).....

39. Have you heard about contraceptives? Yes ( ) No ( )

39a. If yes what methods do you know? (Please List)

- I. \_\_\_\_\_
- II. \_\_\_\_\_
- III. \_\_\_\_\_
- IV. \_\_\_\_\_
- V. \_\_\_\_\_

40. Have you used any form of contraceptive during the last two years? Yes ( ) No ( ) if 'No' Go to question 40(c)

40(a) If yes why? \_\_\_\_\_

40(b) If Yes what type of contraception have you used? \_\_\_\_\_

40(c) If No why have you not been contracepting?  
\_\_\_\_\_

41. Did your husband ever say that you need to prevent or delay having the next baby by using contraceptive?

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**A.** during your last pregnancy? 1. Yes ( ) 2. No ( )

     **B.** within 2 years after the birth of your last child? 1. Yes 2. No ( )

**42.** Have your husband used any form of contraceptives during the last two years? 1. Yes ( ) 2. No ( ) if 'No' Go to question 42c

**42 (a)** If yes why?-----

**42(b).** If yes what kind of contraception was he using? -----

**42 (c)** If No, why ? -----

**43.** When you realized you were pregnant for your last child were you surprised? (Please tick) 1. Yes ( ) 2.No ( )

**43a.** If yes why were you surprised?.....

**43b.** If No, why were you not surprised? -----

    

**44.** When your husband realized you were pregnant was he surprised? 1. Yes ( ) 2.No ( )

**44a.** If yes why was he surprised?-----

**45.** How many years interval do you think is proper to have after the birth of a child? (Please specify) -----

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### APPENDIX 3

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**FGD GUIDE FOR MEN AND WOMEN: INFLUENCE OF SPOUSAL INVOLVEMENT IN  
EARLY CHILDCARE ON MEN'S ~~FERTILITY-DESIRED~~ FAMILY SIZE S IN IBADAN  
NORTH LGA, IBADAN**

#### **Introduction**

Dear discussant,

My name is EKECHUKWU Esther Chinonso; I am a student of the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan. I am presently carrying out a research to determine the Influence of male involvement in early childcare on their fertility desires in Ibadan North LGA, Oyo State. Findings from this study will add to the body of existing knowledge in areas of parenting and men's fertility desires. It can provide insight into male involvement in maternal and child care during pregnancy, delivery and post-delivery period and its possible influence on family planning uptake.



**INSTRUCTIONS:** We will love to have a brief conversation with you. During our conversation, we will be asking you some questions. Some questions asked in this questionnaire may be a little personal/ please don't be offended. Your answers to the questions will enable me learn from you and better understand and appreciate the issue being investigated. We will appreciate it if you will respond to respond to the questions asked to the best of your ability. However, you are at liberty to withhold any information you do not feel comfortable disclosing. Here with me is an assistant who will be helping me to take notes as we discuss. Kindly permit us to make use of a tape recorder so that we are able to capture and later translate every bit of information we will be sharing during our conversations.

**Reference Number:**-----

Location\_\_\_\_\_

**FOR MEN**

**1. Perceptions About Men's Early Child Care Responsibilities**

Outcome of discussions from this section will be used to determine subjective norms i.e. Family and societal expectations about male participation in prenatal and Early child care

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1. Generally, what are the responsibilities of a father to a child?
2. What kind of help should a man give to his wife when she is pregnant for his child?
  - Probe for what kind of help do husbands in this community give their wives when they are pregnant
3. What kind of help should a man give to his wife during delivery of his child?
  - Probe for 'what kind of help do husbands in this community give their wives during delivery
4. What kind of child care roles should a man perform in the first 2 year of his child's life?
  - Probe for 'what kind of child care roles do men in this community perform during the first 1 year of their children's life
5. What kind of help should a man give his wife when she gives birth to a male child
  - Probe for 'What type of help do men in this community give their wives when they give birth to male children'
  - Probe for reasons
6. What type of help should a man give his wife when she gives birth to a female child
  - What type of help do men in this community give their wives when they give birth to female children
  - Probe for reasons
7. What type of child care roles do men in this community perform when they give birth to male children in the first 2 year of the child's life
  - Probe for reasons
8. What type of child care roles do men in this community perform when they give birth to a male child and in the first 2 year of the child's life
  - Probe for reasons

## 2. Intentions towards Contraceptive Use

9. How many children should a family have and why?
10. How many male children should a family have?
  - Probe for reasons
11. How many female children should a family have?
  - o Probe for reasons
12. What are the advantages of using contraceptives/family planning?

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13. What are the disadvantages of using contraceptives/family planning?

### 3. Early Childcare Related Stress Perceptions and Experiences

14. What factors influence the number of children a man decides to have?

- i. Probe for how economic factors influence the number of children a man decides to have ( Level of income as a factor: High income, middle income, low income)
- ii. Probe for how the level of pressure associated with pregnancy and child birth influence the number of children a man decides to have
- iii. Probe for how the level of demand on time associated with pregnancy and child birth influence the number of children a man decides to have.
- iv. Probe for What factors influence the number of children men in this community decides to have

#### FOR WOMEN

##### 1. Perceptions about Male Early Child Care Responsibilities

1. Generally, what are the responsibilities of a father to a child?
2. What kind of help should a man give to his wife when she is pregnant for his child?
  - Probe for what kind of help do husbands give their wives when they are pregnant in \_\_\_\_\_ the community
3. What kind of help should a man give to his wife during delivery of his child?
  - Probe for 'what kind of help do husbands give their wives during delivery in the \_\_\_\_\_ community
4. What kind of kind of child care roles should a man perform in the first 1 year of his \_\_\_\_\_ child's life?
  - Probe for 'in this community what kind of child care roles do men in this \_\_\_\_\_ community perform during the first 1 year of their children's life
5. What kind of help should a man give his wife when she gives birth to a male child
  - Probe for 'What type of help do men in this community give their wives when they \_\_\_\_\_ give birth to male children'
  - Probe for reasons
6. What type of help should a man give his wife when she gives birth to a female child

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- What type of help do men in this community give their wives when they give birth to \_\_\_\_\_ female children
- Probe for reasons
- 7. What type of child care roles do men in this community perform when they give birth \_\_\_\_\_ to male children in the first 1 year of the child's life
- Probe for reasons
- 8. What type of child care roles do men in this community perform when they give birth \_\_\_\_\_ to a male child and in the first 1 year of the child's life
- Probe for reasons

## **2. Intentions towards Contraceptive Use**

- 9. How many children should a family have and why?
- 10. How many male children should a family have?
- Probe for reasons
- 11. How many female children should a family have?
- Probe for reasons
- 12. What are the advantages of using contraceptives/family planning?
- 13. What are the disadvantages of using contraceptives/family planning?

## **3. Early Childcare Related Stress Perceptions and Experiences**

- 15. What factors influence the number of children a man decides to have?
  - i. Probe for how economic factors influence the number of children a man decides to have ( Level of income as a factor: High income, middle income, low income)
  - ii. Probe for how the level of pressure associated with pregnancy and child birth influence the number of children a man decides to have
  - iii. Probe for how the level of demand on time associated with pregnancy and child birth influence the number of children a man decides to have.
  - iv. Probe for What factors influence the number of children men in this community decides to have

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**APPENDIX 4**

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**CONSENT FORM**

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Dear Sir/Madam,

Good day to you!

My name is Esther Chinonso Ekechukwu. I am a student of the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan. I am presently carrying out a research to determine the Influence of male involvement in early childcare on their fertility desires in Ibadan North LGA, Oyo State.

Findings from this research will add to the body of existing knowledge in areas of parenting and men's fertility desires; and can provide insight into male involvement in maternal and child care during pregnancy, delivery and post-delivery period and its possible influence on family planning uptake.

You will not need to mention your name but you will be given a serial number. Your responses and opinions will be kept confidential. They will not be used against you but will be used to protect you as an autonomous person where the need arises.

Your candid opinion will be appreciated. You are free to accept to participate or not to participate. You are also free to withdraw from the study during the course if you wish without victimization.

CONSENT: Now that detailed information about the study has been explained to me, and I fully understand, I am ready to participate in the study.

\_\_\_\_\_  
Signature of Participant

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Signature of Interviewer